Maternal and Child Health Services Title V Block Grant

Hawaii

FY 2023 Application/ FY 2021 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 3, 2022

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) 2023 (October 1, 2022 – September 30, 2023). The FY 2023 application and FY 2021 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,

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: January31, 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 (39% Asian, 25% White, 11% Native Hawaiian/Pacific Islander, 2% Black) and a large heterogeneous Pacific Islander and Asian population. Nearly 23% of the population is mixed race with indigenous Native Hawaiians comprising 20.1% of the population (when combined with other races). Also, about 19.3% 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 (MCH) 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.

For FY 2021, Hawaii identified eleven Title V priorities, adding four additional state priorities in 2021 resulting from the COVID pandemic. The priorities are listed below across the six Title V MCH population domains.

Population Domain	State Priority Need
Women's/Maternal Health	Promote reproductive life planning
Perinatal/Infant Health	Increase the rate of breastfeeding
	Reduce food insecurity for pregnant women and infants through WIC program promotion and partnership
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
	Promote child wellness visits and immunizations among young children ages 0-5 years
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 transition to adult healthcare
Cross-Cutting	Address health equity by expanding pediatric mental health care access in rural and underserved communities
	Address health & digital equity by expanding access to telehealth services in underserved communities

COVID in Hawaii

Hawaii managed the COVID-19 pandemic better than many other states. This was reflected in some of the lowest COVID case numbers, hospitalizations, and deaths in the U.S., despite severe COVID variant surges over 2021-2022. Aptly, the Commonwealth Fund ranked Hawaii number one among states in managing COVID response in June 2022.

Policy: Hawaii's success relied on the ability to restrict all travel early in the pandemic and the State's close adherence to Centers for Disease Control (CDC) safety guidelines and cautious loosening of safety mandates/restrictions. Governor David Ige acted swiftly in 2020 at the first signs of travel-related cases, issuing the first of 21 COVID-related emergency proclamations in March 2020. Mandatory shutdowns of non-essential services; stay-at-home orders; self-quarantine for all travel within and entering the state; limitations on gatherings; mandated mask wearing; and physical distancing were ordered to reduce disease spread. The State also implemented active COVID-19 testing and contact tracing.

The State cautiously relaxed COVID restrictions to reopen the economy, including the launch of the Hawaii Safe Travels program in October 2020, requiring proof of vaccination or a negative COVID test to avoid quarantine for all travelers. A severe COVID Delta variant surge in summer 2021 followed by another winter Omicron surge delayed lifting of all COVID restrictions till March 2022. Hawaii was the last state in the U.S. to end an indoor mask mandate although masks were still required for public schools through the remaining school year.

COVID: The state reported a cumulative 283,574 COVID-19 cases and 1,482 deaths as of June 2022. Compared to June 2021, cases increased 585% and deaths increased 172%, reflecting the effects of the surges related to COVID variants. The Omicron surge led to a wave of infections greater in magnitude than the Delta wave; however, hospitalizations and deaths were far lower than 2021 levels. Hawaii's cumulative death rate of 99/100,000 is the lowest in the country.

COVID highlighted long-standing disparities with Native Hawaiian, Filipino, and Pacific Islanders experiencing higher rates of infection and death. With targeted messaging and concerted outreach to these communities, disparities have improved somewhat. Pacific Islanders remain overrepresented in total cases but whites are now also overrepresented. Sadly, Pacific Islanders and Filipinos are still much more likely to die of COVID-19 than other ethnic groups.

Vaccinations: The coordinated actions by Hawaii state, county and private healthcare partners also contributed to Hawaii's successful COVID management by expanding the availability of testing, vaccinations, and therapeutics. As of July 2022, 79.3% of Hawaii's population was fully vaccinated, the sixth highest rate in the U.S., with another 40% receiving a booster dose. An estimated 78% of youth ages 12-17 years old and 40% of children 5-11 years old have been fully vaccinated.

Economic Impact of Closures: Initial COVID shutdown saw an unprecedented contraction of the state's economy:

- There was a 98.8% decrease in travelers to the state in April 2020.
- Hawaii's unemployment rate rose from 2.1% in March 2020 to 21.9% in one month, the lowest to the highest rate in the country.
- Food banks in the state reported serving 60% more people than prior to the pandemic.
- Enrollments for government assistance soared with 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 WiFi were left with limited or no access to educational, health, or social resources.

Recovery: In 2021, the economy made an astounding turn around fueled by an unexpected domestic tourism rebound, with visitor arrivals reaching nearly 90% of 2019 levels. Unemployment came down sharply; however, many workers who left the labor force during the pandemic have not returned, resulting in a very tight labor market. An unprecedented level of federal spending provided essential support for the state economy. Direct aid to state and local governments offset significant budget shortfalls. Direct stimulus payments, expanded unemployment insurance, entitlement supports, and subsidies helped to maintain personal income through 2020-21. Continued recovery remains uncertain given everchanging factors: rising inflation, record high home prices and rents, flat international visitor market, and the course of COVID variants.

Response: The Department of Health (DOH) 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 coordinated the statewide development and dissemination

of COVID safety practices, data, resources, and funding throughout the prolonged pandemic response.

Title V Programs/Services: Though the pandemic, Title V programs continued to embrace flexibility in response to changes in service delivery, population needs, and new norms. Programs shared relevant guidance, resources, and messaging to help community partners and families during COVID. Although hampered by vacancies in critical data positions, FHSD continued monitoring/collecting data in new partnerships with university researchers. Programs supported more efforts to address health disparities, exacerbated by the pandemic. FHSD also acknowledged existing public health and healthcare workforce needs to minimize burnout and staff turnover.

In 2021, Title V programs, as reported in Form 5a, continued to see declines in direct client services with a 32.7% reduction over 2019 numbers. The 2021 decrease was not consistent across all program and population groups and also reflects the loss of Title X Family Planning funding. Other public health services, as reported in Form 5b, reflect a 37.4% increase in outreach to adults and a 47.5% increase in outreach to children compared to 2019. This was largely due to more media initiatives to provide critical updates on services and health messaging/guidance.

5-Year Plan Changes for 2021-2025

FY 2021 marks the first year of the Title V 5-year project period. Four new state priorities were added last year as a result of pandemic impacts and federal funding opportunities.

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

Revisions to plan strategies and activities continued with delays in the plan implementation as a response to everchanging pandemic circumstance/conditions. Key highlights are provided by domain and priority health issue.

DOMAIN: WOMEN'S/MATERNAL HEALTH

Promote reproductive life planning

- In partnership with the Hawaii Maternal Infant Health Collaborative (HMIHC), Hawaii continues to implement two evidence-based strategies to 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). OKQ training is now offered online with over 1,000 providers trained. Most Hawaii birthing hospitals now stock LARC for same day access.

DOMAIN: PERINATAL/INFANT HEALTH

Promote safe sleep practices

- Conducted a media campaign using TV, radio, and digital ads to promote safe sleep messaging and resources available through the statewide The Parent Line (TPL). TPL staff were trained on safe sleep information and safe sleep materials (available in 11 languages), which can be mailed or downloaded from the website. Families may also access safe sleep online workshops.

Address Food Insecurity through Improving WIC services

- Partnered with the Hawaii Children's Action Network and received a Partnership for Children grant to help improve WIC services. A Community Advisory Committee was formed with community programs, university researchers, as well as three WIC parents. Maintaining long-term enrollment of WIC families and addressing underutilization of benefits are the key priorities identified. A research study of WIC families will help identify potential recommendations to pursue.

DOMAIN: CHILD HEALTH

Improve early and continuous screening for developmental delay

- Established a community-based model for development screening, referrals, and supports for children in Maui County, which was funded by the Early Childhood Comprehensive Systems (ECCS) Impact grant. Funding helped to screen over 800 children, create a network of healthcare and service providers to promote developmental screening, and establish a parent leadership council to help guide grant activities.
- Partnered with American Academy of Pediatrics on a Centers for Disease Control (CDC) Act Early grant to promote development screening through trainings of pediatric and other service providers. Projects included training of WIC clinical staff to pilot a developmental checklist, launching a social media campaign with parent social media influencers, and translating education information to reach Pacific Islander populations.

Reduce the rate of child abuse and neglect (CAN)

- Forged critical partnerships to promote evidence-based prevention practices in collaboration with the state's Child Welfare Services (CWS), Judiciary, Department of Education (DOE), and community service providers. Supported implementation of the CWS five-year Service Plan by sponsoring community-based projects that prevent CAN through family and parenting support programs and activities.
- Supported statewide trainings/information dissemination to increase awareness about adverse childhood experiences and promote trauma-informed care models of practice.
- Maintained MIECHV evidence-based services for at-risk families.

Increase Child Wellness Visits

- Launched a media campaign to promote child wellness visits. Resources and a website were developed to assist families without regular sources of care. Families from the Hawaii Parent Leadership Training Institute tested messaging and appeared in the TV spots. Planning partners included the AAP-Hawaii, state Medicaid program, and Hawaii Children's Action Network.

DOMAIN: ADOLESCENT HEALTH

Improve adolescent health and well-being

- Partnered with TeenLink Hawaii, a youth-driven, empowerment program, to conduct a survey to identify health issues/concerns for youth during the pandemic. Based on the survey findings, website resources were developed to address priority issues, and a media campaign was launched to promote the TeenLink website using popular social media 'influencers.'
- Developed a scope of work to partner with the Pacific Islander community to identify needs/resources to support well-being of Pacific Islander youth.

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 2021.

DOMAIN: CROSS-CUTTING/SYSTEMS BUILDING

Expand telehealth services to underserved rural communities

- Implement $5M CDC Health Equity grant award to establish 15 new telehealth access points with health and digital navigators in public libraries located in underserved communities statewide.

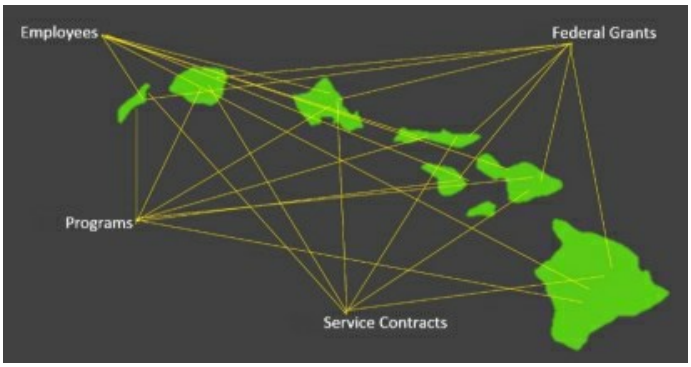
Expand pediatric mental health care access to underserved rural communities

- Support integration of behavioral health into pediatric primary care practice by establishing a pediatric mental health teleconsultation service, training, and care coordination so pediatric providers can better diagnose, treat, and/or refer children and youth with behavioral health conditions to available services.

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, 26 federal grants, and approximately 150 service contracts with community-based organizations totaling roughly $60 million—all with 277 FTE positions statewide.

Title V funds played a critical role in supporting the state's overall MCH efforts. In 2021, the FHSD budget was $100.3M million. Nearly $2.1 million was provided by Title V, with $45.3 million state matching funds and an additional $45.7 million in other federal funds. Of the state's overall population, FHSD programs reached an estimated 99% of pregnant women; 99% of all infants; 66% of children 1-21 years of age, including 24% of children with special health needs; and 42% of others (general adult population).



Title V funds were used for key program capacity and public health infrastructure positions needed to administer MCH programs statewide (19.55 FTE). Positions included: 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.

III.A.3. MCH Success Story

Given the greater social isolation experienced by families and the limited availability of direct services during COVID, Title V decided to use mass media efforts to promote safe sleep messaging. In 2021, a Safe Sleep media campaign was planned to educate parents and caregivers as part of October's Safe Sleep and SIDS Awareness Month. The supervisor for the Family Strengthening and Violence Prevention (FSVP) Unit under the MCH Branch (MCHB), who serves as the Title V program lead for safe sleep, worked with the Title V-funded Information Specialist to launch a paid media campaign to promote safe sleep.

A 30-second TV spot and display ads were developed using the ABC messaging (Alone, on their Backs, in a Crib), which are the evidence-based recommendations from the American Academy of Pediatrics. The creative mirrored the content of a widely used Hawaii *Safe Sleep Guide for Parents*. The guide was jointly developed in collaboration with several state agencies. Safe Sleep Hawaii, a statewide coalition that promotes safe sleep efforts, reviewed the content before its release. The call to action for the campaign steered the public to Safe Sleep information available via The Parent Line, which is the primary Title V hotline.

The planned Safe Sleep media campaign launched in October 2021 as part of the Safe Sleep and SIDS Awareness Month. A press release announced the campaign, with interview spots scheduled on the major morning television news programs as part of the added value negotiated with the media buys. The television and digital spots ran through December 2021, reaching approximately 590,819 people/households; with over 6 million impressions (total amount of times our ad is seen or heard). The combined digital and social media spots totaled 863,824 total virtual contacts.

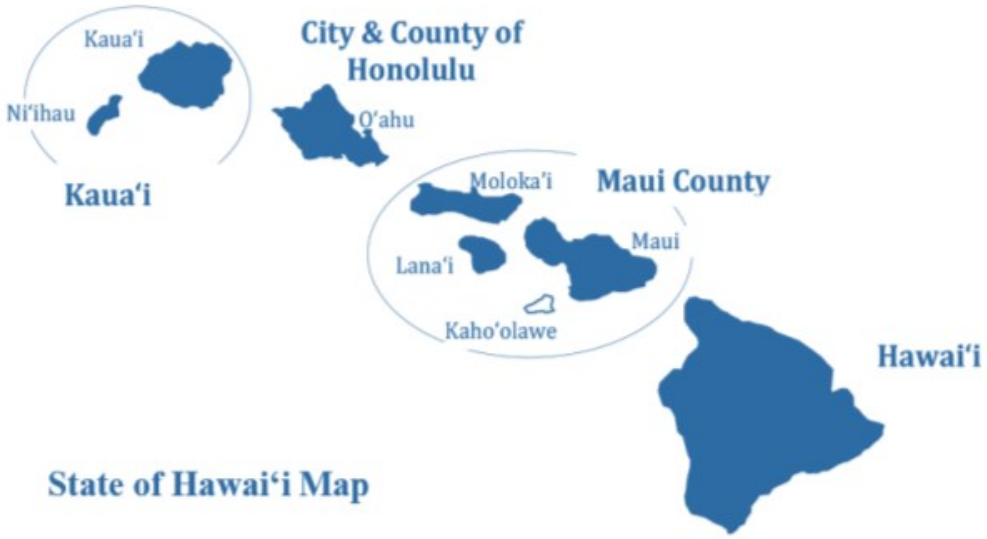
The Information Specialist negotiated the media buys with major broadcast and cable TV stations, including KHON2 (Fox affiliate), Hawaii News Now (NBC and CBS affiliate), and Spectrum. Locally, safe sleep messaging has not been widely disseminated to the general public and the paid media campaign increased access to key information for a wider range and more diverse population. With paid media as part of a larger safe sleep communications plan, greater strides can be made to meeting objectives related to improving the number of infants being placed on their back to sleep, on a separate approved surface, and without objects or loose bedding.

As safe sleep messaging is always relevant, the FVSP Supervisor is working with the FHSD Information Specialist to create a plan and budget to continually push that messaging out to the public. This includes plans to better target high-risk and underserved populations, which means expanding translations for all campaign materials and finding the most appropriate and effective mediums to reach these communities.

III.B. Overview of the State

GEOGRAPHY

Situated in nearly the center of the Pacific Ocean, Hawaii 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 United States. Hawaii is the 11th smallest state in the nation 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. Counties 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. 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 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

Due to the impact of COVID-19, 2020 Census data for population estimates is not available. Instead of providing the standard 1-year data products, the Census Bureau released experimental estimates from the 1-year data. This includes a limited number of data tables for the nation and states, but no county information. Therefore, information from 2019 data is provided here.

The estimated 2019 state population is 1,415,872 residents, the 30th most populous state in the U.S. Oahu is home for 69.0% (980,080 residents) of the state's population, while 14.2% (201,513 residents) live on 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 the most ethnically diverse state in the nation,[1] with no single race majority. According to the 2019 American Community Survey (ACS) data, 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 the indigenous Native Hawaiians (6.4%). The individual Asian and NHOPI subgroups from the U.S. Census are listed in the table below, and shows the heterogeneity of these aggregated race groupings.

Asian	Native Hawaiian and Other Pacific Islander
013 - Asian Indian	051 - Polynesian
014 - Bangladeshi	052 - Native Hawaiian
015 - Cambodian	053 - Samoan
016 - Chinese	054 - Tongan
017 - Chinese (except Taiwanese)	055 - Micronesian
018 - Taiwanese	056 - Guamanian or Chamorro
019 - Filipino	057 - Melanesian
020 - Hmong	058 - Fijian
021 - Indonesian	088 - Tahitian
022 - Japanese	089 - Tokelauan
023 - Korean	091 - Carolinian
024 - Laotian	092 - Chuukese
025 - Malaysian	093 - I-Kiribati
026 - Pakistani	094 - Kosraean
027 - Sri Lankan	095 - Mariana Islander
028 - Thai	096 - Marshallese
029 - Vietnamese	097 - Palauan
030 - Other specified Asian	098 - Pohnpeian
072 - Bhutanese	099 - Saipanese
073 - Burmese	162 - Yapese
075 - Mongolian	164 - Papua New Guinean
076 - Nepalese	
077 - Okinawan	
078 - Singaporean	

Reporting is further complicated by the growing category of those that report two or more race groups. They are not included in the single race groups commonly reported. Hawaii Department of Health (DOH) guidance instructs race data to be reported as “Alone” or “Alone or in Combination” with another group. For example, Native Hawaiians accounted for 25.1% of the state population when reported as “Alone or in Combination,” compared to just 6.4% when 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 Asian subgroups that 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.

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%
Native Hawaiian Alone	90,070	6.4%	0
Native Hawaiian Alone or in Combination	284,996	20.1%	65.9%
Asian Alone	547,843	38.7%	0
Asian Alone or in Combination	801,987	56.6%	31.7%
Filipino Alone	221,724	15.7%	0
Filipino Alone or in Combination	371,528	26.2%	33.6%
Japanese Alone	172,049	12.2%	0
Japanese Alone or in Combination	306,129	21.6%	31.3%
Chinese Alone	81,209	5.7%	0
Chinese Alone or in Combination	*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. 2020 data is not available due to the impact of COVID-19.			

Immigration

Hawaii is considered a gateway to the U.S. for immigrants from Asia and the Pacific, and has a sizeable immigrant community. Based on the 2019 ACS, 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. Hawaii's immigrants were 58.9% women and 5.9% children (under 18 years old). The largest ethnic group of immigrants comprised of Asians (74.7%), followed by NHOPI (10.9%), and White (8.6%).

Most immigrants in Hawaii (81.6%) speak a language other than English, and 49.3% speak English less than "very well." About 19.2% had a bachelor's degree, and 7.6% had a graduate or professional degree. Approximately 60.3% of immigrants 16 years and over were employed in labor force in 2019.

Undocumented Immigrant Estimates

According to the Pew Research Center, in 2016, there were an estimated 45,000 undocumented immigrants in Hawaii (3.3.% of the population).[2] The majority were from the Philippines. Hawaii was 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	45,000 (3.3% of population)	10.7 million (3.3% of population)
Proportion of all immigrants that are undocumented	17.0%	24.0%
Proportion of adults that have been in the U.S. 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 March 2020, 340 active DACA recipients live in Hawaii, with 368 people granted DACA status since 2012.[3] As of 2019, 11% of those DACA-eligible immigrants in Hawaii had applied for DACA status.

Compacts of Free Association (COFA)

COFA migrants come from the Federated States of Micronesia, Republic of Marshall Islands, and Republic of Palau. Under these unique agreements, COFA migrants are legally residing noncitizen nationals who can freely live, work, and study in the U.S. without a VISA or green card, indefinitely. This status was negotiated in exchange for exclusive U.S. military control to 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. However, in December 2020 Medicaid benefits were restored to COFA migrants with the passage of federal legislation sponsored by Hawaii's congressional delegation.

Among COFA migrants, there are reports of high rates of morbidity due to chronic diseases, communicable diseases (tuberculosis), and other medical concerns (i.e., cancer) that may be related to U.S. nuclear tests conducted in their Pacific nations. Challenges also exist due to language and cultural barriers within the population. Estimates of the COFA population in Hawaii range from 16,680 (U.S. Department of the Interior) on the low end to 28,000 on the high end (University of Hawaii).[4] COFA migrants are consistently overrepresented among homeless surveys (roughly 1,000 migrants) and account for about 2-3% (400-600) of births annually in Hawaii, with low utilization rates of prenatal care and high rates of low birth weight and Neonatal Intensive Care Unit (NICU) admissions.[5]

In 2019, the Title V agency served an estimated 4,371 COFA migrants at a cost of $2.7 million. Programs reporting service to COFA clients included: WIC; state-funded Primary Care (for uninsured/underinsured); Maternal, Infant, and Early Childhood Home Visiting 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. According to the 2019 ACS, 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.[6]

In School Year 2019-20, an estimated of 18.0% of the state's public school students are or have been English Learners (EL).[7] The top five languages spoken by Hawaii public school students are Ilokano, Chuukese, Marshallese, Tagalog, and Spanish.

Hispanics

Like much of the U.S., Hawaii has areas of growing Hispanic population. Anecdotally, recent Hispanic workers to the state have helped address labor shortages in agriculture (coffee and pineapple farms) as well as the service and construction industries, primarily in Maui and Hawaii counties. Service organizations report they originate from Mexico, Guatemala, and Honduras.[8]

Disaggregated Data

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

Military

Other subpopulations within the state include the U.S. Armed Forces personnel and their family members which, in 2020, comprised an estimated 7.1% of the state's population (100,594 people).[9] 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.

Homeless

Hawaii's 2021 Point-in-Time homeless study estimates the number of sheltered homeless for Oahu was 1,853, and for the neighbor islands was 636, with a total of 2,489 sheltered homeless individuals in the state.[10] Data for unsheltered homeless individuals is not available for 2021. There was a 11.8% decrease in sheltered homeless when compared to 2020 data for Oahu (2,102) and about a 9.9% decrease in sheltered homeless for neighbor islands (706).

Maternal and Child Population

Based on 2019 data, the 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. Vital statistics data show the number of births continued to decrease between 2019 (16,810), 2020 (15,780), and 2021 (15,608).

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 2019-2020 National Survey of Children with Special Health Care Needs (CSHCN), there are an estimated 43,575 CSHCN, representing 14% 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 aged 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. Initial COVID shutdowns in 2020 resulted in the virtual closure of Hawaii's tourism market, causing an unprecedented contraction of the state's economy. Equally unexpected, the economy made an astounding rebound in 2021 with the return of U.S. domestic travelers, driven by healthy U.S. incomes and pent-up demand.

The recovery is reflected in the 2022 State of the Economy report published by the Hawaii Department of Business, Economic Development and Tourism (DBEDT),[11] showing the state's major economic indicators were mainly positive in the fourth quarter of 2021. Visitor arrivals, wage and salary jobs, state general fund tax revenues, and private building authorizations all increased in the 2021 fourth quarter compared to the fourth quarter of 2020.

Tourism

In 2020, during the COVID-19 pandemic, total visitor arrivals decreased by 7,556,762, or 73.8%, and the average daily census decreased 167,699, or 68.2%. However, in 2021, Hawaii experienced a sudden surge in visitor numbers in the second quarter, aided by the availability of COVID vaccines, reduced disease counts, and loosening of safety restrictions across the U.S. By the fourth quarter of 2021, domestic visitor arrivals and, to a lesser extent, international visitor arrivals both increased. The total number of visitor arrivals increased 1,420,798, or 285.8%, in the fourth quarter of 2021, compared to the same quarter of 2020.[12]

Despite the increases, visitor expenditures remained below pre-pandemic levels. In 2021, visitor expenditures totaled $12,995 million, a decrease of $4,662 million, or 26.4%, from 2019. The absence of the lucrative Asian market and short-lived visitor reductions during COVID variant surges account for the slower recovery.

Unemployment

Hawaii's unemployment rate soared during the early COVID-19 pandemic shutdown from 2.4% in March 2020, the lowest rate in the nation, to 23.8% in April 2020, the highest rate in the nation. The 2020 average annual unemployment rate was 11.6% but decreased to 5.7% in 2021 (compared to the U.S. average of 5.3%) as the economy rebounded with the return of the tourism market.[13] Hawaii unemployment ranked the 15th lowest among the 50 states in 2021.

Job Market

Labor market conditions were mainly positive for 2021: Hawaii averaged 583,000 jobs, an increase of 46,300 jobs, or 8.6%, from 2020. The largest increase was in Accommodations (Hotels & Resorts), which increased by 90.2%, followed by Food Services and Drinking Places (25.6% increase). The construction sector increased 1,600 jobs, or 4.5%, compared with the same quarter of 2020.[14]

Wages

According to 2020 data from the U.S. Bureau of Labor Statistics, the average annual wage for employees in Hawaii was $57,934, $6,087, or 9.5%, lower than the U.S. average. Hawaii ranked 23rd among the 50 states. This was roughly a 10% increase over 2019 despite COVID shutdowns. Economists believe this is largely due to direct federal stimulus payments/supports, including supplemental unemployment insurance benefits.

Income

Per capita real income for Hawaii also increased in 2020 ($56,840) and 2021 ($60,389) by 3.5%, even as real earnings from jobs fell by more than 6%. As noted, income loss from the economic shutdown was offset by government stimulus/relief supports.[15] Federal income and housing support programs were crucial in preventing economic collapse for some families and communities.

Data Limitations: Standard income/wage indicators were not able to measure the disparate effect on high- and low-income workers. During the pandemic, professional workers were able to continue work in relative safety (remotely) through 2021, while many lower-income households were dependent on face-to-face service jobs that were hardest hit by COVID. This led to disproportionate economic hardship for these families. This divergence in economic (social and health) impacts reflected pre-existing structural inequalities.

State Budget/Revenues

The state general fund revenue for 2021 ($8.15M) increased by 27.0% over 2020 ($6.42M).[16] This reflected robust tax collections stemming from the rapid recovery of tourist arrivals, renewed consumer spending, additional tax collections due to inflation, and a significantly larger share of the transient accommodations tax on visitors. Based on this, the State Council on Revenues (Council) increased its forecast for revenue growth from 15.0% to 21.0% for fiscal year (FY) 2022.[17] However, it lowered its forecast from 6.9% to 6.0% for FY 2023.

The Council acknowledged the risks that may inhibit the economic recovery include new variants of the COVID-19 virus; an aggressive monetary policy response from the Federal Reserve to combat inflation; high oil and commodity prices; the economic disruptions associated with the war in Ukraine; supply chain disruptions; sustained travel restrictions in Asian markets due to the pandemic; and the reduction in Federal stimulus spending.

Poverty

Based on 2019 ACS 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 on 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% points higher than the official poverty rate of 10.5%.[18]

ALICE Report

Hawaii's United Way agency tracks working residents who live just above the poverty level and are unable to afford basic necessities through a survey titled Asset Limited, Income Constrained, Employed (ALICE).[19] In 2018, there was 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 FPL. In 2020, the Hawaii Data Collaborative revised this estimate upward to 59% of households that were ALICE during the initial year of the pandemic.[20]

The reason for the high percentage of ALICE households is:

- Low-wage jobs dominate the economy.
- 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. 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. 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 April 2022, the median housing cost for a single-family dwelling on Oahu was $1,105,000 and for a condominium was $510,000.[21] Based on ACS 2019 1-year estimate, 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* on housing, 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. Based on the ACS 2019 1-year estimate, 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 of rent among the 50 states.

Multigenerational Households

For some groups, cultural preference and tradition have led to multigenerational 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,[22] 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 Hawaii.[23] 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 system sites. Maps of these facilities are in the Supporting Documents section.

Healthcare Workforce

There are 350 family and general practitioners, 190 obstetricians and gynecologists, and 240 pediatricians in the state.[24] Based on the 2020 population estimate (1,407,006), there are 13.5 per 100,000 population obstetricians and gynecologists, which is significantly higher than the national rate (5.7 per 100,000 population). There are 17.1 pediatricians per 100,000 population, which is significantly higher than the national estimate (8.4). The rate for family/general practitioners (24.9 per 100,000 population) is similar to the national rate (29.9). Despite Hawaii's high ratio of providers to population, many of the state's medical and specialty providers are located on Oahu, and most of the state's rural communities are designated as shortage and/or medically underserved areas.

COVID exacerbated Hawaii's healthcare workforce shortages for the state's rural counties but also created shortages for some professions on Oahu. During the COVID Delta and Omicron variant surges in 2021-2022, the state flew in hundreds of emergency healthcare workers to address shortfalls at hospitals and long-term care facilities. Strains on Hawaii's healthcare workforce continued into 2022.

Healthcare Shortage Designations

Shortage Designations are a representation of an area's or population's need based on several factors, including health professional presence, socioeconomic and demographic data, language barriers, health indicators, 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 designations 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 designations include the six major islands of Kauai, Maui, Molokai, Lanai, Hawaii Island, and Oahu. Hawaii's dental health HPSA designations 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 MUAs 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 having a shortage of health resources (manpower, facilities, services) or a population group having a shortage of such services. Hawaii's MUPs 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. Prior to the COVID public health emergency, the number of people enrolled rose significantly from 292,423 in 2013 to about 345,231 in 2019.[25] 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.

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
- Prohibiting health insurance entities from using an individual's gender to determine premiums or contributions

Through these efforts, Hawaii consistently reports low uninsured rates: 4.5% in 2019.

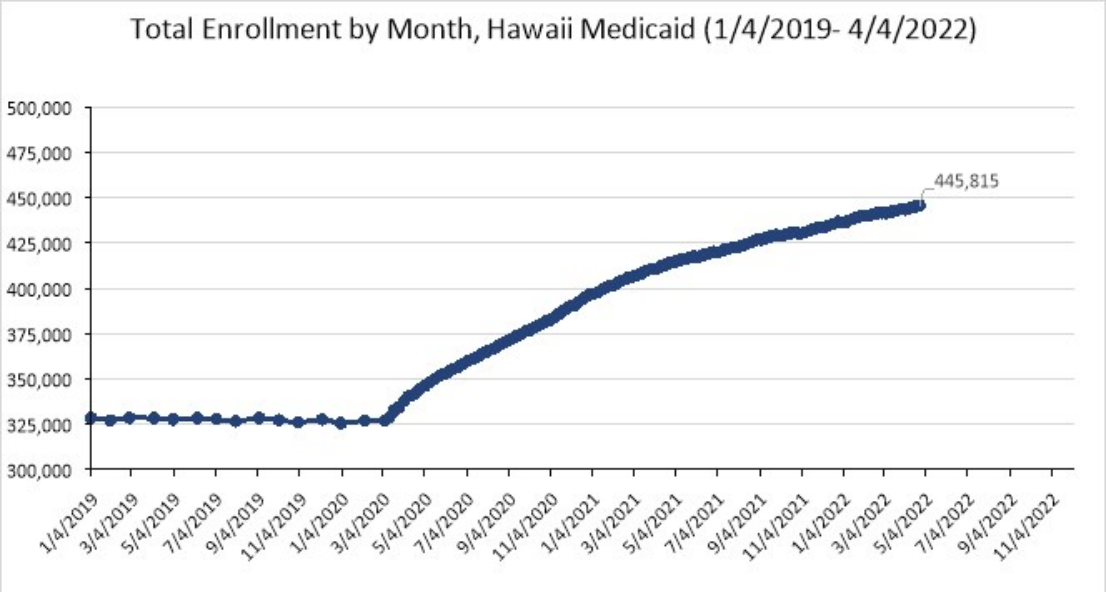
MEDICAID

The Department of Human Services (DHS) Med-QUEST Division (MQD) administers the state Medicaid program (QUEST). The QUEST program is designed to provide **Q**uality care, **U**niversal access, **E**fficient utilization, **S**tabilizing costs, and to **T**ransform 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 beneficiaries, 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 are about average for pregnant women and parents.

- Children ages 0-18 qualify with family income up to 300% of the FPL.
- Pregnant women qualify with family income up to 191% of the FPL.
- Parents and other adults qualify with family income up to 133% of the FPL.

During the COVID public health emergency, Medicaid was not permitted to disenroll any individuals from coverage. Hawaii Medicaid enrollments increased by 36.3% for the duration of the pandemic, with over 445,815 new enrollees statewide from March 2020 to April 2022. The County of Maui had the largest increase (41.5%) in enrollment since March 2020, compared to other counties. Kauai County had a 38.3% increase in enrollment, Honolulu County had an increase of 37.2%, and Hawaii County had an increase of 30.1% in total enrollment since March 2020.



Of the 445,815 individuals enrolled in Medicaid, 163,096 are children through traditional, CHIP, and current and former foster care eligibility rules.[26] The Medicaid Program also provided coverage for 2,742 pregnant women. Additionally, the program continues to support medically needy children who require nursing home level of care.

Adult COFA migrants who make up a large proportion of the Pacific Islander population in Hawaii have not been eligible for federal Medicaid coverage since the 1996 Personal Responsibility and Work Opportunity Reconciliation Act. After December 27, 2020, following hard-fought efforts by many, federal Medicaid eligibility was finally restored to COFA citizens. As of February 7, 2022, there were 9,257 COFA adults enrolled with Med-QUEST.

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 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 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.

Governor David Ige's second term ends in December 2022 when a new administration will be sworn in after the November General election. The DOH Director is Elizabeth Char, M.D. (appointed in 2021 during the pandemic); the former FHSD Chief, Danette Wong Tomiyasu, MBA, is the Deputy Director for HRA; and Matthew J. Shim, Ph.D., MPH, is the current FHSD Chief/Title V Director.

STATUTORY AUTHORITY

The Title V agency, FHSD falls within the purview of Title 19 Chapter 321 of the Hawaii Revised Statues. For listing of statutes pertaining to the division programs, see the Supporting Documents.

Legislature

With a $2B surplus, the 2022 Legislature was one of the most significant sessions in state history, passing long-awaited bills to alleviate financial hardships on Hawaii's families:

- Approved $1B for affordable housing, including $600M for the Hawaiian Homelands program, finance starts for low-income rental housing projects, and expanded public housing projects
- Raised the minimum wage to $18 by 2028
- Made the state Earned Income Tax credit for low-income families permanent
- Approved Medicaid funding to extend postpartum coverage to 12 months and restored adult dental preventive benefits
- Restored funding for preschool subsidies and funding to expand pre-kindergarten classrooms
- Passed a bill to collect data on the state's childcare workforce, which is the first step in solving the current childcare crisis

Specific bills impacting FHSD programs included: mandating reporting of newborn hearing assessments to assure follow-up and convening stakeholders to establish consistent standards for hearing and vision screening and follow-up.

COVID-19 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.

Governor Ige acted swiftly in 2020, issuing the first of 21 COVID-19 related emergency proclamations in March 2020 at the first signs of travel-related cases and preceding the federal government's response to the pandemic. Mandatory shutdowns of non-essential services; stay-at-home orders; self-quarantine for all travel within and entering the state; limitations on gatherings; and mandated mask wearing and physical distancing were ordered to reduce disease spread. The state also implemented active COVID-19 testing, contact tracing, and once available, implemented vaccinations to mitigate disease impacts.

COVID-19 cases and deaths, as a result of these actions, were minimized. As of June 2022, the state reported a cumulative 283,574 confirmed COVID-19 cases and 1,462 deaths. Compared to June 2021, cases increased 585% and deaths increased 172%, reflecting the effects of the smaller but more lethal summer wave of the Delta variant and the winter surge of the Omicron variant. The most recent wave of Omicron subvariant infections has led to

a wave of infections greater in magnitude than the Delta wave; however, hospitalizations and deaths are far lower than 2021 levels. Hawaii's cumulative death rate of 99/100,000 is the lowest in the country (Statista, 2022). Whites and Pacific Islanders are overrepresented in total cases, while Pacific Islanders and Filipinos are much more likely to die of COVID-19.

The coordinated actions by Hawaii state, county, and private healthcare partners also contributed to Hawaii's successful COVID-19 management by expanding the availability of testing, vaccinations, and therapeutics. As of July 2022, 79.3% of Hawaii's population was fully vaccinated, the sixth highest rate in the U.S., with another 40% receiving a booster dose. An estimated 78% of youth 12-17 years old and 40% of children 5-11 years old have been fully vaccinated.

The DOH 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 the largest federal fiscal support on record as COVID-19 stalled economic recovery. Federal support helped to bring the pandemic under control by replacing lost tax revenue, strengthening support for vital public services, providing assistance to individuals and households, and helping to retain jobs.

Data from the U.S. Census Pulse survey helped track impacts on families and individuals during the pandemic through periodic surveys. Overall, responses from Hawaii mirror those on the mainland as a whole.

- Health and economic well-being have improved marginally since the beginning of the COVID-19 pandemic in both Hawaii and nationally, though these improvements are fragile and subject to change during infection surges.
- Households with children reporting difficulty paying for usual household expenses have remained steady over the pandemic for both Hawaii and the U.S., at roughly 40% of respondents.
- Food sufficiency and health insurance coverage tend to be better in Hawaii than nationally.
- While food insecurity has improved since June 2020, one in four families with children still report difficulty affording food purchases in April 2022.
- Childcare disruptions have become an increasing burden for parents returning to work, particularly since the Omicron wave of infections during winter 2021-22.
- The Delta and Omicron waves saw greater loss in income for households with children in Hawaii than nationally, though recently these differences have receded.
- Hawaii's proportion of households with children where housing was insecure was slightly lower than the national estimate early in the pandemic, became substantially higher in late 2021 and early 2022, and has since returned to pre-pandemic levels.
- Rates of depressive symptoms have not improved over the past few years, and disparities in mental health status are striking, with those of two or more races far more likely to report poor mental health status than Asians or Whites.
- In both Hawaii and the U.S. as a whole, there has been a substantial and steady decrease in the proportion of adults in households with children using telehealth or delaying medical care due to the pandemic. These indicators suggest that residents are increasingly confident and able to access medical care compared to earlier in the pandemic.[27]

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.

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III.C. Needs Assessment
FY 2023 Application/FY 2021 Annual Report Update

The impact of the COVID-19 pandemic is unprecedented in this generation and has far ranging impacts across the health, economic, education, and employment sectors in Hawaii. The Overview narrative captures much of the timely available data.

Ongoing NA builds upon the method and findings of the 2020 Five-Year Needs Assessment and continues using a mixed methods approach for data collection and evaluation purposes with the same guiding principles: 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.

In addition to reviewing primary and secondary data sources, NA efforts involved collecting input from staff/programs and engaged external stakeholders in discussions of ever-evolving conditions and emerging needs and changing priorities. The information supports and informs Hawaii's Title V planning, decision-making, and resource allocation.

The Title V Federally Available Data (FAD)[1] continued to serve as the primary data source for ongoing needs assessment. The FHSD research statistician completed most of the data analysis and a summary highlighting trends and subgroup analyses to identify disparities can be found in the Supporting Documents. Because the FAD utilizes the federal race/ethnicity classifications, state vital statistics data may be used to report data for Hawaii detailed ethnicity groups.

Services were also contracted to review the data analysis and assist with data interpretation since FHSD epidemiology vacancies persist. The epi assistance, while very helpful, was not available to allow for in-depth review, discussion with staff/stakeholders, or development of more substantive findings. In general, FHSD had difficulty finding qualified epidemiologists who are knowledgeable and experienced working with diverse population-based MCH datasets. Unfortunately, there are no dedicated MCH faculty in Hawaii public health university programs. Thus, data findings and activities have been limited when assessment is a critical public health function.

C.1.a. Ongoing Needs Assessment Activities

Several needs assessment activities were completed or in progress through contractual services:

- Title V epi support for this annual report was secured through an epidemiology doctorate graduate from the MCH Center of Excellence at the University of California-Berkeley.
- The University of Hawaii (UH) Center for Disabilities Studies is assessing children and youth with special health needs using data from the National Survey of Children's Health (NSCH), conducting a survey of youth with special health needs (translated into several languages) and follow-up focus groups.
- Collaboration with the MCH LEND (Leadership Education in Neurodevelopmental and Related Disabilities) program to conduct focus groups with CSHN families as part of research training curriculum were complete. A final report is forthcoming.
- Working with youth through TeenLink Hawaii to assess health concerns during COVID through youth surveys.
- Domestic Violence Action Center using Pacific Islander staff conducted focus groups/interviews with Pacific Islander youth regarding health concerns/issues.
- A Title V program survey was conducted on family engagement activities/needs.
- The PRAMS 2020 data is now available on through the DOH Data warehouse.

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

Four new state priorities were added in FY 2021 in response to COVID 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

The most recent data suggest that the health status of the MCH population in Hawaii overall remains similar to or better than the national average on many health indicators. However, there are some concerning trends that suggest worsening health in certain key areas. In particular, the increase in severe maternal morbidity (SMM) rate and postpartum depression is concerning. Children's health status shows some signs of worsening, especially in physical activity and routine vaccinations; some evidence suggests that children's overall well-being maybe worsening. Adolescent health indicators are generally stable.

Persistent racial and ethnic disparities continue. In general, White, Japanese, and Chinese groups fare better on most health outcomes compared to those of Filipino, Native Hawaiian or Other Pacific Islander race, and multiple races. These latter groups tend to fare worse on socioeconomic indicators, reflecting structural discrimination and a need for greater investment/partnership to improve health outcomes.

It is important to note that most of the data reviewed does not capture impacts of the COVID pandemic due to time lags or other surveillance limitations. Worsening trends identified are largely pre-COVID with a few exceptions.

Women/Maternal Health - An estimated 262,848 women of reproductive age (WRA), aged 15-49 years, live in Hawaii, making up 43% of the female population in the state (ACS). Most WRA in Hawaii are Native Hawaiian (20.8%), followed by White (20.2%) and Filipino (18%), with all other groups under 11%, respectively (BRFSS, 2019). Compared to the state's population, the proportion of Native Hawaiians and other Pacific Islanders WRA are significantly greater, while the proportions of Whites and Japanese are significantly smaller. Most WRA are married (47%), heterosexual (90%), a high school (30%) or college graduate (34%) and employed (66%) with an annual household income of $75,000 or more (39%).

Key health indicators suggest that WRA use the healthcare system and their health status is relatively stable with health insurance coverage at 92% (21% with public insurance). In 2020, 81.1% of women in Hawaii received a preventive medical visit (a slight increase over 2019) and significantly higher than the national estimate (71.2%).

Most WRA use conception for family planning and 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.

Other WRA health highlights (BRFSS, 2020) include[2]:

- 87% report having good physical health
- 19% have two or more chronic conditions
- 17% report having depressive symptoms
- 16% have at least one physical or mental disability
- 50% are current drinkers with 17% binge drinkers
- 12% are current cigarette smokers and 6% are current e-cigarette (vape) users

Rising trends in obesity and other risky health behaviors, particularly in younger women, underscore the need for

preventive healthcare for this population.

Perinatal and Infant Health - In 2020, there were 15,780 births to Hawaii residents. In 2019, the fertility rate was 61.1 per 1,000 for women aged 15-44 years (slightly above the national rate of 56.0). Among teen mothers 15-19 years, the birth rate is 13.0 per 1,000, similar to the U.S. rate of 15.4, and is highest among NHOPIs. Despite significant decreases in perinatal deaths, an emerging concern is Hawaii's increase in severe maternal morbidity (SMM).

Most live births occurred to women who were Asian (31%), Native 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 increased slightly compared to 2020 (from 72% to 73%).

The proportion of women who smoke during pregnancy was 1.9%, which was significantly below the national estimate of 5.5%. Those with lower education, WIC recipients, and mothers of Hispanic or multiple races were more likely to smoke. About 6.6% of mothers drank alcohol during pregnancy, similar to the national estimate (7.9%), and 42.4% had a dental visit during pregnancy. Both rates have been relatively stable over the past five years.

Data from 2019 indicates severe maternal morbidity (SMM) was 104.8 per 10,000 hospitalizations, similar to 2018 (104.3) but substantially higher than 2017 (84.7). Hawaii's SMM rate is significantly higher than the U.S. rate of 81.0 (HCUP-SID 2019) and the HP 2030 objective (61.8).[3] Small numbers (146 in 2019) make subgroup analyses difficult. A MCH Alliance for Innovation (AIM) grant to study SMM was awarded to the University of Hawaii John A. Burns School of Medicine. FHSD is assisting with securing access to hospital data for the grant project.

The maternal mortality rate was 16.9 per 100,000 live births (aggregated over 2017-2021), an increase over the previous indicator (11.7 for 2016-2020) but close to the HP 2030 objective (15.7). Annual deaths are very small (10-14 annually); thus, the increase does not represent a significant change. Postpartum depression rates have also increased over time (PRAMS). Other indicators being monitored because of concerning rates are infant sleeping environments and disparities in preterm births.

Data from 2020 indicated 10.0% percent of births were preterm. Asian (10.2%) or multiple race (10.3%) and Hispanic (10.3%) mothers had significantly higher rates of preterm birth when compared to Whites (7.9%). Those under age 20 (13.1%), 35 years and older (12.8%), or with a high school education (13.5%) also had elevated rates. The rate of early term births (37-38 weeks) was 28.7% and was slightly higher than the national estimate (27.8%). Risk factors for early term birth were similar to those of pre-term birth, although no significant differences were observed among mothers of different age groups.

Data from 2019 shows infant mortality decreased (from 6.8 per 1,000 previously to 5.1) but is still up significantly compared to 2016 (4.5). Hawaii's rate almost met the HP 2030 objective (5.0) and is similar to the national estimate (5.6). Infant mortality was significantly higher for Native Hawaiians (5.8) compared to White (3.2) infants. Sleep-related unexpected infant death (SUID) rates were 111.9 per 100,000 live births (NVSS 2018)[4]; this was a decrease from 2015 (76.0) but similar to the national estimate (90.6). There were 1.1 cases of neonatal abstinence syndrome per 1,000 hospital births (HCUP-SID, 2019), lower than national estimate (6.1) and unchanged since 2014.

Low birth weight (LBW) deliveries have remained constant since 2016 (8.1% in 2021, 8.3% in 2016). Data from 2020 indicates rates were statistically higher for Black (10.4%), Asian (9.9%), and NHOPI (9.7%) than White

mothers (5.3%) (NVSS). Among very LBW (VLBW) infants, 90.6% were born in a hospital with at least a level III NICU (Vital Statistics 2020-2021). Among low-risk first births, 23% were delivered via cesarean section (NVSS), significantly below the national estimate (25.9%) and meeting the 2030 HP objective (23.6%), but significantly higher than the 2015 estimate (20.3%).[5] Older mothers and those with any health insurance were more likely to receive cesarean sections.

Data from 2018 indicates 94.6% of infants were ever breastfed, significantly higher than the national estimate (83.9%). A lesser proportion of mothers continue to breastfeed exclusively through six months at 36.6%, though this rate is still higher than the U.S. estimate (25.8%) (NIS).[6] PRAMS data from 2020 showed that 80.1% of infants are placed on their backs to sleep, with Native Hawaiian (72.9%) mothers less likely to do so than Filipino (81.2%), White (85.3%), Chinese (86.3%), and Japanese (88.3%) mothers; mothers under 20 (69.4%) and 20-24 (72.8%) were also less likely to do so than those 25-34 (81.8%) and 35 and older (93.6%).[7] Only 24.7% of infants were placed on an approved sleep surface, significantly below the national estimate of 36.9% and 2021 state objective of 29.0%. In 2020, 45.9% of infants were placed to sleep without soft objects or loose bedding, lower than the national estimate (52.5%) and the state objective (49.0%); small numbers prevented subgroup analysis.

There has been a significant increase in the percent of mothers experiencing postpartum depressive symptoms (13.7% in 2020 compared to 9.0% in 2015, PRAMS); this is similar to national estimate (13.4%). NHOPI mothers were more likely to experience postpartum depression than White mothers.

Child Health - There are approximately 296,000 children under 18 years old in the state, roughly 21% of the total population.[8] Since 2012, there has been a steady decline in the percentage of children under 18 years old. Compared to the overall state population, children in Hawaii are more likely to be of two or more races (32% vs 24%), Hispanic or Latino (20% vs 10.7%), or NHOPI (12% vs 10%), and less likely to be Asian (22% vs 38%) or White (13% vs 26%). Prior to the COVID outbreak, the economic well-being of Hawaii's children in general had been improving since 2010 (14%) with a marginal decrease in the proportion of children in poverty in 2019 (12%) and a larger decrease in children whose parents lack secure employment (24% in 2019 vs. 30% in 2010). A slightly smaller percentage of children in Hawaii (32%) live in single-parent households compared to all U.S. children (34%).

Children's health status improved in some areas but worsened in others. While there was a significant decrease in the child mortality rate and hospitalizations over time, physical activity is lower than national rate. Also, the seasonal influenza vaccination rates declined over time. Hawaii also ranked 26th in overall child well-being among all U.S. states per the 2021 Casey Foundation Kids Count, a large drop from 17th place in 2020. This was due to several factors including rates of children not in school, low birthweight, and single-parent families worsened compared to 2010 and contributed to the decline.[9]

Hawaii's child mortality rate decreased significantly among those aged 1 through 9 years, from 18.2 per 100,000 in 2018 to 10.3 in 2020. This rate was significantly lower than the national estimate (16.0). Hospitalizations for non-fatal injury for children aged 0–9 years declined from 99.7 per 100,000 in 2016 to 72.1 in 2019, significantly below the national rate of 124.2. There were no significant subgroup differences in pediatric injury hospitalization rates.

Although most of Hawaii's young children do not receive developmental screening needed to identify and diagnose unmet behavioral and learning milestones (41.2% in 2019-2020, NSCH), Hawaii's rate was similar to the national estimate (36.9%) and met the HP 2030 Objective (35.8%).[10]

Per 2019-2020 data, children in Hawaii are more likely than children nationally to be insured and able to obtain needed health care: 80.6% insured in Hawaii compared to 66.7% nationally (NSCH). No significant subgroup

differences were reported. In this same population, 2.1% were unable to obtain needed health care in the last year, significantly lower than the national rate (3.5%). Children with special health needs (5.9%) were significantly more likely to be unable to obtain needed health care compared to those without special needs (1.5%).

The percent of children aged 1-17 years with a preventive medical visit within the past year (79.7%%) was similar to the national average (80.7%). The percent of children with a preventive dental visit (85.6%) was significantly higher than the national average (77.5%). Routine oral health care is markedly lower among children 1 and 5 years (73.4%) compared to older age groups; no other significant differences across subgroups were reported.

Other NSCH indicators suggest children have challenges related to maintaining a healthy lifestyle:

- 15.5% of children aged 10–17 years were considered obese, similar to the U.S. estimate (16.2%).
- Less than a fifth (18.7%) of children aged 6–11 years were physically active for at least 60 minutes per day, which was lower than the national average (26.2%).
- 14.8% of children ages 0-17 live in households where someone smokes, similar to the national estimate of 14.0%. Children in lower socioeconomic position and of NHOPI race had elevated exposure to household smoking.

The annual rate of seasonal influenza vaccination has declined significantly over time (59.5% in 2020-2021 compared to 67.0 in 2019-2020 and 71.8% in 2015-2016, NIS), closely matching national rates (58.6%). Disparities exist along socioeconomic lines.

Adolescent Health - There are an estimated 161,000 adolescents in Hawaii, and the racial and ethnic profile of adolescents suggests that most are of two or more races, NHOPI, or Asian (Census). Trends of several health indicators suggest that adolescents in Hawaii are as healthy as most U.S. adolescents. Encouraging trends include a significant decrease in non-fatal injury hospitalizations. However, concerning trends include Tdap (tetanus, diphtheria, and acellular pertussis) vaccination rate, which is lower than the national rate. Disparities in health measures require further analysis.

Data from 2019-2020 indicated 73.4% of 12–17-year-olds had a preventative medical visit within the past year; this rate was similar to the national estimate of 75.6% (NSCH). Adolescents with college-educated parents (83.8%) were more likely to have a preventive visit compared to those whose parents had completed some college (61.2%). Asians (66.0%) were less likely to have a preventive medical visit than Whites (88.6%).[11] However, adolescents ages 13-17 in Hawaii were significantly less likely (83.7%) than adolescents nationally (90.1%) to have received at least one dose of the Tdap vaccine (NIS, 2020).

Data from 2019-2020 indicated only 12.5% of 12–17-year-olds were physically active for at least 60 minutes per day, similar to the national estimate (15.2%). Among 12–17-year-olds, 12.3% bullied others and 31.1% were bullied (NSCH), which was similar to the national estimates. Asians and Hispanics were more likely to be bullied. There were 158.7 hospitalizations for non-fatal injuries per 100,000 10–19-year-olds in 2019 (HCUP-SID), which represents a significant decrease from 2015 (205.2) and is lower than the national rate (204.2). Females, those of Hispanic ethnicity, and younger adolescents were less likely to have injury hospitalizations.

The overall mortality rate in 2020 for adolescents aged 10–19 years was 20.9 per 100,000, which was significantly lower than the U.S. estimate of 37.6 (NVSS). Males had a noticeably higher mortality rate (33.0) than females (17.9); there were no significant differences across racial groups. Common causes of adolescent mortality in Hawaii are include motor vehicle injuries (8.6 per 100,000, significantly lower than national estimate of 11.8) and suicide (9.9 per 100,000, similar to national estimate of 11.1). These rates have not changed significantly over time; small numbers prevent subgroup analysis of higher risk groups.

The percent of adolescents engaging in sexual activity remains stable; preventive sexual health practices seem to be improving. In 2019, 18% of high school students were currently sexually active, with 84% using some form of birth control (YRBS). A high percentage (84.9%) of adolescents in Hawaii received at least one dose of the HPV vaccine, which is higher than the U.S. overall (75.1%) (NIS 2020); non-Hispanic Asian (86.7%) and those with income 400% or greater of FPL had the highest rates (86.6%). Births among females ages 15-19 in the state reduced significantly from 15.7 per 1,000 in 2019 to 13.0 in 2020 (NVSS) and was similar to the U.S rate at 15.4. Hispanic (22.2), NHOPI (22.7), and teens of multiple races (15.7) had higher birth rates than Asian (3.9) and White (8.5) teens.

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%). The DOH Chronic Disease program has an aggressive anti-vaping messaging and policy initiative to combat this trend.

For suicide and depression, 35% of high school students report experiencing depression and 10% attempted suicide within the last 12 months. There are significant disparities by race/ethnicity and county across the risk factors. The 2021 YBRS results will be released in FY 2022. This data supports selection of the Hawaii state performance measure on pediatric mental health. As part of the project, further analysis will be conducted to identify key disparities.

Children with Special Health Care Needs (CSHCN) - The population of CSHCN in Hawaii is estimated to be 43,575, which is approximately 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 health care for this domain.

According to data from the 2019-2020 (NSCH), 14% of children ages 0-17 years in Hawaii have special needs, significantly lower than the national estimate (19%). This difference may be due to the small sample size of CSHCN in Hawaii (N=235). About 42% are identified as "other, non-Hispanic" race, followed by Asian (26%), White (14%), and 15% Hispanic/Latino (data on race/ethnicity was missing for about 3% of CSHCN in Hawaii). There is no significant difference in race and ethnicity between CSHN and children without special health needs. Among CSHCN, there are more males (57%) than females (43%), a trend that was not observed nationally.

The same percentage of CSHCN in Hawaii (97%) have health insurance compared to non-CSHCN in Hawaii (97%), with 73% using primarily private insurance for medical services, 20% using public insurance, and 3% using both. Most CSHCN live in two-parent households (71%) and have at least one adult in the home with a college degree or higher (63%). About 43% of CSHCN in Hawaii live in a home with an annual income at 400% or greater of the federal poverty level, while 31% have between 200-399%, 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 2019 to 2020, nearly half (48%) of CSHCN ages 0-17 in Hawaii had a medical home, which was similar to the national estimate (47%) but lower than the Healthy People 2020 objective (52%) (FAD). Among this group, a relatively small percentage (20%) are in a well-functioning system of care that integrates a family-centered home with comprehensive needs-specific medical attention; this percentage is higher than the rate amongst CSHCN nationwide (16%), although this difference was not statistically significant. During the same period, among children ages 3-17 with a mental or behavioral condition, only 50% received treatment or counseling, suggesting that only about half of children acquire the psychological care they need.

Of concern, 2019-2020 data show that only 18% of adolescents with and without special health care needs, ages 12

-17 years, received services needed to make transitions to adult health care.

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

Title V programs continue to provide all levels of services statewide. A list of programs is in the Supporting Documents. Through 2021, direct service programs continued to provide telehealth services, staff continued to telework, and continued cross-agency/community partnership remotely. With the loosening of COVID restrictions, all staff returned to the office in April 2022. Some direct services have returned to an in-person option.

FHSD has 277 FTE staff, of which 19.55 FTE are Title V-funded, and 42 FTE are located on neighbor islands.

	Total FTE (all funding sources)	Title V FTE*	Hawaii FTE	Maui FTE	Kauai FTE
FHSD	30.0	5	2.0	2.0	2.0
MCH Branch	40.0	6.5	1.0	0	0
CSHN Branch	138.0	8.05	6.0	3.0	2.0
WIC Branch	69.0	0	13.0	7.0	4.0
TOTAL	**277.0**	**19.55**	**22.0**	**12.0**	**8.0**

**Includes vacant positions.*

FHSD's staffing decreased by roughly 8 FTE, including one Title V funded FTE. The positions were related to the loss of Title X family planning funding and elimination of positions in the Early Intervention program. At the close of 2021 and through 2022, there have been a number of new vacancies with retirements and staff departures.

Title V COVID-19 Response. No Title V funds were used for direct COVID-19 disease prevention/control. Two FHSD nurses deployed for COVID are no longer serving in this capacity. The Maui and Kauai RN Supervisors continue to provide reduced COVID-19 support largely for vaccinations and limited contact tracing. In 2022, the FHSD research statistician is providing part-time data support to the DOH Disease Investigation Branch.

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, Child/Adolescent Mental Health); other state and county organizations (Department of Education, Department of Human Services, Executive Office of Early Learning); over 25 healthcare organizations (Shriner's Hospital, Federally Qualified Health Care Centers); over 35 community-based organizations (Coalition for a Drug-Free Hawaii, Healthy Mothers, Healthy Babies, Hawaii Youth Services Network); and national partners (Centers for Disease Control and Prevention, Department of Agriculture). A list of Title V partners can be found in the 2020 NA summary.

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

Title V staff issue leaders work to evaluate and revise program practice based on ever-changing healthcare conditions, collaborations with partner agencies/programs, federal guidance, and family input. Staff work collaboratively across programs and with partners to meet short- and long-term outcomes to support improvements in national and state performance measures that impact the Title V national outcome measures.

5-Year Plan Changes for 2021-2025

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 ensured health equity strategies/activities are integrated into all Title V priorities. Activities for the new equity strategies were selected from national presentations/resources (AMCHP, MCH Evidence Center, MCH Workforce Development Center) and Hawaii DOH Health Equity reports.

Other Plan Changes: Many planned FY 2021 activities were delayed or revised due to COVID-19 circumstances/conditions. The lack of epidemiology staff hindered more detailed data analysis and also evaluation initiatives. All Title V programs continue ongoing assessment activities through engagement of stakeholders, families, and youth to identify COVID changes.

Objective Setting: Hawaii generally did not revise objectives for NPM and SPM since the impacts of COVID are difficult to predict.

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

No organizational changes were made to State or DOH structure. Leadership for the Department has remained stable after several changes in FY 2021. A new administration will be elected in November 2022 and DOH appointed leadership will change. This change will not impact the FHSD Chief position.

C.1.g. Emerging Public Health Issues

The COVID-19 pandemic remains a dynamic and ongoing public health concern. The ongoing emergence of COVID variants, uncertainty about the state's economic recovery, and long-term impacts of the pandemic will continue to challenge the health and well-being of Hawaii's population and healthcare system. The availability of vaccinations, therapeutics, and testing have greatly reduced severe illness and death to date. Continued racial and ethnic disparities that are consistent across multiple domains of health indicators suggest structural racism and discrimination as determinants of health remain an important priority.

FHSD will continue to secure services to support ongoing needs assessment with data collection and analysis to monitor health consequences due to COVID. FHSD programs and staff will continue to work with stakeholders (including youth and families) to identify and respond to emerging needs and concerns.

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[1] The Title V federally available dataset (FAD) includes data for all Title V National Performance and Outcome Measures. States have the options to utilize other local data sources to provide more timely and disaggregated analysis.
[2] BRFSS is the Behavioral Risk Factor Surveillance System, a survey of adults.
[3] HCUP-SID is the Healthcare Cost & Utilization Project-State Inpatient Databases conducted by the Agency for Healthcare Research & Quality
[4] Note Hawaii Sleep-related SUID death numbers are very small annually (14-19 per year).
[5] NVSS is the National Vital Statistics System
[6] NIS is the National Immunization Survey
[7] PRAMS is the Pregnancy Risk Assessment Monitoring Surveillance
[8] KIDS Count 2020, 2020 Census
[9] Kids Count rankings may not use the most current data and may not reflect worsening health trends in Hawaii but significant improvements in other state health measures. Closer analysis of the data is needed to understand Hawaii's ranking decline.
[10] NSCH is the National Survey of Children's Health
[11] The combined data for all Asian categories used in the NSCH maybe masking disparities among more detailed race/ethnicity groups.

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,394,340	$2,027,508	$2,077,106	$2,055,426
State Funds	$28,350,378	$28,133,440	$31,499,929	$26,944,383
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$203,441	$49,934
Program Funds	$13,205,575	$7,672,215	$13,584,510	$8,622,714
SubTotal	$43,950,293	$37,833,163	$47,364,986	$37,672,457
Other Federal Funds	$51,294,329	$38,374,744	$45,765,848	$30,928,565
Total	$95,244,622	$76,207,907	$93,130,834	$68,601,022

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,083,027	$2,021,007	$2,319,160	
State Funds	$31,499,929	$26,180,239	$29,759,413	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$18,439,145	$19,530,529	$18,474,919	
SubTotal	$52,022,101	$47,731,775	$50,553,492	
Other Federal Funds	$37,230,305	$37,566,837	$40,729,830	
Total	$89,252,406	$85,298,612	$91,283,322	

	2023	
	Budgeted	Expended
Federal Allocation	$2,138,833	
State Funds	$29,962,854	
Local Funds	$0	
Other Funds	$0	
Program Funds	$18,474,919	
SubTotal	$50,576,606	
Other Federal Funds	$41,413,149	
Total	$91,989,755	

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's accounting system, *Datamart*, which captures and details all federal and non-federal spending reflected in the state fiscal year (SFY).

FY 2021 Expenditures as reported on the FY 2023 Application:

The Hawaii State Department of Health (HDOH), 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 277 full and part-time employees in FY 2023, 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 previously noted, the HDOH is the only public health agency in the state. 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 HDOH, FHSD's three branches – Maternal and Child Health (MCH), Children with Special Health Needs (CSHN), and Women, Infants & Children (WIC) Services – addressed this need with a FY 2021 Program Income budget of $18.5M with same year expenditures of $19.5M. This income is managed through five state special funds, which 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 & 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 has a legislatively approved budget ceiling but will no longer be funded; therefore, actual expenditures will be zero. FHSD will request the ceiling be legally removed from the State budget and this category will eventually phase out of the Tile V application.

Form 2 also notes that expenditures from other federal funds administered through the various FHSD programs in FY 2021 totaled $37,566,837. These other federal fund expenditures include programs such as WIC ($25.9M), Home Visiting (MIECHV) ($4.7M), Early Intervention (Part C) ($2.4M), Genetic Services ($559K), and 15 or more additional 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 27,453 broken out as follows:

Pregnant Women: 1,237
Infants 1 < 21 Years of Age: 671
Children 1 through 21 Years of Age: 10,034
Children with Special Health Care Needs: 8,217

Others: 15,511

Form 5b estimates FHSD programs using all funding sources were able to reach: 99% of the Pregnant Women, 99% of all Infants < 1 year of age, 66% of Children 1-21 years of age, 24% of Children with Special Health Needs (0-21 years of age), and 42% of Others.

Use of Title V Funds. To support the infrastructure needed to administer FHSD programs statewide in FY 2021, Title V funds were used for key staff positions (19.55 FTE out of a total of 277.0 FTE), including an epidemiologist, branch research statisticians, MCH and CSHN program managers, Title V CSHCN Director, nurses, a nutritionist, an audiologist, contract specialists, information specialist, and general office support staff. These positions are critical to securing, leveraging, and managing FHSD's statewide service system, its broad array of funding sources, addressing statewide surveillance needs, developing critical statewide partnerships, as well as improving quality to assure services are family centered, culturally competent, and community based.

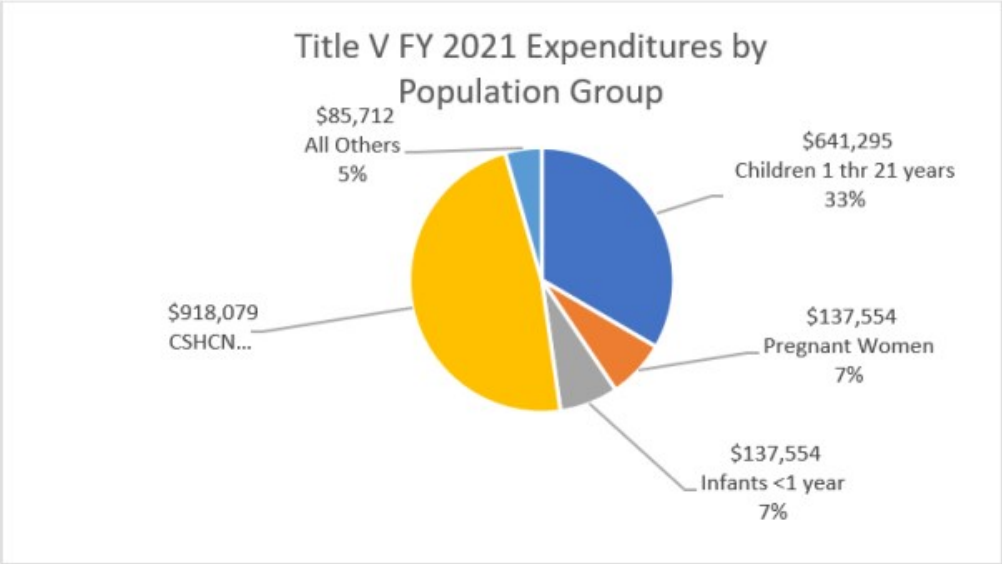
Legislative Requirements Met. The State maintains expenditure and budget documentation for all MCH Block Grant funding allocations for tracking and reporting. Consistent with the requirements in the Title V legislation, expenses are tracked through the state's accounting system, *Datamart*, and carefully 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 to 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 2021 expenditures. The table below outlines the FY 2023 budget and FY 2021 expenditures across these categories. Preventive/Primary care for children was 31.7% of FY 2021 Title V expenditures, while CSHCN received 45.4% of Title V funds in the same year. Hawaii was able to keep administrative costs relatively low (5%) because HDOH relinquishes all indirect costs for the Title V grant.

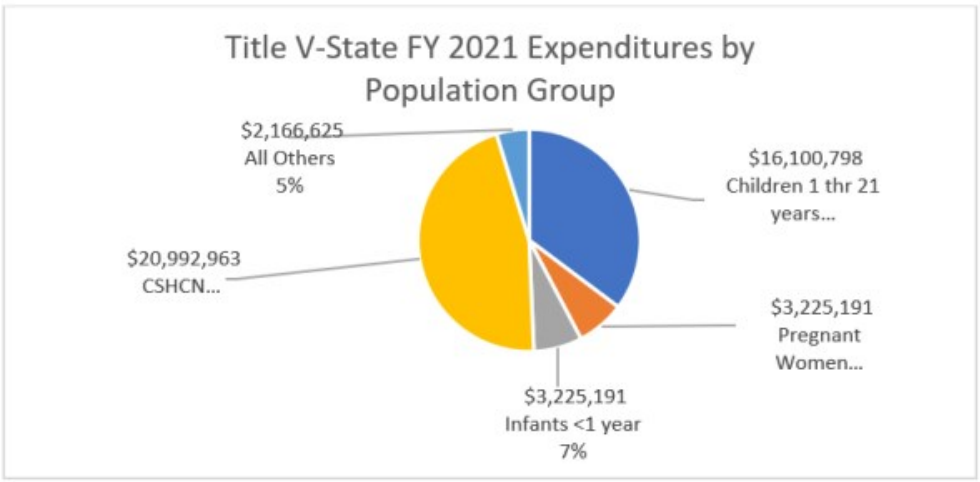
Category	FY 2023 Budgeted		FY 2021 Expended	
Preventive and Primary Care for Children	$699,363	**32.6%**	$641,295	**31.7%**
Children with Special Health Care Needs	$1,030,127	**48.1%**	$918,079	**45.4%**
Title V Administrative Costs	$70,508	**3.3%**	$100,813	**5.0%**

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 2021 state expenditure match of $45.7M far exceeds the match requirement.

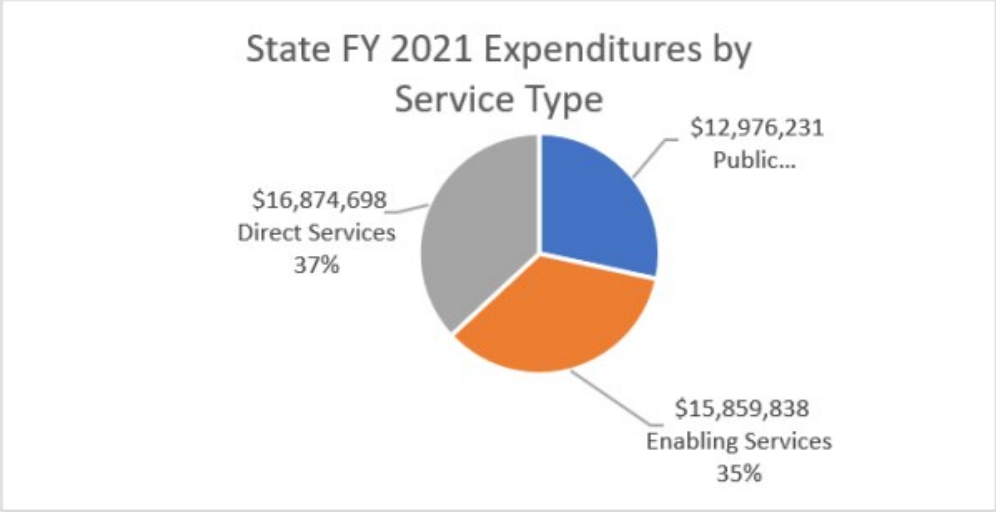
Expenditures by Population Group. The chart below shows how the FY 2021 $1.9M Title V funds were expended to serve the five Title V population groups. The amounts reflect expenditures for FHSD Title V funded personnel (19.55 FTE in 2021) who support FHSD programs across the state. No Title V funds were used for direct services. The breakouts confirm Hawaii expended over 48% for CSHCN, 33% for Children 1 through 21 Years, 7% for Infants < 1 year, 7% for Pregnant Women, and 5% for All Others.



The chart below shows how the FY 2021 $45.7M 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). Nearly half of FHSD's state funds were dedicated to serve CSHCN (46%). The remaining budget was divided by the remaining four populations groups: all Others (general adult population/families), pregnant women, infants less than 1 year, and children 1 through 21 years.



The chart below Illustrates how both Title V and state matching funds in FY 2021 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 well over half of all FHSD Direct Service expenditures. Of the Non-Federal total expenditures, Direct Services made up 37% of all expenditures. The remaining state expenditures were divided between enabling (35%) and public health services (28%). In an analysis of these expenditures, Hawaii clearly leveraged Title V funding to advantageously provide infrastructure support for its MCH programs.



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

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

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

Form 2, Item 1. B. Children with Special Health Care Needs. There were $116,079 more in expenditures than was budgeted in FY 2021. The variance is directly related to a smaller budget forecast due to position vacancies when

the budget was forecast vs. actual expenditures attributed to CSHCN.

Form 2, Item 3. State MCH Funds. Actual FY 2021 expenditures as reported in Datamart. Expenditures are usually lower than the budgeted amount due to position vacancies and changes or reduction in contractual execution and performance. In FY 2021, expenditures were $5,319,690 below what was budgeted due to both vacancies and the timing of expenditures.

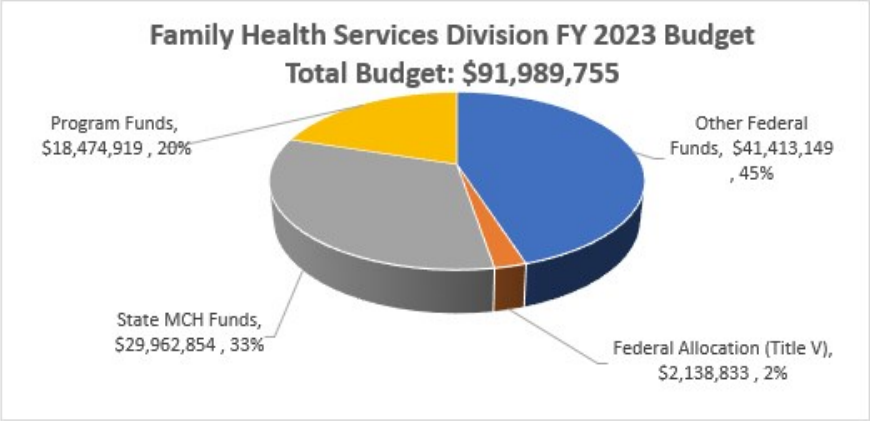
Form 2, Item 6. Program Income. In FY 2021, the budgeted amount for program income was $18,439,145 but expenditures exceeded this by $1,091,384. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and Domestic 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 legislature reappropriated $10M for a one-time need to address economic uncertainties related to the COVID-19 global pandemic. This transfer of funds is booked as an expenditure, which greatly increased FY 2021 Program Income expenditures. 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.

III.D.2. Budget

The Hawaii State Department of Health (HDOH), Family Health Services Division (FHSD) is committed to improving the health of women, children, and families throughout the state of Hawaii. FHSD initiatives are carried out through its Division, Branch, and District Health Offices, which consists of approximately 30 programs, nearly 150 annual service contracts, and in federal fiscal year (FY) 2023, a $92M total state MCH budget. Title V will fund 25 unique FHSD positions in part or in whole out of 277.0 FTE. The FY 2023 budget plan builds on the assessment of state MCH population needs while complying with the legislative financial and block grant program regulations and requirements.

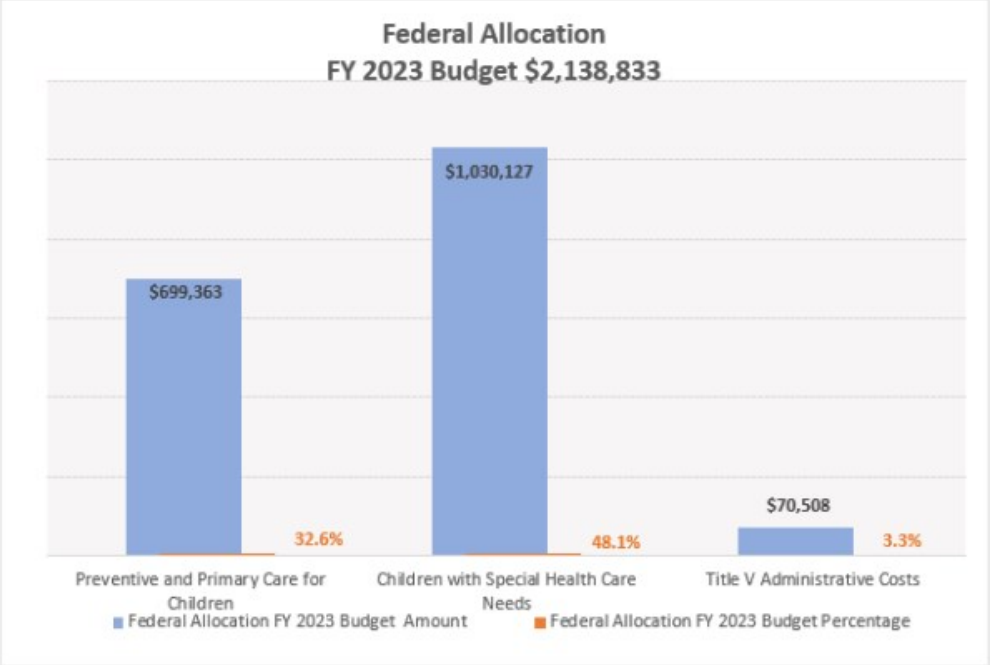
Budget Overview

The chart below provides an overview of FHSD's FY 2023 budget as reported on Form 2. The $92M budget consists of $2,138,833 from Title V; a state match of $48.4M (including Program Income of $18.5M); and Other Federal Funds totaling $41.4M.



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's accounting system, *Datamart* and comply with the state annual audit. The state easily satisfies the required match, a $3 match in non-federal funds for every $4 of federal MCH Block Grant funds expended.

FHSD is committed to continued compliance with Title V 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 may be used for administration. For FY 2023, Hawaii is allocating $699,363 (32.6%) for Preventive and Primary Care for Children, $1,030,127 (48.1%) for CSHCN, and just $70,508 (3.3%) will be budgeted for Title V Administrative Costs as reported on Form 2.



Federal Funds. The FY 2023 Other Federal Funds budget includes 26 federal grants totaling $41.4M (excluding Title V). The Title V allocation is roughly 5.2% of all FHSD federal fund appropriations and 2.3% of the overall FHSD total budget.

The overall federal fund budget increased by $4,182,844 (11.23%) from FY 2022 in part due to CARES Act and the American Rescue Plan Act (ARPA) fund appropriations for several programs:

- Pediatric Mental Health Care Access $445,000
- SHIP Covid Testing and Mitigation $2,583,760
- IDEA Part C (ARPA) $1,218,273
- AMCHP Cares Act: MCH Telehealth $275,000
- MIECHV ARPA funding for Home Visiting $1,009,550
- Community-Based Child Abuse Prevention (CBCAP) grant $1M of ARPA funds over next 5 years.

CDC Health Equity Grant. In FY 2022, FHSD received a $7.6M carveout (outside of FHSD's regular budget) for rural health initiatives through a $24.5M CDC National Initiative to Address COVID-19 Health Disparities awarded to the HDOH. A portion of the funding is supporting the state Title V telehealth priority; however, these funds are not reflected in the Title V budget forms.

FHSD relies heavily on federal funds (47% of budget). Most grants are utilized to fund the positions that manage and administer these programs. In FY 2021, most of the federal grant funding levels did not increase, despite program cost increases. Operating and personnel costs for federal grants like Title V are stretched very thin. Regular increases in collective bargaining agreements for public employees contribute to steady increases in salaries and fringe benefits. The FY 2021 the 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. To offset fixed costs, FHSD requested a waiver of indirect costs from the HDOH. Title V is one of a few grants that the Department has allowed an annual indirect cost waiver, which ensures maximum use of the grant dollars for personnel and operating expenses.

Other means of cutting costs include reorganizations to promote efficiencies, postponing filling positions when they are vacated through retirement or attrition, and redescribing vacated positions from high salary medical professional positions (e.g., nurses) to public health program specialists. State and federal budget cuts coupled with rising operating costs has led FHSD personnel numbers to shrink from 337.5 FTE in FY 2018 to 277 FTE in FY 2023. This represents a nearly 17% decrease in staff over the past five years.

Finding creative ways to maximize and leverage FHSD federal and state resources will remain a challenge in FY 2023. Economic forecasts predict moderately strong growth for the state, but the optimism is tempered given the global economic environment and uncertainty regarding COVID. In the short term, the 2022 FHSD budget should continue to benefit from federal COVID relief funding.

State Funds. The FY 2023 state funds budget is approximately $30M. Additional state funds generated from Program Income is budgeted at $18.5M in FY 2023, according to SFY 2022 legislative budget worksheets. The FY 2022 legislature indicated support to increase the general fund appropriation for the Early Intervention Program by approximately $3.6M annually. Specifics of the state budget will not be known until the Governor's Budget Execution Policy is released later in FY 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, which supports staffing that provides public health infrastructure services for FHSD's programs. The 25 positions which are fully or partially funded by Title V are critical to securing and managing new grant and state funds by providing support for surveillance, partnerships development, quality assurance, administration, and communications.

Although, WIC does not receive Title V or state funds, the program benefits from FHSD administrative, communications support, data assistance, and technical assistance through other FHSD programs. The WIC State Agency continues to improve its services to assure the state's most vulnerable families have healthy pregnancies, positive birth outcomes, and a strong start in life for infants and young children. By proactively addressing food insecurity, WIC services are responding to urgent family needs that worsened with COVID. Given the large client base served by WIC, the program is a critical conduit to promote Title V priorities in collaboration with other Title V programs that serve pregnant women and young children including CSHN.

Because the 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, a Title V funded position provided support for the Child Death Review and Maternal Mortality Review while a position vacancy was filled. Title V also helped continue the Lead Poisoning Screening and Prevention program while it applied for renewed CDC funding.

Another example of leveraging Title V funding is seen in the funding distribution to support key positions within FHSD. For example, the CSHN Branch Chief, also a pediatric M.D., is 75% funded by Title V and 25% funded by IDEA Part C. She also supervises Hawaii's Part C Early Intervention Services program as part of the CSHN Branch. A portion of both grants support this critical management and medical professional position for FHSD. As the Title V funded Epidemiologist position remains vacant entering FY 2023, FHSD will use Title V funds to contract for epi services to monitor COVID impacts on MCH populations and support other data/research projects.

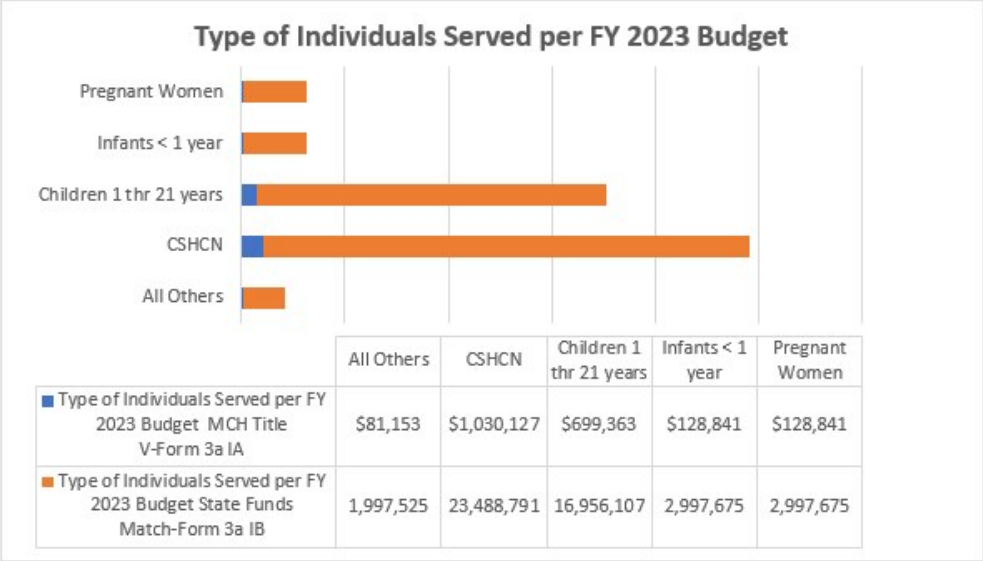
The program support for the Title V priorities reflects the diversity in the FHSD budget and the importance of leveraging program funding to support the priorities. The table below shows how FHSD uses both state and federal

funding to support the work on the priority issues.

Title V Priority	Program Lead Funding	Key FHSD Partnerships
Women's Wellness Visits	Women's Health Section (Title V)	Title V – Data/Epi Support WIC
Safe Sleep	Family Strengthening and Violence Prevention (State)	Title V – Data/Epi Support Early Childhood Comp Systems Child Death Review (State) PRAMS (CDC) Title V - Public Information Officer
Food Insecurity	WIC Services	Title V – Data/Epi Support Early Childhood Comp Systems Public Information Officer
Developmental Screening	Early Childhood Comp Systems	Title V – Data/Epi Support EIS (Part C/State) MIECHV Hiilei Developmental Screening (State)
Child Abuse & Neglect	Community-based Child Abuse Prevention Program (ACF)	Title V – Data/Epi Support, Admin support MIECHV Sexual Assault and Domestic Violence Prevention programs
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 Title V - Audiologist, Nutritionist Social Workers (State funded)
Telehealth	Genetics (State/federal)	Title V – Data/Epi Support CDC - Health Equity Funding
Child Wellness Visits	CSHN Early Childhood Coordinator (State)	Title V Coordinator Title V - Public Information Officer
Pediatric Mental Health Access	CSHN Early Childhood Coordinator (State)	Title V Coordinator Rural Health Coordinator

The 5-year plan narratives describe the program leads for each priority and their primary sources of funding. Partnerships within FHSD, HDOH, and the community are also described in the plan narratives to assure program progress.

Form 3a, Budget and Expenditure Details by Types of Individuals Served. They FY 2023 application describes the federal and non-federal budget. The chart below shows the state and federal breakout of planned resource allocation for each of the five population domains. The 2023 Title V Federal Allocation budget of approximately $2.1M and a State Match of $48.4M create a Federal-State Title V Partnership budget of approximately $50.5M. 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 Hawaii's families.



	All Others	CSHCN	Children 1 thr 21 years	Infants < 1 year	Pregnant Women
Type of Individuals Served per FY 2023 Budget MCH Title V-Form 3a IA	$81,153	$1,030,127	$699,363	$128,841	$128,841
Type of Individuals Served per FY 2023 Budget State Funds Match-Form 3a IB	1,997,525	23,488,791	16,956,107	2,997,675	2,997,675

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 2023 budget year.

Significant Variations – Form 2 and Form 3 (Fiscal Year 2023) – Budget

Form 2, Item 3. State MCH Funds. The budgeted amount $31,499,929 was based on the SFY 21 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. Actual expenditures were approximately 16.89% below the FY 2021 budgeted amount.

Form 2, Item 6. Program Income. The amount budgeted on the FY 2021 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. The FY 2021 amount budgeted was $4,228,306 more than was actually expended.

Form 3a, IB. Federal State MCHB Block Grant Partnership Total. The amount budgeted in FY 2023 is $50,506,098, which is $2,875,136 more than was expended in FY 2021 for the same category. The budgeted number represents the legislative authorized ceiling, which will generally always be greater than actual expenditures due to the timing to execute contracts and procurements within the Title V reporting period.

Form 3b, IIB. Item 1. Direct Services. The FY 2023 budget for Non-Federal MCH Block Grant direct services is nearly $9,001,035 more than was expended in FY 2021. The large variance can primarily be attributed to the budget reflecting the legislative authorized ceiling, whereas expenditures are actual as reported in the state's accounting system.

Form 3b, IIB. Non-Federal MCH Block Grant. Non-Federal Total. The FY 2023 budget for Non-Federal MCH Block Grant direct services is $2,727,006 more than was expended in FY 2021. The disparity reflects the legislative authorized ceiling, which represents the budget, whereas expenditures are actual. The budgeted number will generally always be greater than actual expenditures due to the timing to execute contracts and procurements within the Title V reporting period.

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 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
- Pediatric Mental Health Access Grant
- 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; workforce training; and collaborate to promote policies that improve outcomes for women, children, and families. Services include reproductive health and interconception care; child and youth wellness; violence prevention programs (child abuse and neglect, sexual assault, domestic violence); home visiting services; fatality reviews; and family supports. Some of the programs include: The Parent Line, Safe Sleep, Child Death Review, and Maternal Mortality Review. The branch has over 35 community provider contracts for women's health, violence prevention, and family support 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'ilei 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 unrelenting and unprecedented changes in all aspects of work and personal life. Staff continue to be challenged to find time to pause, assess, understand current conditions, and respond to the needs of both staff and populations served. FHSD continues to support selfcare, promote resiliency, and honor those who retire or choose to leave FHSD. Given the consequences of the pandemic, this report reflects the continued changes, delays, and innovations that occurred in the second year of the pandemic.

FHSD Vision/Mission: Since FY 2020, FHSD intended to update its 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 the future.

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 stakeholders to address priority issues
- Fund for staff, 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 including data on health disparities
- 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

The health and well-being of the MCH population requires a highly skilled, diverse workforce that involves ongoing training and support in order to address the complex and broad scope of public health issues for this population.

With 277 employees and a budget of $92.3M 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. Few FHSD program staff have formal training in public health. Most have program management experience or subject matter knowledge in their respective areas.

MCH training resources in Hawaii are limited. Hawaii has two university graduate programs in public health at the state University of Hawaii (UH) and Hawaii Pacific University, a small private college. Both programs are located on Oahu. Although these programs shifted to online courses during COVID, there are formally limited online degree opportunities as classes return to in-person learning. Neither program offers an MCH specialization, nor do they have faculty with MCH training/focus. There are several undergraduate programs for community health workers and community heath education certification. Thus, there are no graduate-level academic pathways for MCH training in Hawaii.

MCH LEND. The UH Medical School administers the MCH Leadership Education in Neurodevelopmental and Related Disabilities (LEND) grant, led by pediatric faculty at the school. Title V continues to encourage existing program staff to enroll in LEND cohorts, primarily Children with Special Health Needs staff including those located on the neighbor islands. LEND shares its annual curriculum with Title V and staff are invited to participate in specific trainings to enhance skills building. In FY 2022, Title V also helped fund family incentives for LEND family focus groups conducted as part of their research methods curriculum. A formal report with findings from the focus groups are forthcoming. Title V and LEND maintains its partnership primarily through a parent leader, Susan Wood, who serves as LEND faculty and FHSD's AMCHP parent representative.

Most workforce development opportunities for Title V 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 little access to these resources.

MCH Academic Pathways: In the past, the MCH Bureau funded an MCH certificate program for a number of years that:

- Created an academic pathway to train MCH workforce/leaders to staff public and private sector MCH programs both here in Hawaii and throughout the Pacific and parts of Asia
- Created research opportunities to highlight Hawaii's unique Asian, Native Hawaiian, and Pacific Islander populations.

The value of such a program is critical in light of epidemiology vacancies, greater emphasis on workforce diversity, and health equity in public health practice. Hawaii may explore the possibility of reestablishing an MCH program with OPHS and the MCH Bureau.

COVID Impacts on Program Staff: The second year of the pandemic continued with changes in all aspects of work and personal life. Economic recovery and vaccinations provided some stability. Title V programs continued to be flexible, adapting/revising plans and operations in collaboration with community partners to address population needs. Resilience remains the operating principle for staff and agency/community partners.

While the state budget was bolstered by federal relief funding and the unexpected rebound of the visitor industry, state operations continue to be burdened by increasing staff vacancies, requirements for new funding opportunities,

and cumbersome personnel/procurement restrictions.

Over the past two years, the high level of change, uncertainty, and resulting stress for management and staff cannot be understated. Personnel (and state systems) have varying degrees of ability to manage and respond quickly to change. Despite the challenges experienced during the pandemic, nearly half of FHSD program managers reported in a 2021 survey that the pandemic strengthened program operations and partnerships. The top three program concerns reported in the survey were:

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

Plans for Employee Survey: FHSD initially planned to field an employee survey to capture staff demographics and concerns. The data would be used to describe staffing diversity, inform succession, and workforce training planning. However, the national Public Health Workforce survey (PH WINS) began fielding in Fall 2021 (after being delayed by COVID), so the FHSD survey was postponed to avoid duplication.

PH WINS. The PH WINS is designed to help public health agencies understand workforce strengths, gaps, and opportunities to improve skills, training, and employee engagement. The survey is normally conducted every three years with the last survey conducted in 2017. The 2020 survey was postponed to Fall 2021 and included new modules on COVID, stress/burnout, and an MCH module sponsored by the MCH Workforce Development Center. The survey is conducted by the Association of State and Territorial Health Officials (ASTHO) and the de Beaumont Foundation. National results were released with state specific results due out later this summer. Key findings are below.

- **Demographics**: Nationally, most public health workers self-identify as white (54%), as women (79%), and as age 40 or older (63%). While the workforce is more diverse and now mirrors the U.S. population more closely, there is much less diversity at senior levels, with 66% of all executives identifying as white.
- **Job roles**: Nearly 3 in 4 public health employees (72%) participated in the response to the COVID-19 pandemic in some way. Relative to 2017, the proportion of employees working in communicable disease tripled and the portion working in nearly all other job categories decreased. The areas where staffing decreased the most were environmental health, assessment, and ***maternal and child health***.
- **Intent to leave**: Nearly one-third of state and local public health employees (32%) are considering leaving their organization in the next year – 5% to retire and 27% for another reason. Among those considering leaving, 39% said the pandemic made them more likely to leave. Another 44% are considering leaving within the next five years.
- **Training needs**: Across senior levels, budgeting and financial management are top areas of importance with low proficiency among public health professionals. More than in previous surveys, policy engagement and topics related to justice, equity, diversity, and inclusion were identified as important areas of training.
- **Stress and burnout**: Findings confirmed high levels of stress, burnout, and intent to leave among the governmental public health workforce.

As with the 2017 survey, Title V will work with the DOH Administrative Deputy to arrange a presentation of the PH WINS results to the department management team and work with the Communications Office to share findings with employees. Title V also work with deBeaumont Foundation to conduct a separate analysis of the responses for FHSD.

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.

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. 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.

Resiliency Training: One Shared Future: To support the FHSD staff, One Shared Future (OSF) was contracted to conduct resiliency training using a strengths-based approach to address workplace stress and minimize additional burnout and staff turnover. OSF is a firm started by the former state Department of Human Services (DHS) director to support public sector professionals to implement positive organizational and community change. The resiliency series, comprised of seven 90-minute virtual sessions, were conducted in cohorts of 20-25 over a period of 6 weeks to allow for easy group interaction, networking, and sharing. The DOH and Title V directors signed written invitations to staff supporting participation, expressing staff appreciation, and endorsing the importance of selfcare. OSF also arranged for appearances by the Governor and DOH Director/Deputy to reinforce the messages of appreciation and selfcare. Two cohorts were completed and more are scheduled. One of the cohorts included Title V and DHS managers to encourage greater collaboration between the departments serving families and youth.

National Resources: Title V continues to sponsor staff and community partners to attend national conferences or share in national presentations and webinars including:

- The annual AMCHP conference
- The MCH Bureau Partnership meeting
- The MCH Workforce Development Center trainings
- The CityMatch/MCH Epidemiology Conference

These TA opportunities help develop staff and community capacity. It also provides an opportunity to share Hawaii's issues with other states and national centers.

Hawaii Public Health Training Hui: Another workforce development effort supported by FSHD is the Hawaii Public Health Training Hui (HPHTH) steering committee. The HPHTH was established to provide statewide leadership and coordination to meet public health training and TA needs. FHSD's Rural Health coordinator serves on the HPHTH steering committee. Training topics are based on surveys disseminated online to public health professional 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 https://www.hiphi.org/phth/.

Health Equity Training: Several trainings on health disparities, structural racism, and systemic inequities were sponsored FHSD to help develop and integrate an equity focus for MCH programs including:

- The Early Childhood Comprehensive Systems grant sponsored a training by the Racial Equity Institute (REI), 'Building a Practical Understanding of Structural Racism.'
- MCH Branch partnered with the Native Hawaiian Health Department, University of Hawaii Medical School, to present 'Contextualizing Maternal Health in Hawaii,' addressing the historical, cultural, and social determinants of health and included findings from original research on implicit racial bias among local perinatal providers toward Native Hawaiians and Pacific Islander patients.

Trainings: FHSD programs also support training for the MCH workforce statewide. Several federal grants include workforce development as a key activity. In 2021, many of these events were switched from in-person to virtual

including:

- Maternal Infant Early Childhood Home Visiting grant supports regular trainings 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 telehealth learning network.
- The Child Abuse and Neglect (CAN) Prevention program sponsored several virtual trainings with national speakers addressing Adverse Childhood Experiences, Trauma-Informed Care, Toxic Stress, Protective Factors to Prevent CAN, and a miniseries of webinars on Fetal Alcohol Spectrum Disorders (FASD) during FASD Awareness Month.
- Sexual Violence Prevention program sponsors several trainings throughout the year to address impacts of the pandemic through Community Reconnections, Mindfulness, Recovering from Trauma, and Violence Prevention During Disaster Response.
- A consortium of Title V programs support the Parent Leadership Training Institute.

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

- Annual DOH Rape Prevention and Education Sexual Violence Prevention Meeting, part of Sexual Violence Awareness Month
- Annual Safe Sleep Summit
- Hawaii State Rural Health Association Annual Conference
- Early Intervention Stakeholder Conference
- Hawaii Home Visiting providers meetings
- Hawaii Mortality Review Trainings/Summit
- WIC Services Branch annual staff meeting

Most meetings continue to meet using 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.

Family Engagement Workgroup: 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 a 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, Rural Health Coordinator, Family Violence Prevention Supervisor, and neighbor island nurses) as well as two key partners:

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

Ideas discussed by the workgroup included:

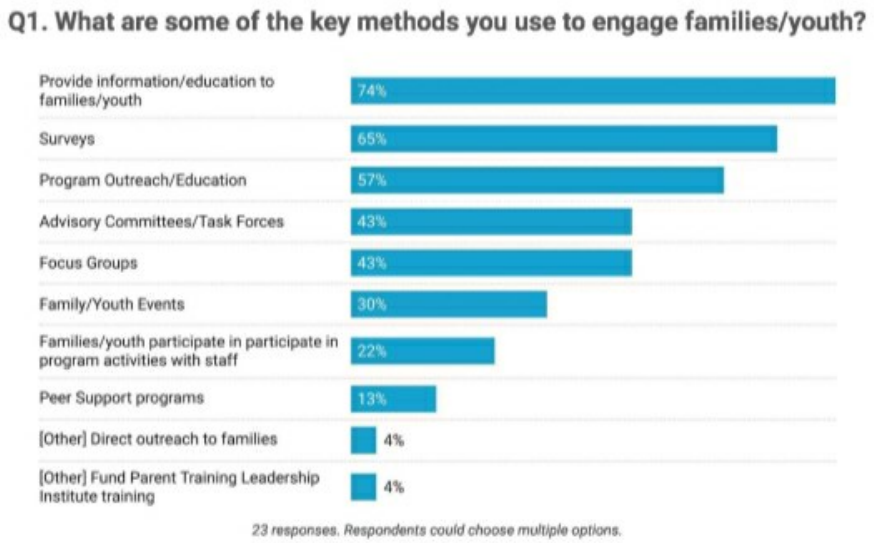
- Development of an FE policy as part of the updating of FHSD vision/mission statements
- Review of national FE guidance/resources
- Assessment/documentation of FHSD staff FE knowledge, current (best) practices, and program barriers/supports needed to implement FE
- Compilation of FHSD FE opportunities and development of materials to promote engagement with families
- 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

Family Engagement Workgroup. To help inform the FE Workgroups activities, several surveys of FHSD programs were conducted to:

- Increase awareness and promote family engagement
- Assess knowledge and family engagement practices
- Collect input on how family engagement practices could be better supported

Two surveys were conducted in 2018-2019. The first survey to assess general FE activities and knowledge across FHSD programs. The second survey focused on specific opportunities for FE and how to support programs expansion of FE activities. Findings were shared with programs and helped inform the FE workgroup activities.

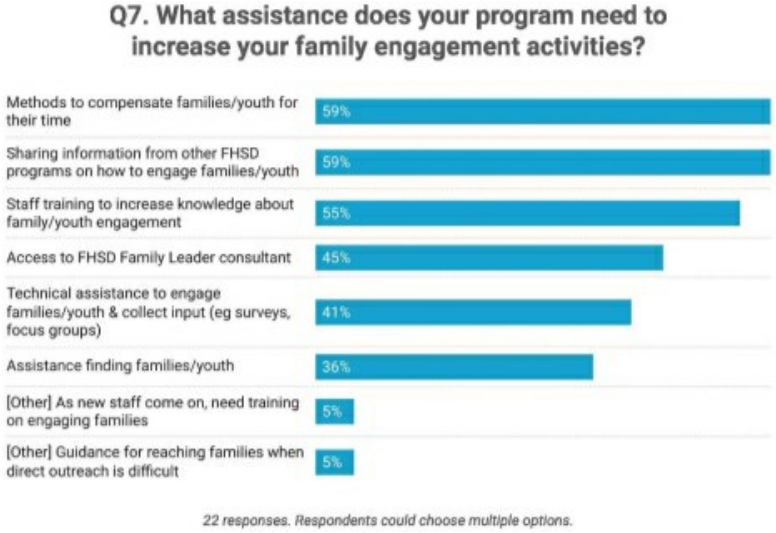
In June 2022, another FE survey was conducted among FHSD programs to assess activities post-COVID. FHSD programs were asked about the key methods used to engage families/youth. The most common method was providing information followed by utilizing surveys, program outreach, advisory committees, and focus groups. Peer support was less likely to be used.



The survey asked how COVID impacted FE:

- As of June 2022, most programs reported the level of family engagement had decreased but returned to pre-pandemic levels.
- There was reported greater use of remote, virtual, and telephonic technology, followed by greater reliance on messaging via radio/TV and conducting more research.

The key supports FHSD programs need to increase FE were methods to compensate family participation, sharing information between programs, and staff training.



Other key findings from the survey included:

- Family/youth input was most often collected to develop educational materials/health messaging, followed closely by needs assessments.
- Programs expressed a greater need for more information sharing among FHSD programs, especially regarding sharing of research/survey findings, promoting family/youth research (surveys), events and trainings.

Additional survey analysis will be done to assess changes from the previous survey responses. The FE Workgroup will meet to review and use the findings to inform planning.

FHSD Advisory Committees. FHSD has eight long-standing advisory committees/task forces identified as needing family volunteers: 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.

Peer Support. Until recently, WIC Services was the only program to employ mothers part-time for its breastfeeding peer counseling program. Since then, FHSD has contracted to support two part-time family leadership positions.

AMCHP/Title V Family Leader. In FY2022, FHSD contracted with Susan Wood to serve as part-time AMCHP/Title V family representative. Ms. Wood serves as MCH LEND faculty and also works for the Hawaii Family to Family Health Information Center staff. She is mother of a special needs adult son with autism. She serves on the FHSD FE Workgroup and participated in most of the Title V staff meetings to review/evaluate progress on each of the national and state priorities. She has also met with programs to consult on family partnership, primarily with the Children with Special Health Needs Branch (CSHNB).

Family Leadership Conference. Ms. Wood and staff from CSHNB and the Department of Education will be presenting on Hawaii's Innovative Approach to Support Youth in their Education and Health Transition Journey to Adulthood at the October 2022 Family Leadership Conference.

ECCS grant: The ECCS HIPP grant awarded to Hawaii in May 2021 plans multiple ways for parents to contribute and participate in the grant's early childhood system-building program and policy decisions. In FY 2022, a parent leader, Krystal Baba, was hired through HCAN to support ECCS activities. Ms. Baba is the mother of a 2-year-old daughter and has a master's in public administration. Her experience is in the fields of domestic violence and underage substance use prevention. She also worked supporting various community coalitions.

Fund to Support FHSD FE Activities
In FY 2022, FHSD contracted with HCAN to engage/partner with families. The contract provides incentives to families to participate in three projects:

- An online survey of parents with young children (in partnership with DOH Chronic Disease program)
- A survey of youth with special health care needs and their parents
- Focus groups with families of special needs children.

Parent Leadership Training Institute (PLTI) 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.

HCAN plans to return to in-person cohorts in 2021-2022 with an additional remote cohort to expand PLTI to neighbor island participants.

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.

Mini-grants: Since 2020, FHSD provided additional PLTI funding to create a mini-grant program to support participants community projects. 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 an emotional support line for families discharged from of the neo-natal intensive care unit (NICU) largest children's hospital; purchase of a Zoom license to host support groups for parents of children with mental health issues; and support for playgroups for parents to spend more time outdoors.

PLTI Alumni: The more than 95 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 2020-2022, 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 2021 and 2022 legislative sessions, providing testimony on bills impacting families. One of the PLTI graduates used her project to form an advocacy group on menstrual equity that successfully passed Act 113 in 2022, which requires the Department of Education to provide free menstrual products to students in public schools.

In 2021-2022, PLTI graduates were featured in a number of media messaging campaigns including:

- A State Oral Health Coalition public service announcement (PSA) video to promote oral health check-ups for children https://www.youtube.com/watch?v=q24CRD5bs28
- PSA helping families get EBT/SNAP food benefits https://www.youtube.com/watch?v=4URT0fb4eYs

PLTI graduates also provided a number of news interviews to promote the temporary expand Child Tax Credit and discuss the challenges of Hawaii's high cost of living for young families.

PLTI graduates also provided important input/feedback to develop, test, and evaluate media/educational messaging, including the promotion of child wellness visits/immunizations for young children.

Convening Parent Organizations: The ECCS grant completed an environmental scan of the state family support/advocacy groups. Members of these state organization were convened and decided to continue meeting to

discuss common issues and potential collaborations. It is envisioned that this group can help to address common barriers, systemic challenges, and opportunities to move forward together. The ECCS family leader will help to staff this collective of family agencies/programs.

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

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

Over the past three years, the two FHSD epidemiologist positions remain vacant. These two division-level epidemiologists 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.

Former Epi staff: 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.

MCH CDC Assignee: FHSD continues to seek another CDC MCH Epidemiology assignee and has submitted applications annually after Dr. Hayes' departure. FHSD has interviewed two prospective assignees over the past three years, but none have accepted the position.

Epi II Position: Initially, FHSD actively recruited for the Epi II position. 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. The posting is currently listed with over 25 other epidemiology positions under recruitment for Hawaii's Department of Health. The SSDI program officer and MCH Bureau staff have assisted with circulating/posting the job announcement.

Research Statisticians: FHSD does have three FTE research statistician positions located at the division and CSHN and MCH branches that provide data analysis support. The Division Statistician is state funded and the branch statisticians are both Title V funded.

Carlotta Fok, Ph.D., has served as the Division Research Statistician since 2016. She received her Ph.D. in 2006 from McGill University, Canada, in quantitative psychology 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 and annual birth files. In 2022, Dr. Fok assisted the Department's Disease Investigation Branch program with data reporting for COVID cases counts.

Title V funding: Title V funds currently support the Epi II and a CDC MCH Epi Assignee. Title V also funds the two branch research statisticians. The Division Statistician is state funded.

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 5 of a five-year project period.

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.

Vital Statistics: In 2017, enforcement of a Hawaii Revised Statute related to data-sharing policies severely limited and stopped access to the Hawaii Vital Records office data. 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. Data for 2020 is 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 only provides summary utilization reports. Record-level data is available for purchase for specific research needs. FHSD used 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. 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 was managed by the state Medicaid program; however, the dataset was recently transferred to the University of Hawaii UHealth program for administration and analysis.

Epi Vacancies: 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, in 2018 and 2019 respectively. Hawaii continued to recruit for the position vacancies but was unsuccessful to date. The SSDI Project Coordinator

has been helpful with circulating the recruitment announcement and sharing opportunities to host epi interns.

AMCHP Epi Intern program: Hawaii applied for an AMCHP Epi Intern, but without an epidemiologist as a supervisor it was determined that this option would not benefit Title V program efforts.

Needs Assessment: The University of Hawaii faculty and resources have helped strengthen and supplement FHSD data activities, given staffing vacancies. From 2018-2021, Hawaii used SSDI funds to contract with University of Hawaii Office of Public Health Studies (OPHS) faculty to complete the Title V needs assessment, review data, and provide technical assistance for planning and evaluation.

OPHS: From 2018-2020, FHSD contracted with Dr. Jeanelle Sugimoto to complete the 2020 Title V needs assessment and provide technical assistance to program staff for planning and evaluation. In conjunction with program staff, Dr. Sugimoto developed logic models for each of the Title V priorities to assess program progress, achievement of short- and long-term outcomes, help with identification of barriers/challenges, and ensure the alignment of strategies with Title V measures.

In 2021, SSDI funds were used to contract Dr. Elizabeth McFarlane to assist with ongoing needs assessment since the 2020 Title V assessment was completed before the COVID pandemic. While there was little 2020 health status data available at this time, Dr. McFarlane assisted with the review of available data from: administrative service enrollment/utilization, state socioeconomic data, the U.S. Census Pulse survey, Hawaii surveys to measure COVID impacts using convenience samples, and informal reports from community partners. The data helped support the selection of four new Hawaii Title V priorities: child wellness visits/immunizations, pediatric mental health, food insecurity, and telehealth access.

Additionally, Dr. McFarlane helped design and administer a survey of Title V programs to capture systematic information on COVID impacts across FHSD programs and neighbor island offices. Dr. McFarlane also assisted with the development of several data publications that are pending FHSD review. This latter effort has been hampered by the FHSD epi vacancies.

AMCHP Poster: Dr. McFarlane's graduate assistant also helped with completion of the 2021 Title V grant report as a summer intern for the Title V grant coordinator. FHSD was able to sponsor her attendance at the 2021 AMCHP conference. In 2022, with Dr. McFarlane, a poster presentation was submitted accepted by AMCHP on the importance of disaggregated race/ethnicity data to understand infant mortality disparities. This experience helped highlight the importance of establishing an MCH academic pathway to FHSD and the larger MCH workforce in Hawaii.

Planning/Evaluation: In FY 2021-2022, 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, assist with planning and evaluation of strategies/activities, and update logic models.

There is no dedicated MCH faculty at OPHS and faculty have declined further offers to work on Title V, returning to their specific research interests. With limited faculty prospects at OPHS, in 2022, Hawaii looked out-of-state for MCH epi support to assist with the Title V report. Specifically, technical assistance was needed to:

- Review of the Title V FAD for interpretation and identify key findings

- Review socioeconomic data to examine social determinants that impact health status, including service administrative data (WIC, SNAP, Medicaid)
- Conduct more detailed analysis of surveillance and hospital data to examine disparities in health along race/ethnicity (utilizing detailed ethnic classifications for Hawaii, if available), geography, and other factors
- Review and evaluate the plethora of local surveys that have been conducted to assess the health and well-being of Hawaii families and residents since the pandemic

Additional projects may include:

- Development of MCH surveillance indicators that could be developed into an MCH data dashboard
- Development of data publications/presentations to help inform planning and policy development
- Conduct primary data collection for MCH populations to assess COVID impacts to inform program planning

MCH Centers of Excellence: With assistance from the MCH Bureau staff (the Hawaii Title V Project Officer, Epidemiologist, SSDI Grant Coordinator, and Workforce Development program) Hawaii contacted several MCH Centers of Excellence (COE) for technical assistance. While COE Directors were very supportive, finding epi assistance was challenging due a lack of qualified or available faculty. Hawaii was able to contract with a recent COE epidemiology graduate to assist with the review and interpretation of data for the needs assessment summary. Although the support was helpful, there were again challenges due to the broad and diverse scope of MCH data contained in the Title V report. A new contract with an epidemiology graduate from the Minnesota COE over the next year (2022-23) will allow for greater, in-depth analysis of the available data. Faculty from the Minnesota COE will also assist with data review/interpretation.

Oral Health data supports policy change: SSDI funds were used to purchase 2016-2020 data on Emergency Department (ED) visits related to oral health conditions in response to requests by the state oral health coalition. The data has been used effectively by other states to reinstate Medicaid adult dental preventive benefits since ED's are not able to treat dental issues except to prescribe pain medication.

FHSD helped fund data analysis by University of Hawaii John A. Burns School of Medicine epidemiologists. Title V was also able to provide national guidance for data analysis developed by the Association of State and Territorial Dental Directors. The findings confirmed that many dental-related ED visits were made largely by adults aged 21-44 years old (62%), Medicaid beneficiaries (49%), and Native Hawaiians (26%). Additionally, the analysis showed Medicaid paid $12.3M for dental-related ED visits, funds that could be better utilized for preventive services.

The data provided evidence of overutilization of costly ED services across the state for otherwise preventable oral health conditions. Data products included a PPT presentation for the State Coalition, a journal publication, and development of a factsheet and other materials to support advocacy efforts to reinstate adult Medicaid preventive dental benefits. In 2022, the Coalition's recommended appropriation ($25.9M) was successfully included into the state Medicaid base budget to assure sustained funding for the program. The Medicaid program is now working to contract for the services. The Coalition is working on a campaign to encourage more dentists to register as Medicaid providers.

Child/Youth Mental Health data: Another small contract was executed to assist with compilation of data on child/youth mental health in response to growing concerns over the impact of COVID restrictions, particularly with the switch to remote learning for Hawaii's public schools and associated after-school activities. Most the data is still largely pre-pandemic: Youth Behavioral Risk Survey, National Survey on Child Health, and Medicaid Quality Assurance Measures. FHSD is also partnering with the DOH Injury Prevention program epidemiologist to analyze Hawaii ED data for 2020-21 related to youth suicide visits. Previously, the data was used to support Hawaii's successful

application for the HRSA Pediatric Mental Health Access grant. The current update will help develop a Mental Health Data Tracker (dashboard) on the State Data Warehouse in FY 2023.

Data Products/resources:
Without epi staff, FHSD data products have been somewhat limited.

Publications

- Fok, C. C. T., Shim, M. J. Race and Depressive Symptoms are Associated with the Prevalence of Adolescent Suicide Attempts in Hawai'i, Youth Risk Behavior Survey 2015-2017. Hawaii J Health Soc Welf. 2022;81(6):155-161. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9168932/?report=classic
- Matsunaga, M.; Chen, J.J.; Donnelly, P.; Fok, C.C.T.; Partika, N.S. Emergency Room Visits with a Non-Traumatic Dental-Related Diagnosis in Hawaii, 2016–2020. Int. J. Environ. Res. Public Health 2022, 19, 3073. https://doi.org/10.3390/ijerph19053073
- Strid P, Fok CCT, Zotti M,et al. Disaster preparedness among women with a recent live birth in Hawaii–results from the Pregnancy Risk Assessment Monitoring System (PRAMS), 2016. Disaster Med Public Health Prep. https://doi.org/10.1017/dmp.2021.274

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.
- Matsunaga, M, Chen, John. Adult ER Utilization for Oral Health Conditions in Hawai'i, Hawaii Oral Health Coalition, 2021. https://www.hiphi.org/hawaii-oral-health-coalition/
- Hawaii Oral Health Coalition, Reinstating Hawai'i Adult Medicaid Dental Benefits in 2022.

Presentations

- Study of Adult Emergency Room Visits with a Dental-Related Diagnosis in Hawai'i: 2016-2020. October 2021 Masako Matsunaga, PhD. & John Chen, PhD. Presentation to Hawaii Oral Health Coalition.

Poster Presentation

- Baloran, R., & McFarlane, E. (2022, May). Infant Mortality and Birth Outcomes in Hawaii: The Importance of Data Disaggregation by Race and Ethnicity. Poster presented at the Associate of Maternal and Child Health Programs (AMCHP), 2022 Annual Conference (Virtual).

Websites/Data Trackers (Dashboards)

Hawaii State Department of Health, Hawaii Health Data Warehouse, Pregnancy Risk Assessment Monitoring System. Data for 2000-2019. https://hhdw.org/data-sources/pregnancy-risk-assessment-monitoring-system/

Hawaii State Department of Health, Pregnancy Risk Assessment and Monitoring System (PRAMS). https://health.hawaii.gov/fhsd/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.

Hawaii State Department of Health, The Oral Health Data Tracker Hawaii Health Matters :: Indicators :: Oral Health Tracker This convenient online tool allows users to review data across 30 oral health indicators for children, pregnant women (PRAMS), and adults.

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, analysis, and the development of publications/dashboards to ensure data is available for public use.

CSHN Ongoing Needs Assessment**:** The CSHN Branch is working in collaboration with the University of Hawaii Center on Disability Studies (CDS) to conduct ongoing needs assessment of children with special healthcare needs (CSHCN) in Hawaii. This effort includes a high-level overview of the Hawaii CYSHCN population, informed by data sources such as the National Survey on Children's Health (NSCH). In February 2021, findings from the 2018-2019 NSCH dataset were presented at the Pacific Rim International Conference on Disability and Diversity. Data from the 2019-2020 is being reviewed.

Primary data collection will be through a widely distributed survey of youth aged 12-22 with special healthcare needs and focus groups with youth and parents. To collect better data from under-represented groups, the survey is being translated into Tagalog, Ilokano, and Hawaiian. Since Pacific Islander communities are so diverse in language and culture, focus groups will be used to access this community. A data sharing agreement with the Department of Education will allow for dissemination of the survey into special education classrooms this Fall.

Results of the needs assessment will be published in a report and disseminated to the public through future conference presentations, open webinars, and freely available online materials such as graphic summaries. This project also supports the CDS 5-year needs assessment required for their grant funding.

TeenLink Hawaii Youth Assessment Survey
This anonymous survey was conducted in partnership with the Hawaii Department of Health Children with Special Health Needs Program (CSHNP) and TeenLink Hawaii, a youth empowerment project of the Coalition for Drug Free Hawaii. The survey was conducted from August – October, 2021 to develop transition to adult healthcare messaging. The survey was distributed to Hawaii teens and young adults ages 12-24 via various avenues (CSHNP client list, TeenLink Hawaii contacts, partner agencies of CSHN Program) in both electronic and paper format. Key findings are reported in the NPM 12 narrative.

Data Publications & Analysis: University of Hawaii Office of Public Health Studies (OPHS) OPHS faculty assisted with drafting of several data products from the 2020 needs assessment, including population domain factsheets, Title V priorities factsheet, and an informational brief on maternal morbidity. Data analysis will be conducted on 2019 Behavioral Risk Factor Surveillance Survey data questions purchased by FHSD on oral health and family planning. The publications are pending completion and review by FHSD staff.

Oral Health Tracker**:** Hawaii dropped oral health as a priority because there is no program funding to provide program leadership/staffing. However, FHSD continues to direct limited funding for oral health-related projects. In FY 2021 Title V contracted with the University OPHS, which manages the DOH Data Warehouse, to create an oral health data dashboard. The Warehouse contains a user-friendly website, *Hawaii Health Matters*, that houses several data dashboards. Without an epidemiologist, the Data Warehouse has been an effective means to disseminate and access data publicly. Also epidemiology staff at the Warehouse help assure reliable analysis, reporting and documentation for all data measures and sources.

OPHS and Title V partnered with the Hawaii Oral Health Coalition to select indicators and design/develop the dashboard, which launched in June 2022. OPHS helped promote and present the tracker to community stakeholders and the tracker is being promoted through DOH and community social media sites.

Mental Health Data Tracker: In FY 2022 FHSD contracted with OPHS to develop a mental health data dashboard.

Title V will partner with the Pediatric Mental Health Access Advisory Group as well as other community partners to select indicators and design the tracker. It is set for completion in FY 2023.

Early Childhood Needs Assessment: The new HRSA Early Childhood Comprehensive Systems (ECCS) grant is designed to improve integration of the maternal/infant health and early childhood systems, which have historically had separate services and programs. To assure family input to the program's strategic planning efforts, the University Center on the Family (COF) and the Hawaii Children's Action Network is developing a survey of families with pregnant women, infants and young children to:

- assess the support families receive from state and federal programs, including but not limited to WIC, SNAP, Medicaid, and childcare subsidies, as well as
- collect input on policies, programs and systems improvements that are needed for families with young children.

The survey findings will inform the ECCS work to build a more responsive and accessible service system for vulnerable children and families in Hawaii.

WIC Family Research: The University COF was also contracted to analyze and acquire data to better understand the WIC service population characteristics, utilization of benefits, and enrollment patterns. WIC has limited internal resources for data analysis. COF is working with the newly formed WIC Advisory Workgroup to help develop the analysis plan. The data will be used to help the workgroup's efforts to strengthen and improve WIC services.

Child Surveillance Data: FHSD has been meeting bi-annually with the DOH Chronic Disease program (and community partners) to explore options to generate better data for younger children and families. The National Survey on Children's Health (NSCH) has been discussed extensively, but was deemed of limited value with only state-level estimates (no disaggregated county or Hawaii-relevant race/ethnicity data). Moreover, the small state sample sizes require the data to be aggregated over multiple years to generate stable estimates which creates limited the ability to monitor trend changes over time. The group looked at other options including creating a Hawaii-based child health survey, the feasibility of digitizing school health data, and conducting convenience surveys.

In partnership with the OPHS, the Chronic Disease program developed an online survey of parents with young children in 2022 to generate better data on nutrition and physical activity. The 2022 survey utilized questions from the NSCH and was broadly disseminated through Hawaii service organizations and social media. FHSD helped support the survey by funding family incentives and disseminating the survey through Title V service programs. A final report is pending. Without a population-based surveillance for children, agencies and programs will rely on 'convenience' surveys to generate needed data for program planning and policy.

National Survey on Children's Health (NSCH): The NSCH addresses the gap in surveillance data for early and middle childhood, CSHN, and their families including social determinants of health. The data is an important surveillance source to track impacts of COVID on the MCH population. However, as discussed there are several issues with the NSCH data that limits its utility to inform state-level planning and address health equity.

Small Sample Sizes: While the survey provides standard state-level estimates the state sample size is small requiring aggregation of data across multiple years. For measures that examine a subset of data (ages 1-3 years for developmental screening) even aggregated data does not necessarily provide stable estimates and states are advised to use the data with caution.

Disaggregated Data: Unlike many states, Hawaii's population is largely comprised of Asian and Native Hawaiian/Pacific Islander groups. As described in the Overview, these categories represent diverse and distinct populations with differing historical, cultural, socio-economic experiences. When diverse groups are aggregated into large classifications, critical differences in health status are hidden. Thus, data findings can be misleading and

contribute to policies and programs that do not address fundamental community concerns, or worse, exacerbate existing inequities. Unfortunately, the NSCH data is reported using standard federal race classifications that combine all Asian groups and Native Hawaiian with all Pacific Islanders.

The need for timely, accurate, disaggregated Hawaii race/ethnicity data cannot be overstated. The COVID pandemic saw the Native Hawaiian, Pacific Islander and Filipino community demand the Department of Health report disaggregated health data for these populations, not only for COVID, but as a standard for all data reporting. During the pandemic, disaggregated data reporting showed these communities were most adversely impacted by COVID and the Department responded by partnering with community leaders and organizations to redirect resources to address this need.

Lastly, the NSCH data does not provide county level estimates. Given Hawaii is an island state, the geographic barriers across counties often results in differing health status and outcomes. This presents a major limitation to NSCH data utility.

State Over-sampling: The MCH Bureau does allow states to fund and develop survey oversampling to generate detailed county and race/ethnicity data. Over-sampling is costly and the process to develop the oversample is complex. To reduce costs, the Bureau recommends generating aggregated datasets over multiple years which means substantial time lags before useable data is available. The cost to generate the county and race/ethnicity data for Hawaii on an annual basis – far exceeds SSDI funds. Because Hawaii uses Title V funding largely for personnel, funds are not available annually to support an oversampling.

In addition to the funding challenges, there are several administrative barriers related to procurement and Hawaii's ability to access the dataset through a Census Regional Data Center (RDC). Since Hawaii does not have an RDC, FHSD would need to work with a site on the U.S. continent. In addition to developing a research application to attain 'security clearance' to an RDC, there is also a requirement for two in-person logins at an RDC before permission is granted for remote access to the dataset. There are also challenging restrictions for remote access to the dataset. The cost and effort required for a small state like Hawaii to conduct an over-sampling is prohibitive and time consuming.

Without an oversample, the NSCH data will continue to have limited value for program planning and policy development; unless the MCH Bureau expands the survey sample sizes for states, especially those with ethnically diverse populations.

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-OEP: 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 an 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 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: OPHP is responsible for developing and maintaining DOH's emergency operations plan (EOP). 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 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 State Emergency Response Team. The Title V Director serves as the DOH EMSF-8 (Public Health & Medical) liaison to the SEOC prior and during the pandemic.

DOH: During an emergency, DOH establishes an emergency response structure to coordinate DOH's activities using the national IMS guidance – Department Operations Center (DOC). 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 DOC Logistics Section Chief. As the pandemic proceeded, Title V's representation in the DOC has been revised to specifically focus on 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, 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 were provided, which facilitated discussion on specific and overlooked areas of need.
- The completion of training sessions, reports, and a checklist 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:

- It brought awareness to the topic of EP&R MCH for those in the ALC, who in turn spread awareness to other colleagues and partners.
- 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 postpartum 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 from which some data sets are available, 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 were 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.

Title V shared the HHS Maternal-Child Health Emergency Planning Toolkit with OPHP to inform planning update efforts.

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, postpartum, 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.

COVID-19 After Action Review: OPHP is currently working with a contractor to assess the Hawaii Department of

Health's response to the COVID-19 pandemic. The assessment process is lengthy and thorough and will ultimately result in a comprehensive After Action Report.

Staff from across the department who were actively involved in the response have been invited to participate in surveys, interviews, and meetings to discuss timelines, actions taken, and areas of improvement (AOI). Partners and community stakeholders will also be included in this assessment process. Based on what AOIs are identified, next steps will be outlined in the report.

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 on both testing and vaccinations.

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.

Title V direct service programs were able to shift from in-person to remote service provision during the large-scale shutdown of businesses/services. Where possible, programs expanded capability to conduct online preventive assessments and screenings. Newborn metabolic and hearing programs worked closely with hospitals, midwives, and families to maintain high rates of screening and follow-up services. Early Intervention Services acquired an online development screening program to assure evaluations could be completed remotely and in a timely manner. Most Title V programs have returned to offering in-person serves in FY 2022 but also maintain remote/telephonic options given several COVID variant surges. The exception is WIC, which continues to offer remote/telephonic services to clients.

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.

Data from the 2020 PRAMS disaster preparedness question will shared with OPHP when available.

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 use a collaborative approach to leverage federal and state resources to assure healthcare service 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 serve contracts or subsidies.

Reproductive Health Care & Support Services provides services and resources for women and men of reproductive age who are uninsured or under insured. The program assists individuals in determining the number and spacing of their children and to increase the likelihood of positive birth outcomes. Services include health education, screening, wellness checks, and pregnancy and perinatal support.

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, Hana 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 department 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 service 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 the 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/designee of the Director of Health
- 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.
- The Hawaii State Commission on Fatherhood is a state mandated commission. The mission of the Hawaii State Commission on Fatherhood is to promote healthy family relationships by emphasizing the important role fathers play in the lives of their children. The Commission serves in an advisory capacity to state agencies and makes recommendations on programs, services, contracts, policies, and laws relating to children and families. Title V Project Director, Matthew Shim, serves on the as an ex officio member/designee of the Director of Health

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, supporting TeenLink Hawaii youth groups to develop a website resource 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 executed a new Memorandum of Agreement (MOU) with the state Medicaid program to comply with Title V requirements for an interagency agreement. 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 vison 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 2021-2022 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 March 2017 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 May 2017 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

- Title V programs are supporting Medicaid efforts to prepare for redetermination of enrollment eligibility by updating addresses for Medicaid enrollees in Title V direct service programs. In June 2022, the Medicaid Public Relations Director conducted a presentation of Hawaii Medicaid's plans for eligibility redetermination (including a prepared media messaging campaign) to rollout at the end of the public health emergency. The presentation also included training of Medicaid eligibility, the enrollment process (both online and in-person resources), a review of benefits, and Medicaid process for transitioning youth to adult health care plans if needed. Ongoing communications and updates continue.
- 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 that arise and are invited to participate in workgroups, including the workgroup developing a media campaign to promote child wellness visits related to the Hawaii Title V state priority.
- MQD is sharing data with the state oral health coalition to assist with planning/evaluation for messaging to promote routine preventive dental visits.
- Most Title V health service programs and contracts promote enrollment to Medicaid.

Title V Priorities

- The Medicaid RFP issued in 2021 includes the Title V priorities of child and adolescent wellness visits, development screening, and a former priority, breastfeeding promotion.
- The Medicaid QI/Community Relations Nurse serves on the new Early Childhood Comprehensive Systems (ECCS) Advisory Board to include efforts to promote development screening and build a system for follow-up care.
- Medicaid is supporting the HRSA Pediatric Mental Health Access grant and is exploring possible funding for the mental health consultation warmline since the estimated costs for the service exceeds the grant award.

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. However, the Women's Health Supervisor position is now under recruitment.
    - 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.
- Project ECHO Hawaii is included in the MQD HOPE plan and managed care RFP. This helps to garner support and participation from the Medicaid health plans and providers for the program. Launched in 2016, Project ECHO Hawaii is a multi-organizational partnership between the Hawaii State Rural Health Association, University of Hawaii, and DOH Office of Rural Health (part of the Title V agency).
- During the legislative session, FHSD and MQD routinely coordinate on the development of policy briefs and testimony. This year included work on a bill to fund/restore adult preventive dental benefits.
- FHSD received MQD data for the Title V annual report/application including SSDI Minimum Core dataset Medicaid measures and Title V data for NPM 6 developmental screening and SPM 5 data for child wellness visits. Medicaid also provides updates on overall enrollment numbers (including enrollments for newly added eligibility for Micronesian under the Compact of Free Association) and policy plans to extend postpartum to one year
- FHSD submitted a request to provide Medicaid oral health data for inclusion in the new Oral Health Data Dashboard located in the DOH Data Warehouse. Data requested includes Medicaid provider registration by level of claims submitted, disaggregated data for EPSDT service utilization, numbers of interisland flights funded by Medicaid to access specialty care.

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
- Title V hopes to meet with the Medicaid staff over the next year to discuss potential partnership efforts around Medicaid/Title V quality measures (including developmental screening, child wellness, immunizations) and the EPSDT program.

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. Hawaii's priorities discussed in this next section are listed below with the associated NPM/SPM number and subject matter.

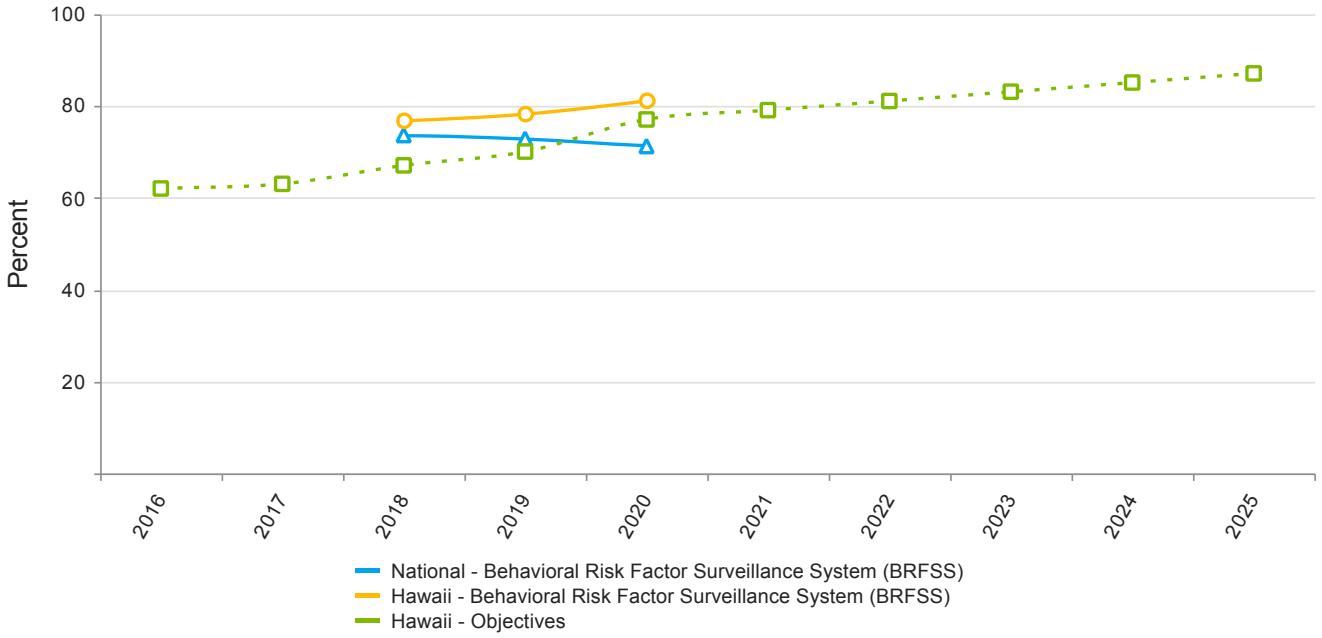
Domain	PM #	Subject
Women's/Maternal Health	NPM 1	Women's wellness visits
Perinatal/Infant Health	NPM 5 SPM 2	Safe Sleep Food Insecurity
Child Health	NPM 6 SPM 1 SPM 5	Developmental Screening Child Abuse & Neglect Prevention Child wellness visits
Adolescent Health	NPM 10	Adolescent Wellness Visits
Children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

Many activities planned for FY 2021 were impacted by the pandemic: delayed, cancelled or changed.

Women/Maternal Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				77	79
Annual Indicator			76.6	78.1	81.1
Numerator			184,106	185,323	191,337
Denominator			240,287	237,398	235,933
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

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

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	81.0	83.0	85.0	87.0

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	34	31	31	31	31
Annual Indicator	31.7	31.9	30.9	32.4	33.3
Numerator	2,849	2,773	2,661	2,558	2,614
Denominator	8,974	8,693	8,599	7,903	7,851
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	31.0	31.0	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

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 2020 five-year needs assessment. The 2025 Title V state objective is to increase the percent of women who have a preventive medical visit to 87.0%.

Data: The FY 2021 data (2020 data) indicates that 81.1% of women in Hawaii received a preventive medical visit, which met the objective, and was significantly higher than the national estimate of 71.2%. The increase from 2019 (78.1%) to 2020 was not significant. It's unclear to what extent this data captures the impact of healthcare provider office closures during COVID, eliminating in-person visits and delayed care during 2020. The BRFSS preventive checkup survey measure was revised in 2018 and is not comparable to previous survey years. There were no significant differences in 2020 data reported subgroups by race/ethnicity, maternal age, household income, health insurance, or marital status.

Objectives: The state objectives reflect a projected annual increase of 2 percentage points.

Title V Lead/funding: This priority was significantly affected by program funding changes and key personnel vacancies over the past year.

- The Title V Women's and Reproductive Health Section (WRHS) in the Maternal and Child Health Branch (MCHB) provides the leadership for this issue and is partially Title V funded. The position remains vacant since November 2021.
- Former Family Planning staff who supported this work were part of a reduction in force when Hawaii did not apply for federal Title X funding in March 2020, due to restrictions placed on abortion information sharing.
- The state-funded Family Planning supervisor position remains vacant since May 2021.
- The programs in the WRHS section also include Adolescent Health. The Adolescent Health Supervisor, which is also partially Title V funded, remains vacant since December 2021.

Due to these vacancies, some program plans and reporting are delayed or hampered due to limited staffing.

Strategies/Evidence: The strategies for this priority reflect, in large part, the work of the Hawaii Maternal and Infant Health Collaborative (HMIHC), which provided community-led leadership for women's health and perinatal issues in the state for the past ten years. Title V helped establish the HMIHC and is part of the organization's leadership team. In FY 2021, a fourth strategy was added, focusing on health equity. The Title V strategies are:

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

Research provided by AMCHP and the MCH Evidence Center indicate that most evidence-based practices focus on clinical and direct service approaches, rather than the broad systems-level change strategies selected by Hawaii. Hawaii is implementing two evidence-based approaches that promote both 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 (CoIIN) as best practices. Updates on the strategy activities for this NPM are discussed below.

COVID Impacts: Some COVID-related safety restrictions were lessened in 2021, with healthcare providers reopening for in-person visits and continuing some telehealth appointments. It is likely telehealth will remain part of the 'new normal,' as the state transitions to COVID as endemic.

In 2021, Hawaii experienced two major COVID surges with the Delta and Omicron variants, so safety protocols remained largely in place with indoor masking mandates and continued promotion of other precautions (vaccinations, social distancing, hand sanitizing). Fears over COVID exposure, prioritizing of daily needs, and other life disruptions resulted in delayed health care for many residents. Throughout 2021, Hawaii's families continued to struggle economically to meet basic needs (rent, employment, education, and food security).

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 (ECAS) 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 healthy women and the health and well-being of infants, children, and families.

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 disrupted routine ECAS and HMIHC meetings and activities. The ECAS network of partners devoted efforts responded to the urgent relief and recovery needs generated by COVID and also supported member organizations' capacity-building to better assist with urgent family needs.

Strategy 2: Promote Pre/Interconception Healthcare Visits

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

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

The Title V Women's and Reproductive Health Supervisor and state Medicaid office provides 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 help to target services to prioritize low-income, high-risk women of reproductive age.

The workgroup continued to meet remotely throughout 2021. HMIHC's work on OKQ and LARC strategies was delayed due to both FHSD and Medicaid focusing on issuing new RFPs for services in 2021.

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, allowing for reimbursement for a 12-month supply of oral contraceptives. The policy 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. HMIHC efforts have focused on ensuring implementation of the polices.

One Key Question® (OKQ): OKQ is a simple tool to engage women in a discussion about their pregnancy intentions 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 a matrix of standardized protocols. Client discussions would then lead to desired reproductive planning and follow-up for preventive healthcare.

Prior to the pandemic, OKQ was reported as being utilized by a wide range of Hawaii organizations/programs serving women of reproductive age.

OKQ training activities were paused in FY 2020, given providers' focus on the COVID-related needs, with the exception of a training conducted for Public Health Nurses. Title V WRHS contracted with Healthy Mothers, Healthy Babies to restart OKQ certified training through the national *Power to Decide* (PTD*)* program. The curriculum and materials were offered as a self-paced, one-month online course, with continuing education credits offered.

Evaluation of OKQ: Each agency utilizing OKQ currently collects implementation data. However, there is no systematic centralized repository to compile this information or a standardized set of indicators to measure the effectiveness of OKQ to prevent unplanned pregnancies and improve reproductive health outcomes. The HMHB contract is designated to assist with development of an evaluation plan for OKQ.

LARC: LARC was chosen as an evidenced-informed approach by Hawaii to help reduce rates of unintended pregnancy. LARC placement occurs in a single provider 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 nondirective 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 birthing hospital prior to discharge. This benefits women who are at-risk for short-interval pregnancies and/or those less likely to return for recommended postpartum care.

The workgroup developed a LARC toolkit that includes billing guidance related to inpatient stocking of LARC and a chart with reimbursement codes, also available at all birthing hospitals and with many providers. Despite the Medicaid LARC policy, changing birthing hospitals operational/insurance practices have been challenging. HMIHC continued working with several hospitals to establish in-patient pharmacy protocols, to ensure that LARC is in-stock. Issues with Medicaid reimbursement and private insurance coverage are also being addressed by HMIHC.

The goal is for all 13 Hawaii birthing hospitals to stock and receive unbundled Medicaid reimbursements for LARC inpatient insertion. Currently, eight of the 13 hospitals now stock LARC for same-day access.

Strategy 3: Promote Reproductive Life Planning

This strategy focused on increasing access to reproductive life planning services and assuring provision of family planning services through FHSD contracts.

COVID Response: Changes to the women reproductive health contracts included:

- Instituted or strengthened telehealth services to meet reproductive and other healthcare needs of clients.
- Maintained clinic hours during COVID, for both in-person and telehealth services, following CDC-recommended safety precautions to protect employees and clients for in-person visits.
- Extended Family Planning and Perinatal Support Service contracts through June 30, 2021, to assure continued funding and services during COVID.

Continued Family Planning Contracts: In response to the Trump Administration's Title X conditions prohibiting grantees from providing any information regarding abortion services, Hawaii was no longer a Title X grantee since April 1, 2020. However, using state funds, limited FP service contracts continued through June 30, 2021. Title V funds helped support FP staff salaries during the transition period. Despite changes to the contracts, the FP program served 4,905 clients for FY 2021, compared to 10,308 in 2020.

New RFP: In anticipation of the PSS and FP contracts ending on June 30, 2021, the MCHB-WRHS developed an RFP to target reproductive health services for the underinsured and uninsured. These contracts were funded with a smaller amount of state general funds beginning on July 1, 2021. Without the Title X award, the numbers served will be substantially reduced.

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	33.3				

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, based on 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 2021 indicator of 33.3% of births did not meet the recommended birth spacing projected measure. 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 acknowledges the need to revise the ESM from a population-based health outcome to a process measure in order to monitor progress on the specific strategies and activities. However, this process is 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.

Strategy 4: Promote Health Equity

Health equity is a priority for all Title V work, including women's' health. The partnership with Medicaid and FQHCs through the HMIHC, assures that program activities are benefiting underserved population groups.

Planned activities for FY 2021 were to focus on completing data publications to highlight disparities in maternal health to help inform planning; however, the work is delayed due to COVID and FHSD epidemiology vacancies. Several data publications were drafted by the University of Hawaii's Office of Public Health Studies (OPHS) but are awaiting review/approval by FHSD.

Current Year Highlights for FY 2022 (10/1/2021 – 6/30/2022)

Service updates:

- MCHB WHRS continued to provide ongoing reproductive health care and support services through eight community-based providers, including FQHCs, the Healthy Mothers, Healthy Babies' mobile van, and university/community colleges.
- Systems-building work, through the HMIHC Pre/Inter-Conception Workgroup, continued to promote OKQ and address LARC issues.

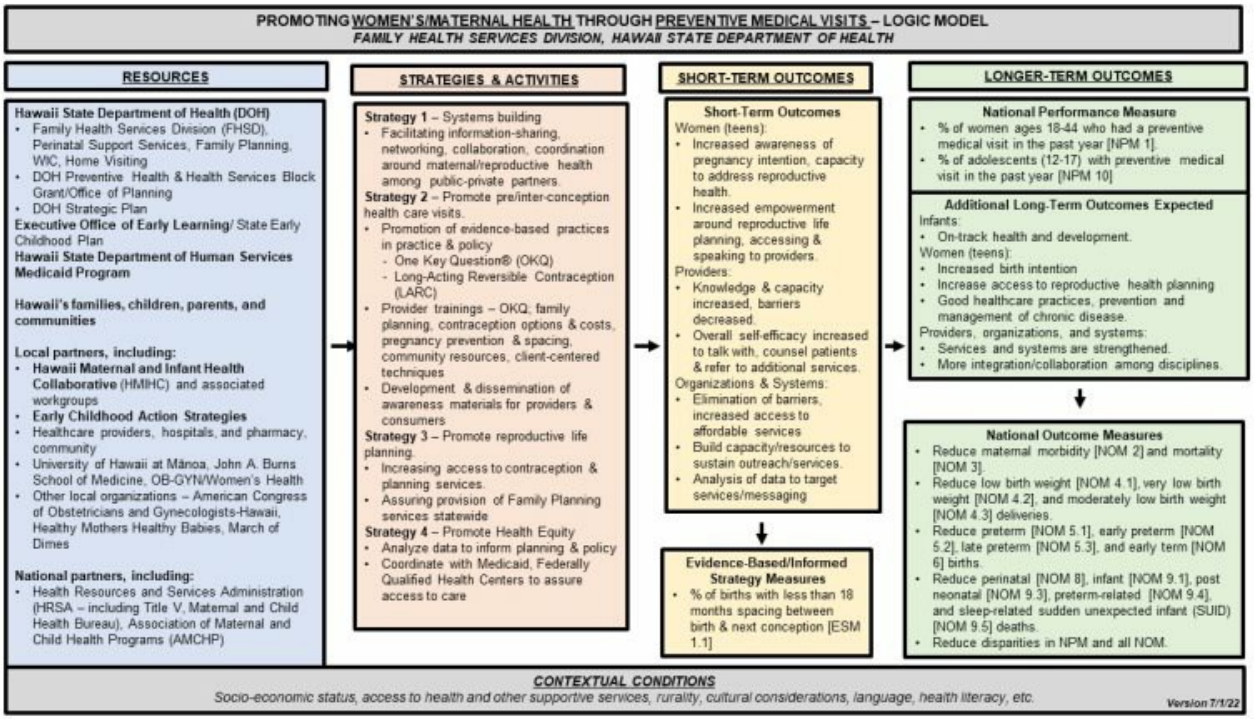
Title X application: The Biden Administration issued a revised Title X funding announcement, reinstating a comprehensive approach to reproductive health service options. Hawaii submitted an application and was "approved, but not funded" for an award. The Hawaii grantee is Essential Access Health (EAH), which serves California's statewide Title X provider network. EAH is partnering with the seven Hawaii healthcare organizations, including FQHCs, the University of Hawaii, and Planned Parenthood.

Health Equity: MCHB responded to community requests for implicit bias training for perinatal healthcare providers by partnering with the faculty of the Native Hawaiian Health Department at the University Medical School. The presentation, 'Contextualizing Maternal Health in Hawaii,' addressed the historical, cultural, and social determinants of health and included findings from original research on implicit racial bias among perinatal providers toward Native Hawaiians and Pacific Islander patients.

To address limited MCH epidemiology capacity, FHSD began discussions with the Minnesota MCH Center of Excellence to review and finalize the three draft data publications designed to highlight key health disparities in women of reproductive age, a review of maternal morbidity and mortality, and a factsheet on Native Hawaiian maternal and child health. The Minnesota COE will also assist with more detailed analysis of Title V data.

Review of the Action Plan

A logic model developed for NPM 1 aligns strategies and activities with performance measures and desired outcomes. The fourth health equity strategy was added to the logic model to help address the need to reduce disparities in Hawaii's women.



The vital work of the HMIHC is continuing despite the ongoing demands and challenges presented by COVID. Health messaging and education efforts for both providers and consumers were developed to focus on OKQ and access to LARC and other reproductive health service outcomes for women, providers, and systems.

Priority Populations: Critical populations include: low-income women particularly in light of the health, social, and economic consequences of COVID in Hawaii. Partnering with Medicaid assists Title V in addressing/tracking this population's needs. Although the NPM data does not show any significant disparities by subgroup, further data analysis of women's health measures should provide findings to guide future program planning.

Teens and young adults are also priority populations in need of reproductive health and other preventive services. Although Hawaii's teen birth rate continues to decrease, early pregnancy will adversely impact the trajectory of a women's life. Coordinated efforts to address teen health needs and promote adolescent wellness visits is described in NPM 10 and is also included in the logic model.

The ESM on birth spacing is population based and does not directly measure the impact of the NPM policy and program activities. Hawaii's plans to revise the ESM are delayed due to COVID and program/staff changes.

Challenges, Barriers

Women's Health Services. With the loss of Title X family planning funding, MCHB is reevaluating its efforts focused on women's/maternal health, as Title X funding was a key cornerstone in supporting reproductive life planning, women's health services, and workforce training.

Workforce Vacancies. Transitions in the workforce during COVID significantly impacted the Title V Women's Reproductive Health section. The section has three key vacant positions. These program vacancies are compounded by a lack of MCH epidemiological support to analyze Hawaii data to monitor COVID health impacts, as well as health disparities.

Some of the challenges specific to advancing widespread use of OKQ and LARC discussed in the narrative include:

- Development/implementation of an evaluation plan to monitor success of OKQ training.

- Lack of resources to develop a centralized data management system to establish OKQ and LARC benchmarks, performance measures, and creating systematic data collection processes.
- Continued administrative hospital barriers to LARC stocking and use, issues with Medicaid reimbursements, and private insurance coverage of the device.
- Lack of standardized healthcare plan coverage for LARC-related medical supplies and services across private insurers.

Overall Impact

Despite the challenges over the past two years, Title V achieved major milestones in promoting 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 in the formation of HMIHC, with Title V and Medicaid as co-leaders for the Pre/Inter-Conception Workgroup. The diverse HMIHC membership helped to staff and fund the ongoing collaboration.
- Progress in advancing two key evidence-based strategies focused on the expanding use of OKQ and LARC, including the establishment of Medicaid provider policies to support OKQ, LARC, and expanded contraceptive use (elimination of prior authorization for contraception, reimbursement for a year supply of oral contraceptives, unbundled LARC reimbursement from delivery fees, stocking of LARC in hospital pharmacies).
- Over 1,000 active OKQ trained health care providers statewide.
- LARC now stocked in most of the state's largest birthing hospital pharmacies.

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 Title V five-year needs assessment. By July 2025, the state seeks to increase to 87.0% the number of women who have a preventive medical visit, including pre- and interconception care. Plans to address this objective and NPM are discussed below.

Due to significant operational and personnel changes during COVID, many of the activities planned for 2020-21 were delayed, paused, or revised. Given the recognition of maternal/women's health in the state's key MCH plans and collaboratives. Strategy 1 (promoting women's wellness visits through systems building) was retired in FY 2022. Collaboration and systems building is integrated into each of specific strategy activities, including a focus on health equity to address long-standing health disparities exacerbated by COVID.

Strategy 1: Promote Pre/Interconception Healthcare Visits

The HMIHC Pre/Inter-Conception Workgroup plans will continue to focus on expanding use of OKQ and improving access to LARC.

OKQ will:

- Continue training activities with a focus on training clinical providers.
- Continue evaluation and online provision of OKQ trainings.
- Develop standardized system to track, monitor, and evaluate OKQ data across programs and agencies.

LARC activities include:

- Continue to assess and address barriers to implementation of the Medicaid LARC policy at Hawaii's 13 birthing hospitals. The University of Hawaii John A. Burns School of Medicine, Department of Obstetrics, Gynecology and Women's Health in partnership with Medicaid will continue leading this activity.
- Continue to assess and help meet the needs for provider training on changes to LARC coverage and codes, placement and removal of devices, and client counseling to increase provider competency.

Strategy 2: Promote Reproductive Life Planning

Title V MCHB will continue to increase access to reproductive life planning services through service contracts to community-based providers. Other activities include:

- Support telehealth use by reducing barriers to access of care through provision of telehealth technical assistance, resources, and training relating to LARC-related coding and reimbursement.
- Revise the NPM 1 ESM to align with new women's reproductive health service contract performance measures and reporting.

Strategy 3: Promote Health Equity

Health equity is a priority for all Title V work, including women's health. MCHB will continue to provide trainings, as needed, on the issues of implicit bias and health equity.

Work on the three women's health publications will be completed.

- 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. Title V will partner with Hawaii's Alliance for

Innovation on Maternal Health (AIM) grantee at the University of Hawaii Medical School to partner on this project.
- A short infographic factsheet on Native Hawaiian MCH will also help provide some health disparities and equity-related data and information on maternal health.

Once completed, the information will be used to engage community partners/leaders to develop targeted activities to help address health disparities and the structural/systemic barriers to 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 (WIC): 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.

Reproductive Health Care & 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 uninsured and underinsured pregnant women through pregnancy and six months post-partum. Services include assistance to enroll in public/private insurance.

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.

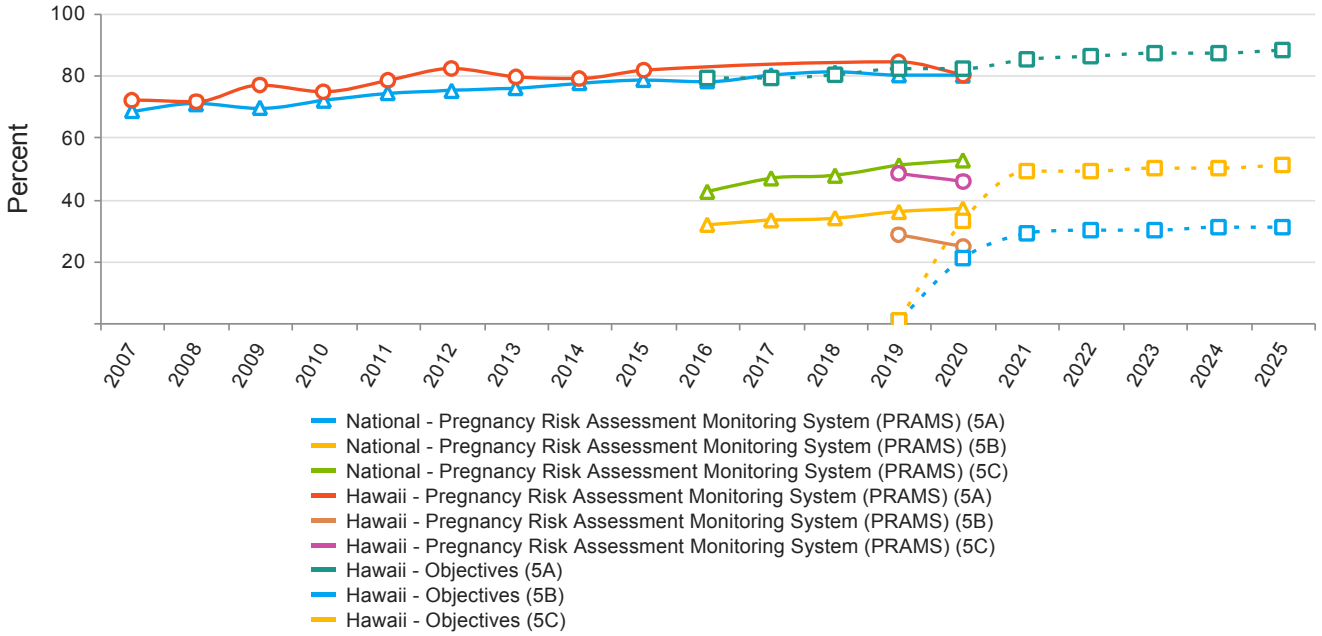
Maternal Mortality Review: Reviews causes of maternal deaths occurring during pregnancy up through one year of giving birth to identify public health and clinical interventions, improve systems of care and reduce preventable deaths; team comprises of a multidisciplinary disciplines and multi-agency committees.

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.

Perinatal/Infant Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	79	80	82	82	85
Annual Indicator	81.5	81.5	81.5	84.0	80.1
Numerator	14,376	14,376	14,376	6,895	12,016
Denominator	17,634	17,634	17,634	8,212	15,003
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2015	2015	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	86.0	87.0	87.0	88.0

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	**2021**
Annual Objective	21	29
Annual Indicator	28.7	24.7
Numerator	2,245	3,565
Denominator	7,829	14,455
Data Source	PRAMS	PRAMS
Data Source Year	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			1	21	29
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				
	2022	**2023**	**2024**	**2025**
Annual Objective	30.0	30.0	31.0	31.0

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	**2021**
Annual Objective	33	49
Annual Indicator	48.1	45.9
Numerator	3,755	6,633
Denominator	7,801	14,447
Data Source	PRAMS	PRAMS
Data Source Year	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			1	33	49
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				
	2022	**2023**	**2024**	**2025**
Annual Objective	49.0	50.0	50.0	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	2021
Annual Objective			11	11
Annual Indicator			0	11
Numerator				
Denominator				
Data Source			Hawaii Safe Sleep Program	Hawaii Safe Sleep Program
Data Source Year			2020	2021
Provisional or Final ?			Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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	2021
Annual Objective		
Annual Indicator	25,584	25,907
Numerator		
Denominator		
Data Source	Hawaii WIC Services	Hawaii WIC Services
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

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

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 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 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

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 2020 Title V needs assessment. The 2025 Title V state objective for NPM 5A is to increase the percentage of infants placed to sleep on their backs to 86.0%.

Data: NPM 5A: The latest data from the 2020 PRAMS survey (80.1%) indicates that Hawaii did not meet the 2021 state objective or the Healthy People 2030 objective of 88.9% but was similar to the national estimate of 79.8%. 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 indicates that Native Hawaiian mothers (72.9%) were less likely to place their infants to sleep on their back, when compared to Filipino (81.2%), White (85.3%), Chinese (86.3%), or 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, when 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, when compared to those at 301% and greater FPL (85.6%).

NPM 5B: The latest data for NPM 5B indicates that 24.7% of Hawaii infants were placed to sleep on a separate approved sleep surface, not meeting the state objective of 29%, which is significantly below the national percentage (36.9%). The decline from 2019 (28.7%) was non-significant. There were no significant differences among subgroups, based on 2020 data (which may be due to the small numbers).

NPM 5C: The latest data for NPM 5C indicates that 45.9% of infants were placed to sleep without soft objects or loose bedding, which did not meet the state objective (49.0%) and is significantly lower than the national percentage of 52.5%. The decrease in the estimate from 2019 (48.1%) was not statistically significant. Higher risk groups could not be reported due to small numbers.

PRAMS data: There was no PRAMS data collection in Hawaii from 2017 to 2018. The Title V 2019 NPM 5 indicators are derived from the 2016 PRAMS survey, and the 2020 indicators are from 2019 PRAMS survey. Note: The 2019 dataset includes only six months of weighted data. The 2020 PRAMS data reported for Title V FY 2021 includes a full year of data.

Objectives: Following a review of the baseline data and the HP 2030 objective, the state objectives for all three measures were updated through 2025.

Child Death Review: Although the total number of child deaths in 2020 was smaller (113) during the COVID-19 pandemic, compared to the Hawaii average of 140-160 child deaths in 2016-2019, infant sleeping conditions continued to emerge as possible factors in several Child Death Review (CDR) cases.

Title V lead/funding: The supervisor for the Family Strengthening and Violence Prevention (FSVP) Unit under the MCH Branch (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; however, state funds are leveraged to support efforts. Title V-funded staff provide branch-level leadership and overall support for safe sleep.

Strategies: In 2021, the strategies for safe sleep were:

- 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 translation of educational materials and safe sleep messages to promote families accessing the Parent Line

Evidence: A recent review of the AMCHP and MCH Evidence Center research indicates that targeting caregivers with education is supported by moderate evidence of effectiveness. National campaigns focused on vulnerable subgroups as having the most significant impact on advancing health equity. In 2020, a Hawaii strategy was added specifically to address disparities in safe sleep behaviors targeting key ethnic groups by developing multilingual educational outreach to limited English-speaking communities. The strategy was also supported by input from local service providers working with underserved, multicultural families. ESM 5.2 was created to measure progress on this new strategy.

A report on the safe sleep strategies and activities are discussed below.

COVID-19 Impacts: The advent of COVID-19 pandemic shutdown orders and social distancing created enormous disruptions to daily life with school and business closures with travel restrictions that led to profound economic hardships and increased stress on families. The lockdown restrictions continued through FY 2021, changing prenatal, delivery, and postpartum services (including family involvement), resulting in less direct support and information for new parents and putting newborns at potential increased risk.

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

Throughout 2021, safe sleep outreach/education efforts were put on hold as more critical messaging around COVID prevention and essential economic entitlements/supports were prioritized. These, and other factors, likely adversely impacted safe sleep conditions for families with newborns and infants. Although 2020 PRAMS data shows a slight decline in the Title V safe sleep measures, the percentages are not statistically significant.

Strategy 1: Increase the awareness of the importance of Safe Sleep and provide safe sleep education through public service announcements and digital media

This strategy focuses on media messaging activities to reach families in response to much of the social isolation created during COVID.

Safe Sleep Hawaii (SSH): SSH is the statewide coalition that promotes safe sleep efforts, focusing on the development of appropriate and consistent parent education materials and general awareness messaging. SSH helps assure information of safe sleep practices follow 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, nonprofits, for-profits, and grassroots organizations and sectors, as well as families who are committed to preventing infant mortality through safe sleep practices. Quarterly meetings were held virtually during the ongoing pandemic and participation remained relatively stable. SSH reviewed trainings and public messaging to ensure that information was consistent with AAP guidelines.

Annual Safe Sleep Summit. An annual Safe Sleep Hawaii Summit is normally held in-person to promote networking and partnering and to provide current information updates to support public and private stakeholders' efforts. The 2020 and 2021 Summits were cancelled due to COVID.

Media Campaign: Given the greater social isolation experienced by families and the limited availability of direct services during COVID, Title V decided to use mass media efforts to promote safe sleep messaging. In 2021, a Safe Sleep media campaign was planned to educate parents and caregivers as part of October's *Safe Sleep and SIDS Awareness Month.* Working with the Title V-funded public information officer, television and digital spots promoting safe sleep were developed using the ABC messaging (Alone, on their Backs, in a Crib), which are the evidence-based recommendations from AAP. The spots mirrored the content of a widely used *Hawaii Safe Sleep Guide for Parents*. The Guide was jointly developed in collaboration with several state agencies. SSH reviewed the content before its release. The call to action for the campaign steered the public to Safe Sleep information available via the Parent Line, which is the primary Title V hotline.

The Parent Line: The Parent Line, which is contracted by MCHB, provides support to parents and caregivers with information on community resources, child behavior, child development, and parent education. The Parent Line is free and confidential and can be accessed by phone, chat, and/or website. The Parent Line was featured in the Safe Sleep media campaign, displaying the web URL and phone number for the public to obtain more information on safe sleep. In preparation for the campaign launch, MCHB worked with The Parent Line to create a dedicated webpage for safe sleep with electronic copies of the Safe Sleep Guide available and a schedule of accessible virtual safe sleep workshops.

Strategy 2: Expand outreach to non-English-speaking families and caregivers through translation of educational materials and safe sleep messages.

Hawaii is a state with a large immigrant and multiethnic population, including many English as a second language (ESL) households. These populations bring diverse traditional and cultural practices for infant sleep, including co-sleeping practices. To expand outreach to these groups, MCHB partnered with the Department of Human Services (DHS) and the Office of Language Access (OLA) to translate the Hawaii Safe Sleep Guide for Parents into 11 of the most common secondary languages spoken in local households. The Guide is also used by all licensed childcare providers and other early child programs statewide.

The translation joint venture began in 2020. The workgroup reviewed several sources of data, including Census data, requests for language interpretation services by DHS entitlements programs, and PRAMS data to identify cultural groups/languages with an increased risk for sleep-related infant mortality. 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 thoroughly reviewed and crosschecked by focus groups of native speakers to ensure that all translations were accurate, and that information and graphics were appropriately displayed in a readable and understandable manner.

Distribution of the Safe Sleep Guides was contracted to The Parent Line to ensure equitable access statewide. Printed versions of the Guide were mailed out upon request and electronic copies can be found on The Parent Line

website. The media campaign spots were designed to promote broader dissemination of the newly translated Safe Sleep Guides via the website or by request (phone or chat).

ESM 5.2 was developed to track progress on efforts to reach diverse populations with Safe Sleep information in multiple languages. The completion of the translations and dissemination plan coupled with the launch of the media campaign in FY 2022 largely completes the work for ESM 5.2. A new ESM will be developed next year with the addition of a new strategy.

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	11				

Current Year Highlights FY 2022 (10/1/2021 – 6/30/2022)

Hawaii continued to convene the SSH coalition through virtual meetings as COVID restrictions continued into 2022

Media Campaign: The planned Safe Sleep media campaign was launched in October 2021 as part of the *Safe Sleep and SIDS Awareness Month*. A press release announced the campaign, with interview spots scheduled on the major morning television news programs. The television and digital spots ran through December, reaching approximately 590,819 people/households; with over 6 million impressions (total amount of times our ad is seen or heard). The combined digital and social media spots totaled 863,824 total virtual contacts.

Cribs for Kids Program: The DOH is contracting to expand the *Cribs for Kids Program,* which provides statewide safe sleep education as well as a pack and play crib to ensure a safe sleeping environment for families in need. This program energizes partnerships around the state. This year, there will be an emphasis on the dissemination of translated safe sleep materials, as well as engagement of homeless or at-risk for homelessness populations statewide.

Responding to COVID-19: Given the broadly changing conditions brought by COVID, the MCHB and SSH developed new safe sleep activities for future implementation.

Statewide Assessment: A contractor was secured to complete a statewide environmental scan and assessment of safe sleep related activities and partnerships in Hawaii. The scan will also identify any significant disparities and gaps in services and information with recommendations to help guide future safe sleep planning and implementation efforts.

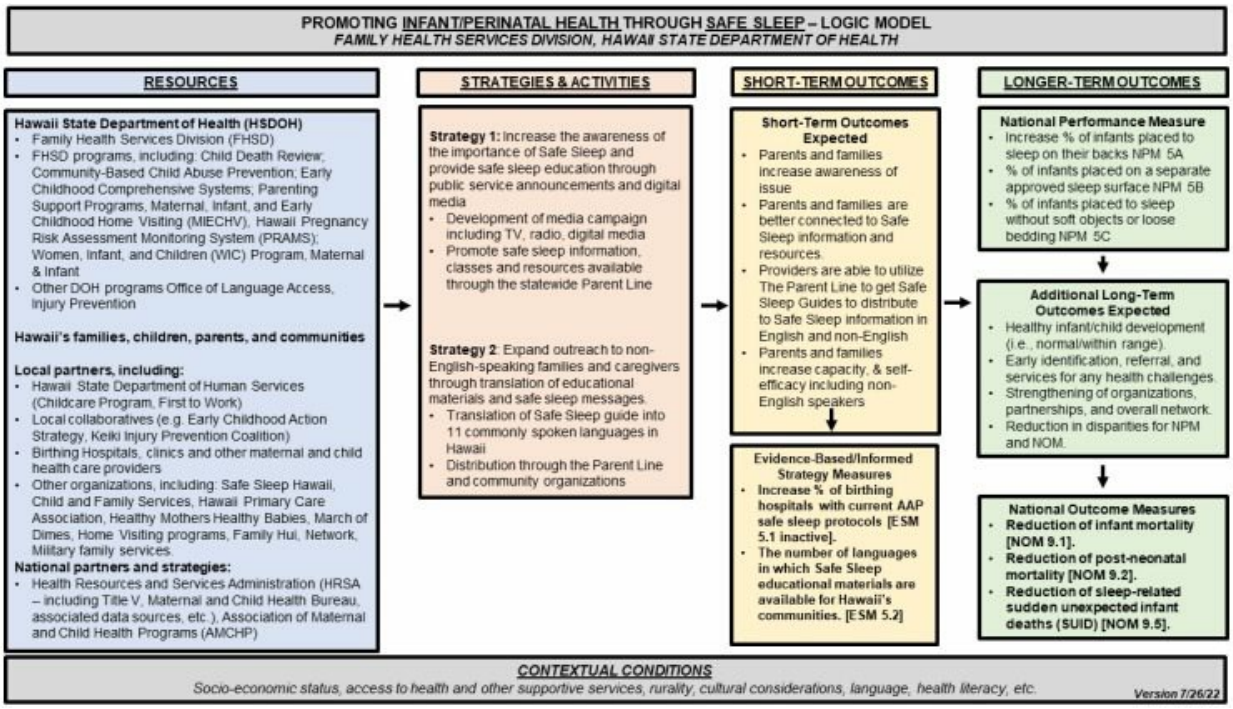
Safe Sleep Hawaii Summit: The annual virtual Safe Sleep Summit was held in May 2022 and featured keynote speaker, Dr. Suzanne M. Bronheim, Adjunct Associate Professor in the Department of Pediatrics at Georgetown University Center for Child and Human Development (GUCCHD). Dr. Bronheim discussed trends in effective approaches to safe sleep education. Barb Himes, IBCLC, Director of Education and Bereavement Services at First Candle, facilitated discussion on personal provider biases that can adversely impact the delivery of messages to families. Nursing Continuing Education credits were offered.

Review of the Action Plan

A revised logic model was developed for NPM 5 to review alignment among the SS strategies, activities, measures,

and desired outcomes. Focusing on two strategic areas (messaging and translating educational materials for limited-English speaking populations), efforts to increase the percentage of infants placed safely to sleep and in safe environments improved. Reductions in disparities are also anticipated for all measures and outcomes. The activities associated with each of the three strategies directly correlate with short-term outcomes and will also impact longer-term outcomes (NPM 5 and NOMs 9.1, 9.2, 9.5). Short-term outcomes include:

- Parents and families increased awareness, capacity, and self-efficacy, specific to safe infant sleep
- Increased accessibility of safe sleep messaging and information to diverse ethno-cultural groups
- Development of a statewide media campaign, with public service announcements on television and other digital media
- Expanded use of The Parent Line, to disseminate Safe Sleep Guides across the state



Challenges Encountered

COVID-19: Safe sleep activities were revised for 2021, as SSH partners and Title V, in response to operational changes and changing community needs due to COVID. SSH continued to conduct remote partner meetings as COVID continues to affect the state.

The *Cribs for Kids* program that provides statewide safe sleep education and distribution of a Pack and Play crib to support a safe sleeping environment for infants switched from in-person parent/caregiver training to virtual in order to adhere to COVID safety guidelines. A program evaluation will determine whether/how this change has impacted the effectiveness of the program.

Addressing Co-Sleeping: As Hawaii PRAMS data confirmed, co-sleeping is a common cultural practice in Hawaii. Initiatives such as Pack and Play crib distribution and education through the *Cribs for Kids Program* have proven effective nationally with at-risk populations. However, addressing local/cultural beliefs and a general acceptance of co-sleeping continues to be challenging. The practice may be attributed to the state's ethnic/cultural diversity and household overcrowding, housing insecurity, and multi-family living arrangements due to the high cost of housing. Data indicates 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 other community organizations will be key to the

success of targeted outreach to these priority disparate populations. SSH will expand efforts to include more diverse coalition participation as the multilingual messaging is disseminated.

Measuring Effectiveness: The Safe Sleep media campaign, *Safe Sleep Guide for Parents and Caregivers* (both in English and translated languages), and the Parent Line were used for public health messaging. Increased access to key information for a wider range and more diverse population had some measure of effectiveness. However, it is unknown to what extent the messaging has changed family attitudes and behavior around safe sleep practices. It is also unclear to what extent service providers have been utilizing the translated information with their client populations. The safe sleep environmental scan will collect and document additional data to better determine effectiveness of these efforts.

Overall Impact

COVID changed outreach efforts on safe sleep practices, relying more on electronic/digital methods that have increased virtual access to key information statewide. The *Safe Sleep Guide for Parents and Caregivers* was primarily distributed through printed posters and is now available in electronic form via the *Parent Line* website. The website also provides virtual safe sleep parent and caregiver workshops at no cost to families. Written information may also be requested via regular mail.

Title V MCHB worked on increasing statewide awareness of safe sleep education by promoting the *Parent Line* through public service announcements aired on TV and digital media, press releases, and television/morning show interviews. This brought more awareness of the issue by the general public and also highlighted the resources available.

The statewide crib distribution programs offered by community-based organizations was paired effectively with safe sleep education to help families. This is particularly geared to low-income families most affected by COVID restrictions and overcrowded living conditions. These community and social media-driven initiatives strengthened widespread dissemination of evidence-based AAP safe sleep guidelines for infants.

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 COVID. The focus for this priority will be promotion and increased utilization of the Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Data: The data for this measure comes from U.S. Department of Agriculture WIC participation reports. The enrollments for WIC continue to increase through 2021 and COVID, with 25,907 women, infants, and children served by the program.

Objective: By 2025, increase the total number of WIC participants in Hawaii to 30,000 pregnant women, infants, and children.

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 state and nation specifically serving pregnant and parenting women with health 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: To improve the outreach for WIC services, a community advisory committee was formed, supported by a small private grant from the Partnership for America's Children (PAC). The key partner in this project is the Hawaii Children's Action Network (HCAN), a nonprofit whose mission is to ensure that all children are healthy, safe, and ready to learn. Other organizational partners include the Appleseed Foundation and the University of Hawaii Center on the Family, which will assist with data analysis.

Evidence: There is strong longitudinal evidence to show the effectiveness of the WIC program in addressing food insecurity. For more than four decades, researchers have investigated WIC's effects on key measures of maternal and 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 ability to help improve maternal, infant, and child health outcomes (Center on Budget and Policy Priorities, 2021).

Strategies: Hawaii's three food insecurity strategies are described in detail 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

Updates on the five strategies follow; however, since the grant was awarded late in FY 2021, this narrative largely reflects collaborative efforts to develop and submit the successful grant application.

COVID Impact Updates: In FY 2021, health and social service disruptions due to COVID continued through much of the year; however, federal relief efforts helped to offset some of the community and financial pressures associated with Hawaii's slowly recovering economy. Unfortunately, many of these COVID-related federal supports ended in December 2021. Several Hawaii surveys and reports from local service providers confirmed that Hawaii families continue to suffer from food insecurity. In recognition of these findings, Governor Ige extended the state COVID disaster emergency period through October 2022, specifically to extend supplemental SNAP food benefits for Hawaii families.

Strategy 1: Partner with agency and community programs to establish a working group that is committed to improving WIC utilization

Expanding the use of WIC and other governmental food support programs continues to be crucial to helping women, children, and families during the economic difficulties created by COVID restrictions and escalating economic costs. WIC total enrollments are now nearly 12% higher than 2019, an encouraging increase from the pre-COVID declines in WIC enrollments since 2016. This pre-COVID decline reflected a similar trend nationally in WIC programs. The reason for the steady decline may have been due to the state's growing economy prior to COVID, and also the steady decline in births. In 2018, the Hawaii WIC enrollment decline resulted in the closure of several WIC offices and staff reductions statewide.

During COVID, community-based family support services mobilized to expand food assistance programs throughout the state. The Hawaii Children's Action Network (HCAN) became actively involved with coordinating and disseminating information on family assistance services, including food assistance programs. 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 improve and enhance outreach and promotion of the WIC program. The grant was

awarded in May 2021. Grant implementation activities were delayed primarily due to the Delta COVID surge and other critical COVID-related community needs.

The first grant strategy focused on the establishment of a community working group to partner with the WIC program to improve numbers of enrollments and expand services. The grant activities included:

- Engage a diverse, multisector WIC working group that includes experts; families that rely on WIC for food support; representatives of racial/ ethnic and geographic populations that experience high rates of family food insecurity; WIC providers; nonprofits that serve low-income children and families; DOH WIC administrators; and policymakers who are capable of promoting and facilitating change.
- The working 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

This strategy focused on the primary data and research work of the WIC Working Group, to identify barriers and challenges experienced by the WIC program and its clients. Activities included:

- The WIC Working Group will collect, analyze, and review WIC data, community perspectives and will research best practices and innovative models in other states that have the potential to succeed in Hawaii.
- The group will examine WIC utilization data disaggregated by ethnicity and geography, trends in WIC usage in recent years, census data, and other sources of information about family and child food insecurity.

Strategy 3: Develop recommendations for initiatives to pursue to improve WIC utilization

The last strategy focused on the development of evidence-based/informed planning, based on the research and findings of the working group. Activities included:

- The WIC Working Group will research policies and systems in other states across the country to assess how to better address program issues.
- The group will determine potential policy and systems improvements on the state administrative level, including partnerships with other service agencies and/or policy/legislation.

Current Year Highlights for FY 2022 (10/1/2021 – 6/30/2022)

This section highlights the start-up work for the PAC grant in FY 2022.

Strategy 1: Partner with agency and community programs to establish a working group that is committed to improving WIC utilization

A cross-sector working group was recruited for the WIC project. Members include WIC staff from the state WIC office, WIC community clinics (including those located in Federally Qualified Health Centers), university researchers, the Native Hawaiian healthcare system, advocates, and current WIC recipient mothers.

WIC Parent Voices: WIC families were deemed an important partner in the working group. HCAN sent notices to recruit WIC parents to join the working group through community networks and via the Parent Leadership Training Institute alumni group. HCAN interviewed those mothers who showed interest and selected three to join the group. Parents were compensated for their participation in the working group at a rate of $30/hour.

Meetings: The WIC Working Group met monthly since October 2021. HCAN coordinated the logistics, facilitated the meetings, and partnered with WIC to develop agendas and debriefed on outcomes/progress. The Working Group's primary goal was to deliberate and decide on feasible steps over the next two or three years to improve utilization of the WIC program in Hawaii. The Group will then create a blueprint/ workplan for WIC implementation.

The Group used the national Food Research and Action Center's (FRAC) May 2019 report, "Making WIC Work

Better," as a guide for its work. The publication provides an extensive menu of strategies to improve the reach of WIC and benefit use, including an understanding of common barriers to participation, based on extensive national research. Based on the FRAC report, the Work Group narrowed down its areas of focus to:

- Partnerships with other agencies and community groups
- Retention of 1–4-year-olds in the program
- WIC contingencies in times of disaster

Strategy 2: Identify key barriers to WIC benefit utilization and enrollments

This strategy focuses on Hawaii data collection/analysis and research work, to identify commonly observed barriers and challenges experienced by the Hawaii WIC program and clients.

Assessment: HCAN conducted an assessment of the Hawaii WIC program, including examining census data and other sources of information about child food insecurity, researching policies and systems in other states across the country that successfully maximize WIC utilization, and analyzing trends in WIC usage in recent years. The FRAC report was identified as a useful resource through the assessment. The final report will be comprised of two analyses:

- An overview of existing data on child food insecurity and participation rates of eligible Hawaii residents
- Recommendations to improve WIC utilization in Hawaii

Data Analysis: FHSD contracted with HCAN and University Center on the Family (COF) to analyze and acquire data to better understand the current WIC service population characteristics, their utilization of benefits, and enrollment patterns. WIC has limited internal resources for data analysis; thus, COF will initially be analyzing the WIC dataset. COF is partnering with the WIC Working Group to help develop the data analysis plan. Additional data collection through survey/focus groups will also be considered.

WIC Store Map: The working group is also developing an updated list of WIC-participating Hawaii stores and WIC program locations map that will be uploaded to the website when completed.

Strategy 3: Develop recommendations for initiatives to pursue to improve WIC utilization

Although the WIC Working Group is still awaiting data and assessment results, a list of strategic recommendations was identified after a review of the national FRAC WIC report.

Some of the report recommendations that the WIC Working Group agreed would be worth pursuing include:

- Using social media, web-based advertisements, and a well-designed and strategic online website that leads to WIC content specific to each island
- Creating a special outreach program for Pacific Islanders and other underserved communities to increase engagement
- Creating a formal WIC Advisory Council with representatives and stakeholders from each island
- Partnering with SNAP and Medicaid to share client data and to extend program reach and increase participation

Data Sharing w/SNAP: In May 2022, WIC executed a data-sharing agreement with SNAP to improve the enrollment process for clients who are eligible for both programs. Implementation of the agreement begins in August 2022 with the exchange of client datasets. Although WIC does not currently share its program data with Medicaid, staff from both agencies share the other's program information with their clients.

Formula Shortage: In FY 2022, WIC addressed the chronic shortage of infant formula due to the Abbott recall and

plant shutdown. WIC Branch notified WIC participants of the recall, and shared critical information on recall efforts. As the formula shortage worsened, WIC took action to allow WIC participants to purchase alternative formula brands at least through August 2022. WIC also shared infant formula updates with the general public, providing information on resources and guidance to local service agencies and programs via media interviews, press releases, listservs, social media, and web postings.

Challenges Encountered

The WIC Working Group actively identified barriers to accessing services and opportunities to improve WIC enrollment, intake, and retention, drawing upon the Working Group's diverse perspectives and experiences with the WIC program.

Some of the barriers identified include:

- WIC's ability to reach young families is limited by reliance on outmoded forms of communication (i.e., printed materials and face-to-face contacts)
- WIC's outreach materials, smartphone app, and website are almost entirely printed/read in English
- Large geographic areas on all islands currently lacking WIC clinics, including parts of rural Oahu.

Operationally, WIC is impacted by the competitive labor market and is struggling to fill its vacant positions.

The Working Group also identified some potential opportunities for WIC improvement:

- Provide a modern approach to communication with WIC clients, using methods such as texting, email, or messaging directly to WIC staff, as well as receipt of timely reminders when their WIC benefits are about to expire
- Emphasize more cultural competence in WIC clinic workers and provide materials available in languages that are common in WIC applicants and participants
- Partner with agencies that work with the Pacific Islander community such as We Are Oceania (WAO), City and County of Honolulu's Resilience Resource Center, and the Big Island's Micronesians United (MU-BI)
- Conduct routine assessment and evaluation of the appropriateness and effectiveness of the WIC Program and services to meet the food security needs of WIC participants

Overall Impact

Prior to the convening of the WIC Working Group, the WIC program had limited opportunity/capacity to dedicate significant resources towards improving the WIC program. This unique private-public partnership has brought sorely needed resources, effort and supports to one of the largest and most significant maternal and child health programs in the state.

The WIC Working Group provided valuable feedback from parties with different perspectives of the WIC program and with direct family experience in the current state social/economic context. The diverse composition of the Working Group – academics, advocates, WIC clinic staff, WIC state office staff, and WIC clients – combines these diverse viewpoints to better inform WIC deliberations and planning.

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

For the Perinatal/Infant Health domain, Hawaii selected NPM 5 Safe Sleep based on the 2020 Title V needs assessment findings. 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 three 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

Media Campaign Repeated: Another Safe Sleep television and digital media campaign is planned in FY 2023. The timing of this campaign is to strategically align with October *Safe Sleep and SIDS Awareness Month, and the campaign will run through December. Activities will include a Governor's proclamation signing and press release. The Safe Sleep Guide for Parents and the Parent Line are the central means to share information on AAP guidelines. There are also plans to work with SSH to promote other community-based programs supporting safe sleep efforts, such as Cribs for Kids.*

Translation of Media Messaging: The television and digital media spots used in the FY 2022 media campaign will be translated into several languages to reach non-English speaking population. The spots will be strategically aired and presented in ways to best reach more limited English-speaking households.

Strategy 2: Increasing reach of Safe Sleep Hawaii and connections to appropriate partners and stakeholders to promote health equity

This is a new strategy that recently emerged from Safe Sleep Hawaii (SSH). The implementation activities for this strategy include:

- Increase membership and messaging connected with SSH
- Engage more diverse community partners and stakeholders throughout the state
- Ensure awareness of the availability of translated Safe Sleep guides in all offered languages
- Foster collaboration and partnership among community programs and stakeholders on safe sleep efforts and other maternal and child health issues
- Develop a new measure to monitor progress on this strategy that can be used for Title V reporting.

Safe Sleep Summit: Based on the success of the 2022 Summit, another Safe Sleep summit in 2023 is being planned.

Implementation of Recommendations from the Statewide Assessment: The environmental scan and assessment of safe sleep activities in Hawaii will be completed in FY 2023. The project includes conducting a focus group with families to learn how families get key information on safe sleep, what messaging they received to date, and perceived barriers to implementing safe sleep practices. The final report, results, and recommendations will be presented to SSH and inform future planning, including clarification of the SSH role, identifying further evidence-based strategies to address disparities, and promote health equity in safe sleep going forward.

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. The goal is that by July 2025, WIC participants numbers will increase in Hawaii to 30,000 pregnant women, infants, and children. Plans to address this objective and the SPM are from the Partnership for Children grant, which was awarded in May 2021. The three strategies and plans are presented below.

Strategy 1: Partner with agency and community programs to establish a working group that is committed to improving WIC utilization

With the formation of the WIC Working Group, this strategy was largely completed but as more Hawaii data and information is available to the working group, additional partners may be added to the membership.

Strategy 2: Identify key barriers to WIC benefit utilization and enrollments

- HCAN will complete its assessment of the WIC program, including estimates of those eligible for WIC services but who are not currently served.
- The University of Hawaii Center on the Family, in partnership with the working group, will develop an analysis plan and complete analysis of the WIC dataset, producing a final report and presentation. The key findings will help develop WIC program recommendations.
- Additional areas for research may be identified through key informant interviews/focus groups with WIC recipients and WIC providers.

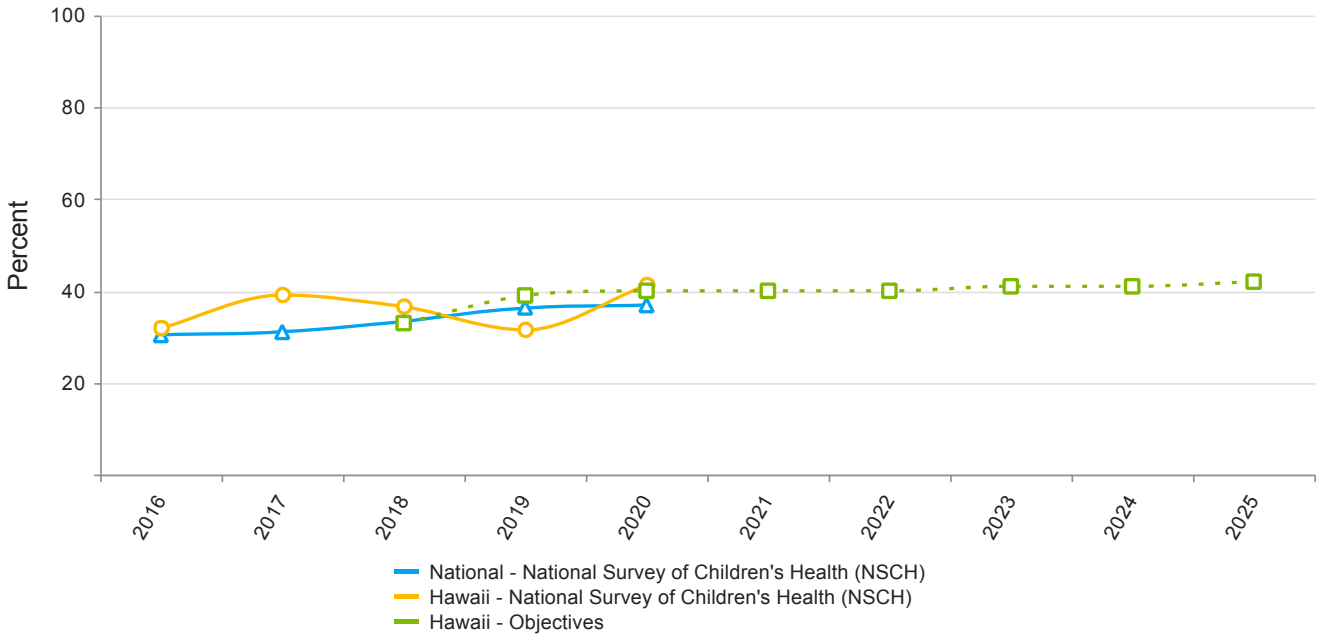
Strategy 3: Develop recommendations for initiatives to pursue to improve WIC utilization

- The WIC Working Group will continue work on developing a 2–3-year Blueprint and/or workplan to improve WIC services, enrollment, and utilization.

Child Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		33	39	40	40
Annual Indicator	32.0	39.1	36.5	31.6	41.2
Numerator	12,946	14,121	13,201	12,899	16,334
Denominator	40,486	36,113	36,145	40,832	39,621
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	40.0	41.0	41.0	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	2021
Annual Objective			12	18	24
Annual Indicator					
Numerator	9	19	23	26	26
Denominator	30	30	30	30	30
Data Source	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	27.0	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**	**2021**
Annual Objective			5.9	5.5	5.4
Annual Indicator		5.9	5.5	5.7	5
Numerator		635	584	591	508
Denominator		108,119	105,815	104,141	101,271
Data Source		DHS CAN annual report	DHS CAN annual report	DHS CAN annual report	DHS CAN annual report
Data Source Year		2017	2018	2019	2020
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	5.0	4.9	4.9	4.8

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	2021
Annual Objective		
Annual Indicator	73.2	63.8
Numerator		
Denominator		
Data Source	Hawaii Med-QUEST	Hawaii Med-QUEST
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	76.0	77.0	78.0

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 - Develop infrastructure to coordinate developmental screening efforts	
Family Engagement & Public Awareness	
Data Collection and Integration	
Social Determinants of Health	
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

Support the collaboration and integration of family strengthening and child maltreatment prevention programs and activities across federal, state, local and private programs, and organizations

Promote safe and nurturing relationships by raising community knowledge about resilience and adverse childhood experiences

Provide training and technical assistance to community-based, prevention-focused programs to strengthening families and prevent child abuse and neglect

Collaborate with the Hawaii State Department of Human Services primary prevention initiative

Promote health equity by addressing disparities in confirmed CAN cases

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

Conduct public awareness campaign

Build capacity for pediatric champions

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 2020 five-year needs assessment. By July 2025, the State sought to increase the proportion of children, ages 9 through 35 months, receiving a developmental screening, to 45.0%.

Data: Aggregated data from 2019-2020 showed the estimate for Hawaii (41.2%) met the 2021 state objective (41.0%) but was not significantly different from the 2020 indicator (31.6%) and the national estimate of 36.9%. Due to the small sample size, results for this measure should be used with caution. The related Healthy People 2030 Objective for developmental screening (35.8%) 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: Considering the baseline data, data limitations, and the HP 2030 objective, the State objectives through 2025 were set to reflect an annual increase of one percentage point.

Title V Lead/Funding: Developmental screening remains a priority since 2010 for Family Health Services Division (FHSD), which coordinates federal, state, and local efforts on screening, referrals, and services. In FY 2022, the lead for this priority transitions from the Children with Special Health Needs Branch (CSHNB) Early Childhood Coordinator (state-funded) to the new HRSA ECCS grant funded coordinator located at the division level. Title V does not directly fund developmental screening program staff and activities but does support management, epidemiology, data, and administrative positions that contribute to the NPM.

Partnerships: There is broad collaboration among statewide agencies and stakeholders working toward a statewide systematic approach to developmental screening. This includes 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 (EOEL) Early Childhood State Plan for 2019-2024
- EOEL Early Childhood Strategic Implementation Plans “Early Childhood Health and Family Wellness”
- Early Childhood Action Strategy (ECAS) and the Hawaii Community Foundation (HCF) and DOH’s Infant and Early Childhood Behavioral Health Plan
- Maui County plan for the early childhood collective impact team, *Kākou for Keiki (translation: All of us [together] for children)*.

Strategies/Evidence: Hawaii’s five developmental screening strategies focus on systems-level approaches and follow guidance from three sources:

- Federal ECCS Impact Grant, which was a five-year grant from 2016-2021 focusing on establishing a system for developmental screening in Maui County
- HRSA’s Title V “State Technical Assistance Meeting” in March 2016
- The 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 grant best practices promote working with early childhood providers to ensure that screenings are done as part of their assessment of children's development and is 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 regularly with these programs to ensure the national standards are implemented.

Research compiled by AMCHP and the MCH Evidence Center indicates that there is 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 Ages and Stages Questionnaires (ASQ) 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 indicates that Hawaii's ESM 6.2 has 'moderate evidence' related to QI activities.

Updates for 2021 on the five strategies follow.

COVID Impacts: Safety restrictions eased as COVID cases remained manageable and vaccination numbers increased. Childcare, early learning programs, and public schools returned to in-person learning in Fall 2021. Doctors' offices continued to implement safety protocols and began in-person as well as telehealth visits. Resurgent pandemic concerns may have led to renewed delays in healthcare visits and could have also led to fewer children receiving screenings for developmental delay. With increased vaccination numbers, pandemic restrictions continued to loosen in FY 2021.

Strategy 1: Systems Development – Develop infrastructure to coordinate developmental screening efforts

The activities for this strategy focused on systems and policy development to support increased child developmental screening. Hawaii's healthcare and early childhood sectors are crucial partners to ensure that the four stages of developmental screening: screenings, referrals, services, and supports occur.

Guidelines on Screening and Referral: "*Hawaii Developmental Screening and Referral Guidelines for Early Childhood and Community Based Providers"* are available online at https://health.hawaii.gov/cshcn/hiileihawaii/ to provide standard information for those conducting developmental screening of children ages birth through five years of age. They are based on national resources, including the American Academy of Pediatrics (AAP), Centers for Disease Control and Prevention (CDC) "Learn the Signs. Act Early"(LTSAE), Bright Futures, and other resource centers.

These 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 with stakeholders to ensure the information was relevant for either in-person or virtual screenings. Adding a seven-day timeframe from positive identification to service referral is under consideration in order to expedite the referral process and also minimize the wait time for families to receive services. However, it may also serve to reduce the number of programs conducting screenings since programs may not be able to meet the recommended timeframe.

Workforce Training: Hawaii received a second LTSAE technical assistance grant from the CDC in 2021. A needs assessment was conducted with system partners who participate in the developmental and autism screening process. Strategies to address barriers to care and improve resiliency among children and families are being developed and implemented. Hawaii's LTSAE Team (comprised of the LTSAE Ambassador, a Project Assistant, and the CSHNB Early Childhood Coordinator) presented to child welfare programs, Early Head Start/Head Start Health Specialists, WIC Nutritionists, and the MCH LEND enrollees on the different screening tools and the referral processes for children identified with a developmental concern. Several ASQ trainings were also conducted for early childhood programs statewide, including EOEL Resource Teachers who will screen children in the EOEL Pre-Kindergarten program.

COVID generated greater provider interest in online tools/services. Five major Maui family service organizations partnered to use the ASQ Online Enterprise program, and training was provided to program staff so online screening services could be offered to families.

The ECCS Coordinator on Maui collaborated with the LTSAE Ambassador to work with Maui pediatricians to promote more developmental screening. However, the pandemic resulted in switching in-person training to online and may have resulted in reduced provider/client attendance. Providers showed interest in the new developmental screening tool, the Survey of Well-being of Young Children (SWYC), but expressed concern that referral source to meet family well-being needs were not readily available. Most Maui early childhood providers continue to use the ASQ-3 and ASQ:SE2. Training is available for providers to learn more about this tool.

New ECCS Grant: Hawaii applied for and received new funding for ECCS Health Integration Prenatal-to-Three Program (HIPP), which shifted the ECCS grant focus from community-based development screening systems building to statewide infrastructure building of a coordinated maternal and infant childhood system of care to strengthen developmental screening supports, among other outcomes. Since the ECCS HIPP grant requires the formulation of a strategic plan, the completed developmental screening strategies and outcomes will be integrated into this Title V priority.

Strategy 2: Family Engagement & Public Awareness

This strategy focused on engaging families to promote the importance of developmental screening and child development. The continuation of COVID restrictions resulted in many childcare program closures and other family support programs shifting to online platforms in 2020-21. Through 2021, families continued to struggle with job/income loss while also taking primary responsibility for the daily care and education of their children. This raised concerns among providers about increased substance use, family violence, and mental health concerns that was exacerbated by social isolation due to the pandemic. While promoting child development remained a priority, service providers focused on addressing more immediate family and child needs and messaging on self-care.

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. The CDC LTSAE project coordinators presented on the LDAH Facebook Live presentation, which was attended by 56 participants and was recorded and archived on the LDAH website.

Social Influencers: The LTSAE project tested the use of social influencers to help promote the importance of developmental screening. Three mothers with young children between the ages of birth through five were selected as social influencers to reflect the target population. The influencers were provided a stipend of $1,500 to promote the material and information through Facebook, Instagram, and Facebook Live. Through the use of the social media platforms, the influencers were able to promote the free CDC Milestones app to track a child's developmental milestones with a total of 972 likes and 1,264 views. On an Instagram story poll, most of the 109 parents of children birth through five had not heard about the app or the material.

Kākou for Keiki, Maui County's early childhood ECCS Impact team, used Facebook and Instagram to promote developmental screening, family engagement skill building/opportunities, program supports in the community, and caregiver self-care as a means to promote healthy development in children ages 0-5. The ECCS Impact team also printed and distributed postcards that marketed the CDC Developmental Milestone App, VROOM App, and Spotify playlist links for young children in order to encourage on-track development. Postcards were distributed at prenatal, fatherhood, early childhood, and early literacy community drive-up events. Developmental, social emotional, and health/wellness kits were also offered at medical offices and food distribution sites, reaching over 400 families in Maui County in 2021.

Screening Information Websites: Hawaii continues to work with the Early Childhood Action Strategy (ECAS), a public-private collaborative that focuses on children's issues from 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/.

Throughout 2021, FHSD and other direct service programs for children and families saw varying levels of service utilization due to COVID restrictions. As vaccinations rates increased and services reopened, client services started to increase but did not return to 2019 levels. Based on a general decline in screening services numbers, Hawaii embarked on a public awareness campaign to promote in-person well-child visits to ensure that biometrics and preventive screenings could be conducted. More information on the campaign is available in SPM 5.

Strategy 3: Data Collection and Integration

This strategy originally focused on internal collection of developmental screening data among Title V early child programs. This activity has been completed, thus the work has shifted to acquiring population-based developmental screening data to monitor system needs.

National Survey on Children's Health (NSCH) data: The latest NSCH data for this NPM is for 2019-2020, which may not reflect the full impact of COVID. In addition, there are several issues with the NSCH data that limit its utility to inform planning and address health equity. While the survey provides standard state-level estimates, the subset of data reported for this measure is small and estimates are unstable and do not reflect clear trends. For instance, although the 2021 indicator (41.2%) is higher than the 2020 data (31.6%), it is not statistically significant and we cannot conclude screening increased since the difference may be due to variability. Moreover, the race/ethnicity data collected by the NSCH is not specific and defined in enough detail to reflect Hawaii's Asian, Native Hawaiian, and Pacific Islander populations, and county-level data is not available to help inform preventive strategies.

FHSD explored NSCH survey oversampling for several years with the MCH Bureau, but there are too many cost/administrative barriers. The NSCH survey question asks parents about screenings that occur only in a

healthcare provider's office; however, Hawaii's developmental screening efforts include work with early childhood providers and other community-based service organizations, so the data may be incomplete and not include the efforts of the Hawaii team and partners since they occur outside of healthcare providers' offices.

Medicaid: The Hawaii Medicaid Program did not report on the CMS healthcare quality measure for Developmental Screening for up to age 3 in 2020. Only 28 states reported on this optional measure. However, a new Medicaid RFP issued in 2021 included development screening as a health priority for Hawaii's five state Medicaid insurance plans, and data should be available on this CMS QA measure in the future.

While Medicaid healthcare providers are requested to 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 be relaying on 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 therefore miss the recommended developmental screenings.

The Hawaii State Department of Human Services (DHS) Child Care Program requires all parents/caregivers at licensed childcare programs to report developmental screening and other health data for each child, but none of this data is currently 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 2021.

Data from the MIECHV Home Visiting program for FFY 2021 indicated that of the total of 559 children enrolled in the program, 222 children were eligible for screening. Per AAP screening recommendations and MIECHV reporting requirements, 71.6 % of the eligible 222 children were screened for developmental delay. Of those children with positive screens for developmental delays, 85.7% of children received services in a timely manner, an over 10% improvement from last year.

The Hi'ilei Developmental Screening Program provides parents and caregivers the option of completing an online screening or completing a paper copy of the developmental screener through the mail. FFY 2021 Hi'ilei data shows that a total of 16 children birth through 5 years were screened. Two of the children were found to be in the "monitoring" range. Five 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 parents.

ECCS Grant: By the end of the ECCS Impact grant, screening data was collected from at least fifteen childcare and early education providers serving Maui County. In FY 2021, the providers screened 324 children, a substantial increase over the past five years of the grant. At the grant ending, over 500 children were screened. To sustain efforts beyond the grant, Maui now has nine certified ASQ Trainers who will offer ongoing trainings to providers at least two to three times a year.

Early Intervention Service (EIS): In 2021, of the 2,640 evaluations that were conducted, the majority of the referrals were found eligible. With the pivot to telehealth during the pandemic, EIS conducted partial evaluations to identify developmental delays since the standardized tool (Batelle Developmental Inventory) could not be administered in person. If the team felt the child was within age expectations and the family concurred, the child was deemed ineligible. Effective April 1, 2021, EIS used the Developmental Assessment for Young Children (DAYC), which is a standardized tool that can be done remotely via interview. All children with partial evaluations were reevaluated and

eligibility established unless the child exited prior to the initiation of the DAYC.

EIS referrals come from various sources, with 61.6% of referrals coming from primary care providers, 24.4% from families, 11.7% from community providers, 0.3% 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.

Developing a coordinated data system for FHSD around screenings and referrals was difficult to address since programs collect data using different parameters, including timeframes and the different ages at which children are screened often based on funding guidance.

Strategy 4: Social Determinants of Health

This strategy focused on partnering with programs and agencies that work with underserved populations.

In late 2019, the Kauai WIC office piloted the use of ASQs and a program was slated to start in Maui WIC clinic waiting rooms, which was disrupted by COVID closures. The CDC LTSAE team did a presentation to the WIC Nutritionists on a simpler CDC Checklist for 2- and 3-year-olds, referring families to the appropriate agencies if there is a developmental concern. The protocol for using the checklist was developed by WIC administrative staff. The launch of this effort began during the pandemic at a time when WIC enrollments increased and visits switched from in-person to remote. Hawaii will be monitoring the effectiveness of this pilot.

SWYC: 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, which can also help screen and identify social economic needs of children and their families.

To support physician concerns about an accessible referral site to provide information for families, planning is underway to create a centralized resource directory of state services. To provide more responsive accessible resources, the site will include county specific resources. Title V is part of a workgroup led by Hawaii's First Lady to create the directory, 'No Wrong Door.' The system will have coordinated intake and referral process to access a large array of state services. The system is operational currently but is adding more services and users.

Strategy 5: Policy and Public Health Coordination

The purpose of this strategy is to track FHSD's infrastructure development efforts to help 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	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. The MCH Evidence Center rated this ESM as a strong quantifiable measure. 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 2021 indicator was 26 and met the annual objective set at 24. 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. Scores show room for improvement in the areas of family engagement, 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**			

Current Year Highlights for FY 2022 (10/1/2021 – 6/30/2022)

Re-examining Strategies: Hawaii is reviewing its strategic approach to improve development screening given the new ECCS grant in 2021, new Medicaid developmental screening quality measures, and opportunities/changes in healthcare delivery due to COVID.

ECCS Grant: As the new ECCS strategic plan is developed, the activities pertinent to development screening will be incorporated into the Title V developmental screening plans. One of the performance measures for the new ECCS HIPP grant is to increase developmental screening. ASQ Training continues to be conducted to encourage this outcome. In May 2022, approximately 100 participants were trained in the ASQ tool, including the DOH Public Health Nurses (PHN). Discussions have begun to include PHN resources at Maui County WIC sites to encourage developmental screenings and provide referral supports, when necessary.

To assure family input to the ECCS strategic plan, the University Center on the Family and the Hawaii Children's Action Network will develop and conduct a survey of families with pregnant women, infants, and children to:

- Assess the support families receive from state and federal programs, including but not limited to WIC, SNAP, Medicaid, and childcare subsidies
- Collect input on policies, programs, and systems improvements that are needed for families with young children.

Media Campaign: The Fall 2021 media campaign to promote child wellness visit was generally well received by providers and the community. Reach data is available in SPM 5. The campaign will relaunch starting July 2022 with a revised message that will promote 'check-ups' and preventive screenings, including development, vision, hearing and behavioral.

Medicaid: Under the Title V/Medicaid Inter-Agency Agreement, a Title V data request was submitted that included developmental screening data. The following data was provided for FY 2021. The percentages representing only children under Medicaid are somewhat lower than the NSCH data.

Developmental Screening in First Three Years of Life - Birth to one year	21.19%
Developmental Screening in First Three Years of Life - >1 year to 2 years	26.00%
Developmental Screening in First Three Years of Life - >2 years to 3 years	20.66%
Developmental Screening in First Three Years of Life - Total	22.41%

Title V plans to partner with Medicaid in the future to help increase these rates.

Health Equity: The CDC Learn the Signs Act Early material were translated into Chuukese, Marshallese, and Samoan to help better understand child development. The Milestones Moments booklets are given to families to write down notes before their next well-child visit and gives information about developmental milestones. The booklets will be printed for distribution.

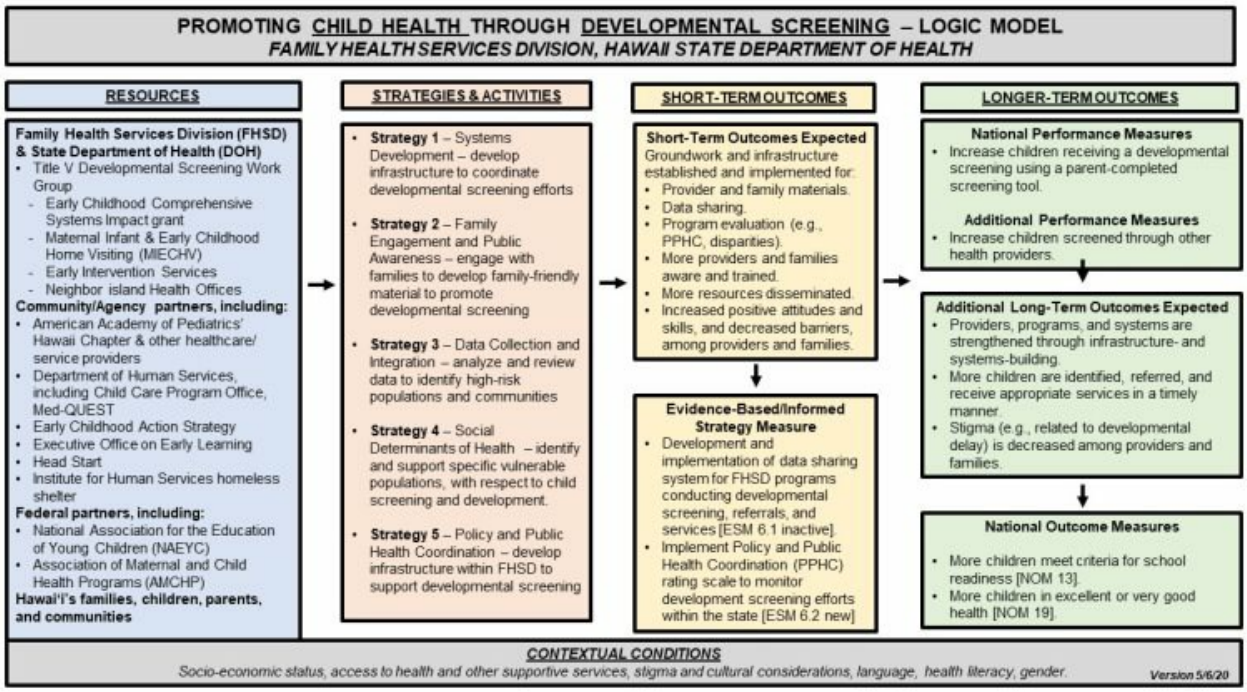
EPSDT-related data: Medicaid child providers are currently asked to complete a detailed EPSDT visit form that specifically asks about completion of developmental and other preventive screens. Medicaid reported it successfully migrated these data to an electronic collection and management system. They are working to share the data in the future.

NSCH: FHSD began work on a proposal to secure grant funding for an NSCH oversample to include Hawaii specific race/ethnicity groups and county level data. However, meetings with the NSCH & U.S. Census staff made clear that funding is not the only challenge. There are substantial administrative requirements/barriers to access the oversample data through a Census Regional Data Center (RDC) that are prohibitive. Hawaii does have an RDC and would need to work with a site on the continent. In addition to developing a research application to attain 'security clearance' to an RDC, there is also a requirement for two in-person logins at an RDC before permission is granted for remote access to dataset. Without an oversample, the NSCH data will continue to have limited value for program planning and policy development unless the MCH Bureau expands the survey samples sizes for states, especially those with ethnically diverse populations.

Telehealth: 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 would normally receive immunizations and developmental screening. Online developmental screening tools may provide greater access to parents more comfortable with online services. Moreover, federal pandemic relief funding is expanding broadband and telehealth services to under-resourced community statewide.

Review of Action Plan

A logic model for Title V NPM 6 was developed based on the ECCS Impact Grant that ended in 2021. The strategies reflected initiatives at the community, statewide, and national efforts and included input from partners and feedback from families and providers solicited at conferences and community events. By working on these five strategies, Hawaii planned to increase the number of children receiving a developmental screening by addressing systemic challenges. With the revision of the developmental screening strategies in FY 2022, Hawaii will revise its logic model in next year's report.



Challenges Encountered

A recent needs assessment conducted by the Hawaii Act Early COVID-19 team found several challenges in expanding developmental screening, some of which are COVID-related and ongoing infrastructure development. Challenges remain in the areas of policy, data, and messaging. There are five challenge areas to be addressed.

Timeliness of referrals continues to be a concern. Hawaii's Title V Developmental Screening partners must ensure timely and accessible interventions. When concerns arrive, providers conducting screenings are required to refer children in the "referral range" to EIS within seven days after being identified, per the Federal IDEA statute. The seven-day referral standard must be more widely promoted and adopted to assure timely referrals are consistent.

Lack of Coordination. Another common issue is lack of coordination during referral and intake. With EIS strict confidentiality standards in conferring with referring providers, the referral process is hampered when signed

consents are difficult to attain.

Access School Services. Once referrals are made, parents of children with developmental concerns have difficulty accessing appropriate school services. Frustration, avoidance, and adversarial perceptions are outcomes when parents combat community stigma and burden of proof as to how the newly discovered developmental issue adversely impacts their child's education. A standardized consideration to consistently use screening results in the school evaluation to better support parents will improve the process.

Data Limitations. Data to help inform planning and policy is another challenge. The funding and administrative barriers are too prohibitive for Hawaii to pursue an NSCH oversample that could generate more stable estimates for NPM 5, disaggregated data for Hawaii ethnic groups, and county-level estimates. While developmental screening data from Medicaid healthcare providers is an important data source, much of Hawaii's developmental screening is conducted by family service agencies. At this time, there is no systematic data source to determine the actual number of screens and follow-up conducted by these service providers.

Public Awareness. Building public awareness and effective messaging to encourage universal developmental screening. COVID created additional challenges to accessing preventive care/screenings, given the drastic shift of family priorities to more immediate needs. Even as mandates were lifted and workforce returned, prioritizing developmental screens remained elusive; however, there is an opportunity to create a more responsive and accessible system. Efforts through the CDC LTSAE grant and the new ECCS grant will help to address barriers and competing family priorities; however, work may be delayed due to ongoing COVID and slow recovery.

Overall Impact

Statewide Partnerships: Over the past five years, Hawaii was successful in convening statewide stakeholders to develop and maintain standard guidelines for developmental screening. The Early Childhood State Plan and other early childhood coalitions continue to identify developmental screening as a key priority. Providers and partners work collaboratively to stress the importance of developmental screening through a validated screening tool. All understand the method to include referral process, including timely and consistent communication with the child's medical home. The work to promote a more seamless system of screening and referral is continuing.

ECCS Grant: Hawaii's ECCS Impact grant was able to complete its goal to develop a sustainable system of development screening and referral for Maui by increasing awareness, changing organizational practices, establishing partnerships/networks (including family engagement and leadership), and training capacity on the screening tools. Parental engagement to support developmental skill-building opportunities and better understanding developmental and social emotional milestone stages for children 0-5 years old was found to be the most valuable support offered.

Providers: Title V continues to make progress working directly with pediatric providers in the AAP-Hawaii Chapter and in collaboration with Hawaii's CDC Act Early Ambassador, Dr. Jeff Okamoto. Title V will continue to work with the Medicaid program to better reach and support this underserved population.

Committed efforts by programs like MIECHV and other early childhood programs to conduct developmental screenings contribute to statewide efforts. Currently, most children are not receiving developmental screenings. Working with early childhood providers, efforts will continue to promote developmental screening and sharing of information with the child's medical home. Normalizing screening in early childhood services and well-child visits will ensure developmental monitoring and follow-up occur.

Data: Accessing Medicaid developmental screening quality assurance data was helpful but only if it can be used to

engage Medicaid plans and providers to increase screenings. Approximately 50% of Hawaii's children are insured through Medicaid, with enrollments significantly increasing during COVID. EPSDT office visit data, when available, also provide vital insights into child health and provider performance.

Hawaii will continue to explore and advocate for improved national and state data on developmental screening.

SPM 1 - Rate of confirmed child abuse and neglect cases per 1,000 children aged 0 to 5 years

Introduction: Child Abuse and Neglect Prevention

The 2020 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 reported in the State Department of Human Services (DHS) 2020 Child Abuse and Neglect Report. The state objective was met as the rate decreased slightly between 2019 and 2020, from 5.7 to 5.0 per 1,000 children aged 0-5 years, possibly due to COVID shutdowns. Cases decreased in the number for children ages 0-5 years from 608 in 2019 to 542 in 2020. Infants under one year of age continue to account for the highest percentage of abuse (15%). Overall, children five and under accounted for 42.5% of all confirmed cases, a slight decrease from 43.7% in 2019. The report presented geographic disparities by community. Hawaiian/Part Hawaiian children are overrepresented among confirmed CAN cases for all age groups, reflecting long-term disparities due to historical racism and discrimination.

The types of confirmed maltreatment types between 2019 and 2020 saw decreases in sexual abuse (37% to 36%), neglect (36% to 25%), and threatened harm (30% to 23%). Sex trafficking increased in 2020 to 26% from 18% the previous year. Two deaths occurred in 2020 compared to one in 2019. There was also a significant increase in the number of children whose abuse resulted in serious injuries, from 30 to 43. In 2020, the highest reported factors contributing to the abuse or neglect of children of all ages were inappropriate child-rearing methods (70.6%), inability to cope with parenting responsibility (64%), and drug abuse (42%). Confirmed CAN cases reflect only a small portion of potential incidents of family violence.

Objectives: Reviewing the baseline data, the objective was set at a 5% improvement over the next five 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 also includes: the sexual violence and domestic violence prevention programs, parenting support program, and 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 MCH Branch support staff such as the Branch research statistician.

Strategies: Child abuse and neglect (CAN) are complex problems rooted in health inequities and unhealthy relationships and environments. Preventing CAN requires addressing factors at the individual, relational, community, and societal levels. For 2022, CAN strategies were revised to reflect a broader public health systems approach:

- Support the collaboration and integration of family strengthening and child maltreatment prevention programs

and activities across federal, state, local and private programs, and organizations
- Promote safe and nurturing relationships by raising community knowledge about resilience and adverse childhood experiences
- Provide training and technical assistance to community-based, prevention-focused programs to strengthening families and prevent child abuse and neglect
- Collaborate with the Hawaii Department of Human Services primary prevention Initiatives
- Promote Health Equity by addressing disparities in confirmed CAN cases

CANP-P addresses primary prevention and secondary prevention work. Grant funds are used to support:
- Community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs, and activities to prevent CAN
- Support the coordination of resources and activities to strengthen and support families to reduce the likelihood of CAN
- Foster understanding, appreciation, and knowledge of diverse populations in order to effectively prevent and treat CAN

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 crosscutting strategies that leverage partnerships to support evidence-based/informed programs and practices.

COVID Updates: COVID-19 upended Hawaii with enormous economic and social implications. Given the increased number of families living in virtual confinement coupled with massive economic disarray, the pandemic created the conditions for a rise in family violence. Lockdowns and pandemic-related economic impacts exacerbated factors typically associated with family violence, such as increased unemployment, stress associated with childcare and virtual schooling, and increased financial insecurity. Poor coping strategies, including the increased use of alcohol and other substances, could elevate the risk of abuse. Client contacts with the Domestic Violence Action Center increased nearly fourfold from 519 in 2019 to 3,038 in 2020. The need to develop safety plans with clients rose from 692 to 1,066 in the same time period. The number of reported child abuse cases grew from 4,697 in 2020 to 5,389 in 2021, a 15% increase.

Updates for 2021 on the five revised strategies follow.

Strategy 1: Support the collaboration and integration of family strengthening and child maltreatment prevention programs and activities across federal, state, local and private programs, and organizations

This strategy focuses on the key system partnerships CAN-P supports to assure a coordinated system of services to prevent and address CAN. State, local, and community programs have distinct strengths and expertise in reducing CAN and building safe and resilient families and communities. Interagency collaborations across child-serving systems include public health, child welfare, education, early childhood service providers, and other public and private systems work. Together, these sectors help strengthen and support families to address the needs of children and their parents/caregivers. A list of the major agencies/programs follow.

Department of Education (DOE): DOE is a key agency partner in efforts to identify, treat, and prevent CAN. CANP-P collaborated with the DOE Trauma Recovery Project to ensure low-income students who experienced trauma received trauma-specific mental health services. The Project expands the capacity of DOE counselors and other staff on the use of Trauma-Informed Care (TIC) as the standard across the DOE. TIC practices ensure agencies and programs serving children and families that experienced any form of violence understand the impact of trauma on child development and how to effectively minimize its effects when providing services. DOE staff were invited to

participate in three CANP-P sponsored TIC technical assistance (TA) opportunities and training events.

CANP-P continued to support the DOE Family Resource Center (FRC) initiative that established four pilot, school-based FRCs on the island of Oahu. Family resource centers (FRCs) are community-based resource hubs where families can access supports to promote their health and well-being. CBCAP monies sponsored FRC Standards Certification Training, developed by the National Family Support Network (NFSN) to build the quality of staff practice.

Department of Human Services (DHS): DHS is a key partner in addressing CAN since it houses Child Welfare Services (CWS) and other state entitlement programs. CANP-P collaborations are described in Strategy 4.

Hawaii Children's Trust Fund (HCTF): HCTF is a public-private partnership between the Department of Health (DOH) and the Hawaii Community Foundation (HCF) that administers grant-making funds for the HCTF. The funds are used to ensure a strong network of family strengthening services and promote child abuse and neglect prevention. HCTF work is carried out through a statewide Coalition, an Advisory Board (AB), and an Advisory Committee (AC) to ensure diverse/broad community input. The DOH serve on all HCTF governing bodies.

Strategy 2: Promote safe and nurturing relationships by raising community knowledge about resilience and adverse childhood experiences

This strategy highlights CAN-P efforts to raise awareness/knowledge to prevent CAN and strengthen families.

CANP-P continued to participate in the development of the *Nurture Daily* website (https://nurturedaily.org/families), a comprehensive resource for families and service providers to support the healthy development of Hawaii's children and strengthen families through the five protective factors. The website includes user-friendly information, activities, games, webinars, event announcements, and resources for families.

Nurture Daily is a project of the Safe & Nurturing Families initiative of the Early Childhood Action Strategy (ECAS), a statewide, public-private collaborative designed to improve the system of care for Hawaii's youngest children and their families.

CAN-P funds were made available to the neighbor island CANP Coalitions to respond to immediate family needs during COVID as well as provide information on family supports to help alleviate stress that could contribute to CAN. Activities included drive-by events with families receiving basic needs hygiene, sanitation, and food supplies. Informational brochures on positive parenting, family resilience, safe sleep, and more were also distributed. Children received education packets and games promoting family-time activities. The events also offered opportunities to talk with an agency staff with specific questions or needs.

Strategy 3: Provide training and technical assistance to community-based, prevention-focused programs to strengthening families and prevent child abuse and neglect

Through COVID, the CANP program continued to sponsor and support virtual trainings.

Webinars: CANP-P funded four unique webinars open to private and public agencies and their staff involved in CANP and family strengthening. The webinar topics addressed the effects of trauma, common responses to trauma, and ways to mitigate negative responses. The webinars included:

- Stamp Resilience Into Your Brain – building mental resources and inner strengths.
- Using our Brains to Create Safe, Connected, Empowered Organizations and Communities – how neuroscience informs actions that help regulate the stress response system.
- When Stress Becomes Toxic – addressing stress.

- Micronesian Migrants in the US: – how health issues, social determinants of health, and effects of COVID-19 played a part in disparities and inequities in the Micronesian community; how services could be more culturally aware.

The CBCAP grant requires awardees conduct outreach to special populations including children and/or adults with a disability since children with disabilities may be at higher risk for abuse or neglect. Parents of a child with a disability may experience more stress addressing special needs and sometimes financial burdens. CBCAP funds sponsored a virtual miniseries conference devoted to building the knowledge and the skillsets of individuals and organizations that work with individuals and their families diagnosed with Fetal Alcohol Spectrum Disorders (FASD). Miniseries topics were: "Behavior Belongs in the Brain," "Recognizing FASD and Modifying Approaches to Enhance Optimal Outcomes for Individuals, Families, and Providers," "Realities and Responsibilities" (conducted by a person living with FASD), and a panel discussion on "Current Activities and Trends in Hawaii."

The CBCAP requires efforts to enhance parent leadership and participation in planning and implementing grant-funded and related CANP initiatives. To accomplish this, the CANP-P participated in funding two virtual Parent Leadership Training Institute (PLTI) cohorts. PLTI is an evidence-based model that provides parents technical skills/knowledge to be effective advocates for children and to be change agents in their community. Parents attend 20 evening sessions and also complete a community project putting learned skills into practice. Several of the PLTI community projects address CANP: create a support group for pregnant women who were abused as children; support a program for girls to develop their leadership skills and self-confidence to keep them out of sex trafficking; an indigenous-based leadership program for mothers and daughters; and an art program for youth living at a transitional shelter to use their voices to share their stories of challenges being turned into victories.

Strategy 4: Collaborate with the Hawaii State Department of Human Services primary prevention Initiative

This strategy focused on the partnership with the DHS Child Welfare Services (CWS) program that investigates CAN reports and provides services to assure the safety of children who are subject to or at-risk for CAN.

In 2018, the federal Family First Prevention Services Act (FFPSA) was enacted to turn the focus of the current child welfare system toward keeping children safely with their families to avoid the trauma that results when children are placed in out-of-home care. In response to the new prevention focus, CANP-P is partnering to write and implement the Collaboration Section of the State Child and Family Services Plan (CFSP). Activities focus on three areas:

- Supporting the Hawaii Zero To Three Court initiative
- Expanding the DHS Child Welfare Ohana Time system of care and services, (*Ohana* means family in Hawaiian)
- Improving connections to family resources including identifying service gaps

Strategy 5: Promote health equity by addressing disparities in confirmed CAN cases

CWS data clearly shows disparities in confirmed CAN cases by geography, race/ethnicity, and age. Not to be forgotten are equity issues of children with disabilities.

Native Hawaiian children are consistently overrepresented in the number of confirmed CAN cases. By age, infants and toddlers experience a higher risk for abuse or neglect. Each island has areas with high numbers of confirmed cases, normally low-income and under resourced areas.

CBCAP funded community-based providers serving populations and areas at high risk and families disproportionately impacted by COVID. The initiative promoted use of Protective Factor supports known to mitigate risk of CAN, including providing basic necessities for families and computer equipment to access remote schooling

and needed medical care. Community organizations distributed bedding, small appliances, hygiene items, toiletries, PPE supplies, clothing, children's activity books, diapers, laptops, and hotspots.

The Title V Family Support and Violence Prevention Section and the Early Childhood Coordinator with the Children with Special Health Needs Branch collaborated on the planning and implementation of a two-day virtual summit addressing the unprecedented needs of the Hawaii's early learning communities due to COVID. The summit included cultural-informed approaches to prevent ACEs by addressing Hawaii's historical and generational trauma and acknowledging the historical trauma experienced by Native Hawaiians and other ethnic groups.

Current Year Highlights for FY 2022 (10/1/2021 – 6/30/2022)

Hawaii CANP Program is refocusing and consolidating Title V strategies to the following three areas:

- Training/workforce development
- Child maltreatment prevention activities
- Public awareness.

Health equity is braided or blended across each of the primary areas.

Contracts with community organizations to promote Protective Factor strategies continue through CANP public awareness events and family fun activities on all the islands. Activity initiatives must be designed to target special population families such as children with disabilities, homeless or at-risk for homelessness, Native Hawaiian/Pacific Island families, and families residing in shelters or public housing.

CBCAP is funding development of a CANP-P training plan, including CANP topic areas, subject-matter expert speakers, and a directory of asynchronous online (self-directed) learning websites with Protective Factors serving as the framework. The potential audiences are broadly defined including cross-sector agency administrators, professional and field staff for family support agencies and programs, as well as nontraditional persons and the general community.

CBCAP received a five-year, $1M award under the American Rescue Plan Act (ARPA). Contracts were awarded for Community Resource Coordinators in each county to expand and manage the acquisition and distribution of concrete supports to meet the needs of vulnerable family populations, i.e., single parents, families with a parent with a history of incarceration, kinship families and others.

CANP-P supported certification of trainers on the National Standards of Quality for Family Strengthening and Support. Expanding the number of certified trainers cross sectors will support better system coordination by promoting common language, quality improvement practices, and measures for Family Strengthening and Family Support programs, including Family Resource Centers, home visiting programs, and child development programs.

CBCAP supports the launch of the new ECAS initiative - *Aloha At Home.* It is rooted in Hawaiian values and the Protective Factors to guide and ground families as they pursue stronger connections. The first phase of the *Aloha At Home* promoted activities that build positive and healthy interactions between young children and their parents/caregivers using simple activity ideas and free activity boxes available through the website.

CBCAP is sponsoring a PLTI pilot targeting special population families, such as residents in public housing, fathers, parents of a child with a disability, parents who have experienced incarceration, parents who were involved in child welfare, and adults who were in the foster care system.

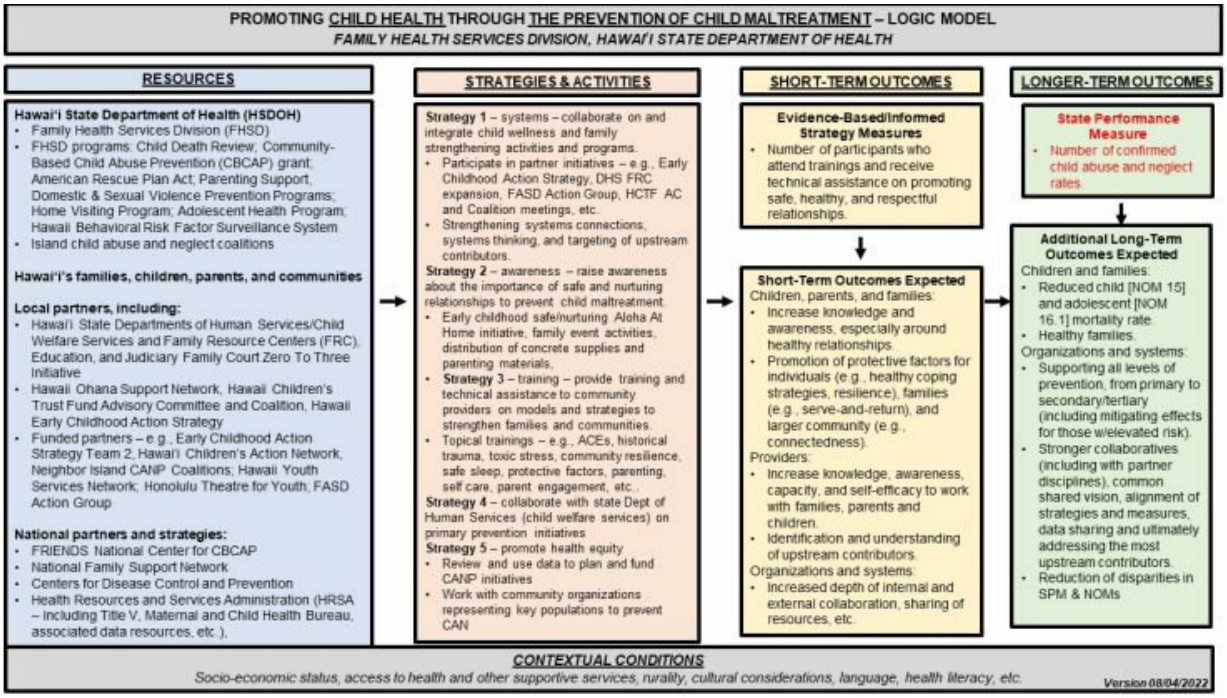
CANP-Program continues to be involved in the DHS State Team work implementing the Collaborative piece of the Child and Family Service Plan and the DOE evidence-based Family Resource Center (FRC) initiative.

The 2022 State Legislature passed two FRC related bills to fund a fulltime a state Family Resource Coordinator position and establish an FRC at the state correctional facility on Oahu. DOH and DOE will partner with DHS on the development of a state FRC plan and implementation activities. CANP-P will be involved in these tasks.

Another other CANP related bill passed in 2022 creates the country's first statewide Office of Wellness & Resilience focused on prioritizing wellness and resilience efforts across the state departments and creating a trauma-informed state to better serve local families and improve community health. CANP-P and several Title V programs are involved in this effort.

Review of Action Plan

The revised CANP logic model provides an overview of the strategic approach to prevent CAN. The effort cannot be addressed as a standalone public health concern capturing the broad array of public partners/resources to address CAN in Hawaii. The logic model also 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.



Challenges and Barriers

Reaching Families during the Pandemic: Services to communities and families were offered virtually, which resulted in a number of challenges. Some service providers did not have sufficient IT equipment. Clients residing in rural areas of the state often lacked access to broadband, digital devices, and skills to use the software programs. In response, federal relief funds were used to support the purchase of IT equipment for community providers and families. CBCAP funds were used to support at-risk Micronesian communities to procure IT supplies and subscriptions to assist children in participating in distance learning and attend telehealth appointments.

Workforce Shortages: The Hawaii Children's Trust Fund Coalition members participated in a workforce development/training survey. Members reported common recruitment and retention challenges such as:

- Job applicants often lacked the necessary position-related credentials.
- Salary levels affected attracting qualified applicants.
- Staff workload stress grew due to number of agency's vacancies.
- Use of hybrid virtual work scheduling did not support staff needs.
- Lack of professional development and career pathways for current staff.

In response to the challenges, some organizations expanded professional development trainings. The DHS/CWS expanded online learning opportunities for staff.

Reduction in Mandated Reporters: The impact of the pandemic is reflected in the reduced number of cases attributed to educational and medical personnel. In 2020, confirmed cases linked to educational staff reports dropped to 91 vs 197 in 2019. Medical personnel are the second highest mandatory CAN reporters in Hawaii. In 2020, 276 CAN cases were reported by medical professionals compared to 320 confirmed cases in 2019. CAN awareness training resources/opportunities are being expanded to more nontraditional reporters.

Overall Impact

Key overall CANP impacts include:

- Establishing collaborative prevention strategies in DHS 2020-2024 Child and Family Services Plan such as expanding Ohana Time with families.
- Continued coalition building and partnerships with state and community-based programs and organizations.
- Sponsoring and expanding accessibility of trainings via virtual platforms is increasing knowledge, skills, and/or attitudes of staff who work with families including those who may be at-risk for CAN.
- Successful implementation and operation of the DOE school-based Family Resource Centers pilot in spite of pandemic restrictions.
- Act 129 signed into law by the Governor that establishes the FRC Pilot Program within the DHS and the coordination of the DOH, DOE, and. Requires the Departments of Human Services, Education, and Health to public and private entities to develop and implement family resource centers.

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 state priority in 2021 to promote child wellness visits and routine immunizations, especially for young children. The priority is a result of ongoing assessment and concerns raised during COVID that many families were postponing or delaying care due to provider office closures, lockdowns, and safety concerns.

Data: The data for this measure is from the annual state CMS Medicaid Core quality assurance measure: Children receiving six or more well-child visits in the first 15 months of life. The 2021 data shows child wellness visits did decrease significantly in 2020 to 63.8% from 73.2% in 2019. There is a second CMS quality measure for well-child visits that showed 75.9% of 3-6-year-olds had a CWV in 2021, slightly better than 73.8% in 2020. There is no disaggregated data for these measures and no national comparison data for FFY 2021 at this time.

Data from the 2019-2020 National Survey on Children's Health indicated 79.7% of children 0-17 years had a preventive visit in Hawaii; an estimated 60,661 children did not receive a preventive visit. The percentage of those receiving a preventive visit by age group:

- 87.6% of children ages 0-5 years
- 78.2% ages 6-11 years
- 73.4% ages 12-17 years

All Hawaii rates were comparable to the U.S. estimates. There was no comparison data from previous years.

Objectives: Considering the baseline data, and the HP 2030 objective, the state objectives through 2025 were set to reflect one percentage point increase annually.

Title V Lead/Funding: The Title V leads for this project include: the Home Visiting Program, the Early Childhood Systems Coordinator, FHSD Public Information Officer (PIO) and Title V grant coordinator. The PIO, who was an essential lead for the effort, is funded by Title V. Other programs include EI, Lead Screening, WIC, and CSHN. State general funds were used to cover the major costs for the media and community outreach campaign.

Partners: The key external partners are the American Academy of Pediatrics-Hawaii Chapter (AAP-H), State Medicaid program, and Hawaii Children's Action Network (HCAN).

Strategies/Evidence: Hawaii plans to conduct a public awareness campaign to promote child wellness visits particularly for young children.

Strategies include:

- Collaborate with pediatric providers and community advocates to promote messaging on the importance of well-child visits
- Conduct a public awareness campaign and measure the effectiveness of messaging (i.e., increased visits to the doctor, increased number of vaccinations for the home visiting population)
- Build capacity for developing pediatric champions to promote ongoing messaging campaign

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 in increasing well-child visits. Another added value of the medical home model indicates collaborating with home visiting serves as emerging evidence. An MCH Evidence Center brief on public health messaging also indicated some emerging evidence for this strategy, especially in reinforcing a mass media campaign with social media and community coordination.

Strategy 1: Collaboration with Pediatric Providers

In 2020-21, nationally and locally delayed younger child wellness visits emerged as a major concern during COVID shutdowns. 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. The concern was amplified by the national AAP, which launched a national 'Call Your Doctor' campaign in May 2020. The federal MCH Bureau also launched a similar social media campaign, "Well Child Wednesdays," in 2020-21 and funded innovative projects to increase child wellness visits.

In 2020-21, the Census Pulse survey data confirmed that Hawaii residents were delaying care due to COVID concerns. Most Title V service programs saw overall reductions in service provision due to COVID as in-person

visits were halted and services shifted to virtual or phone visits, continuing through early 2021. Title V early childhood programs were particularly concerned about delays in child wellness visits among the families served, potentially missing routine immunizations and critical preventive screenings for children ages 0-5 years. Through 2021, the increased availability of adult COVID vaccinations resulted in safety restrictions removed with services reopening.

In Spring 2021, Hawaii convened a workgroup to develop a public awareness campaign to encourage more Child Wellness Visits (CWV), especially for young children. Most doctors' offices were reopening for in-person visits with well-established safety procedures and easy access to PPE (initially in short supply). Workgroup partners included: representatives from the local chapter of the AAP (the president and vice-president), Hawaii DHS-Med-QUEST (Hawaii's Medicaid agency), Family Health Services Division, DOH Chronic Disease Prevention and Public Health Promotion Division, and the Hawaii Children's Action Network (a local advocacy organization for young children and families).

The workgroup began planning the campaign and was able to secure state funds for the project. Contracts were executed with media vendors, AAP-Hawaii, and HCAN; the latter to coordinate community resources for the campaign.

The workgroup met to:

- Develop effective messaging
- Collect parent input to help identify the barriers to accessing care
- Test messaging with families in home visiting programs, Parent Leadership Training Institute (PLTI), and other Title V service programs
- Identify referral options for families to help secure health insurance or find a provider, if needed.

AAP-Hawaii leadership provided helpful input in developing effective messaging, guidance with the general campaign, direction/timing in coordination with its provider membership, and recruiting doctors for the commercial campaign filming in their medical offices. Additionally, pediatricians with diverse backgrounds were enlisted to reinforce the messaging through media appearances. Both the Medicaid Medical Officer, who is also a pediatrician, and the Medicaid Clinical/Community Services Nurse were also key planning partners. Both assisted with requesting evaluative data and coordination with the state's Medicaid health plans.

Based on input from family focus groups, the campaign tagline was developed: *Time for Check Up: Call Your Keiki's Doctor Today*. *Keiki* in the Hawaiian language means child. The location of the campaign message takes place in a doctor's office, identified as a 'trusted messenger' by the focus groups. Other key focus group findings were incorporated into the media messaging campaign:

- Inclusion of a 'real' family with small children
- Explanation and demonstration showing that doctors are following COVID safety precautions for in-person visits
- Explaining why wellness visits are crucial, especially after delays: for routine immunizations, screenings, physicals
- Explaining that, even if a child is not sick, it's important to visit your doctor/healthcare provider annually. Visiting the pediatrician makes sure your kids are healthy and to ensure their optimal physical and mental health.

The group also coordinated with efforts by the Hawaii Oral Health Coalition's social media campaign to promote child dental visits, also demonstrating that in-person dental visits were safe.

Strategy 2: Conduct Public Awareness Campaign

Originally, the media campaign launch was set for September 2021, well-after public schools opened in August to full in-person instruction (after more than a year of distance learning due to COVID). The September launch was timed to avoid any conflict with health messaging promoting routine immunizations required for school entry, as well as COVID vaccinations for eligible adolescents (from age 12, at the time).

The planning committee also closely monitored progress on national FDA approvals for a COVID child vaccinations for ages 5-11 years to avoid interference with any media planned for the child vaccine rollout. Conducting parent focus groups to develop and test effective messaging also extended planning efforts.

The major campaign delay occurred due to the severe summer surge in COVID cases and hospitalizations relating to the highly infectious Delta variant. The surge occurred at a time of lessening safety restrictions in the state and the general public sentiment that COVID was nearing an end with vaccination availability. The Delta surge, however, proved far more virulent than the initial COVID outbreak in Hawaii, with all hospitals reaching or exceeding capacity and suffering significant healthcare workforce shortages. Hundreds of emergency healthcare personnel were flown in from other states to address the staffing shortages. The surge led to the Governor issuing a public national plea for visitors to temporarily postpone vacation/trips planned to Hawaii.

With schools opening during the Delta surge, the Department of Education struggled to ensure the health and safety of children, teachers, and staff. Conflicts occurred over the adequacy of safety procedures, testing on campuses, and the accuracy of COVID case reporting for all 257 Hawaii schools. Despite mask mandates, several hundred COVID cases and several COVID clusters were reported throughout the school system in the first few months. This created hardships on families, who were required with little notice to pick up their children based on potential disease exposure and then find COVID testing, which was not widely available at the time.

It was decided that the height of the Delta surge, coupled with school reopening, was not a conducive time to launch the WCV campaign. Campaign planning continued through FY 2021. Below is some key information developed for the campaign:

Messaging: Time for a Checkup

Media Campaign: Television ad time was purchased during the news broadcast and on a local ethnic radio station, focusing programming to the Chuukese, Filipino, and Samoan populations. A promotional toolkit for pediatric and family service providers was planned, but not completed, due to COVID variant surges (first Delta and later Omicron). Community partners were busy addressing more immediate needs resulting from COVID in workplaces, homes, schools, and childcare sites.

Website: A website was developed at www.keikicheckup.com, which housed information from the national AAP Chapter, as well as information on locating a pediatrician with information from the Med-QUEST provider directory.

Metrics: The team would rely largely on media viewership measures (i.e., number of views) to document the reach of the messaging campaign. Title V programs that track CWV as a part of their client visit data would also monitor changes.

Measures of Effectiveness: Finding a population-based metric for the most underserved children proved challenging. Title V decided to use data from the state Medicaid program. Child wellness visit data is reported by Hawaii as one of the managed care plan quality measures. Surveillance data from the National Child Health Survey (NSCH) on child preventive visits for ages 0-5 years was considered, but the aggregation of data over two-year periods and the small sample size limited the use of data for evaluation.

Strategy 3: Build Capacity for Pediatric Champions

Although the primary focus of the project was to conduct the public awareness campaign promoting annual well-child visits, Hawaii used this opportunity to build capacity for pediatric champions by supporting AAP members as speakers for improving child health. Pediatric providers actively participated in media activities, including the production of the public service ads (voiceovers, “actors”) as well as providing live and taped interviews on morning TV shows and news programs. These providers represented diverse populations by race, ethnicity, and gender.

While Hawaii recognizes that some children are cared for by varied primary care providers, parent focus groups identified pediatric healthcare providers as trusted sources on information for their children (vs the Department of Health, politicians, celebrities, or ‘paid’ actors, who were not seen as trusted).

The local AAP-Hawaii Chapter also worked on developing pediatric champions and assisted providers with professional training on public speaking. Hawaii partners continued to work together on the following:

- Developed list of provider speakers for speakers’ bureau for other media opportunities
- Worked with AAP-Hawaii Chapter to augment resources, if needed, for other media campaigns and opportunities to promote pediatric champions
- Promoted collaboration with healthcare providers, insurers, and other critical partners including families.
- Worked with AAP-Hawaii Chapter on other medical home messages, COVID-related information, and other Title V priority issues

Current Year Highlights for FY 2022 (10/1/2021 – 6/30/2022)

The planning group decided to delay the CWV campaign until the surge in COVID cases lessened and the AAP provider membership expressed readiness to support in-person visits again. Plans were revised to launch the campaign in November – December 2021. Public Service Announcement (PSA) commercials targeted adults, ages 25-54, in approximately 245,271 households. The paid media campaign included television spots coupled with live morning news interviews and taped news stories with pediatricians discussing the importance of the well-child visits. The radio spots also ran over the two-month period and were translated into Chuukese, Tagalog, Ilocano, and Marshallese languages, which were determined to be the populations having the lowest number of well-child visits per service provider. Print campaign materials were developed and shared on community websites.

The messaging was also shared through the DOH Community Bulletin, which is the state source for COVID-related information and resources. The Bulletin featured short interviews with families, providing a family-focused perspective on the importance of CWV.

Display ads were drafted and shared with community partners and agencies to post on their websites. Medicaid also shared the PSA and digital ads to promote more wellness visits via their managed care contractors. Previews

of the commercial were shared with pediatricians via the AAP to prepare providers for potential increased calls from families wanting to schedule a visit.

Building on the success of the first campaign, additional funding was secured in June 2022 for a follow-up campaign, focusing on the importance of well-child visits and preventive screenings (developmental, hearing, vision, lead, behavioral), using footage from the original campaign. Planning is being conducted with the same organizational group, with TV and radio messages scheduled to be aired prior to September 2022.

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%.

Given changes brought on by COVID and the new ECCS grant and strategic plan under development, Hawaii is deleting two strategies, will retire ESM 6.2, and develop a new strategy measure in next year's report.

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).

New ECCS grant: Hawaii's new ECCS grant is developing a strategic plan to focus on strengthening integration and promoting maternal, infant/child health, and family well-being. The plan will focus on addressing health disparities in this population. Developmental screening remains a part of the plan's performance measures. Community-level initiatives piloted in Maui County and supported by the previous ECCS Impact grant will be used to inform statewide program efforts. Coordination will be maintained with other state early childhood entities. The ECCS activities assure family engagement (with parent leadership integrated into the Advisory Committee) and will help address other system issues, including policy development, agency coordination, standards setting, public awareness, and workforce training.

Medicaid partnership: With the inclusion of developmental screening as a priority into Hawaii Medicaid managed care contracts, Hawaii has a new data measure to assess screening efforts conducted by pediatric primary care providers serving Medicaid enrollees. For FY 2021, developmental screening rates in the first three years of life for Medicaid enrollees was 22.41%. Collaboration with Hawaii's Medicaid and the five managed care plans will be explored. Progress on the new EPSDT client dataset will be monitored as an additional data source to track screenings and health status information collected during each pediatric visit. Race/ethnicity data shared by Medicaid on their enrollees confirms they represent populations that are underserved with health disparities and poor health outcomes.

Hi'ilei Developmental Screening program: The program services are underutilized. With staffing changes in FY 2021, CSHNB will use this opportunity to evaluate and re-envision the program scope to better address the statewide challenges and needs for developmental screening, especially in light of COVID changes in healthcare delivery. Purchase of an ASQ Enterprise license that can be used broadly will be explored. Results of the Enterprise license piloted in Maui County are being reviewed to assess the benefits to expand screening reach.

Strategy 2: Data Collection and Integration

Data from Hawaii's Medicaid program for the developmental screening CMS quality measure will be monitored. A request for further disaggregation of the data will be requested. Medicaid progress on the EPSDT-related office visit data will also be followed, as the dataset is analyzed and findings generated.

Oversampling for the National Survey of Children's Health (NSCH) will be sought, although funding and other administrative barriers exist.

Strategy 3: Social Determinants of Health and Vulnerable Populations

Media Campaign. A media campaign to promote child wellness visits and preventive screenings for development, vision, hearing, and behavioral health will continue through Fall 2022. Messaging will be translated into several languages and broadcast on radio. Screening information will be translated for viewing or downloading from the campaign website. Social media and community outreach activities are also planned.

The Hawaii CDC "Learn the Signs. Act Early" (LTSAE) team will continue to work with WIC to utilize the 2-year-old and 3-year-old developmental checklist to see if parents have any concerns about their child's development. WIC staff will help with referral 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.

The translated milestones booklets based on the CDC LTSAE materials will be distributed to Chuukese, Marshallese, and Samoan speaking families in partnership with community-based organization.

The use of the Survey of Well-being of Young Children (SWYC) developmental screening tool that also examines family well-being will continue to be explored with partners to better address the social determinants of health and identify vulnerable at-risk families who may be in need of resources.

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.

For 2023, CAN strategies were revised/consolidated to reflect a broader public health systems approach:

- Support the collaboration and integration of family strengthening and child maltreatment prevention programs and activities across federal, state, local, and private programs, and organizations.
- Provide training and technical assistance to community-based, prevention-focused programs to strengthen families, prevent child abuse and neglect, and foster appreciation and knowledge of diverse populations.
- Promote health equity by addressing disparities in confirmed CAN cases.

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 be addressed through both established and new government and private organization collaboratives to address broad areas of workforce development, CANP activities, training, and health equity.

The Hawaii State Departments of Health, Education, Human Services (including Office of Youth Service), and Judiciary currently collaborate on several important child abuse and neglect prevention-related initiatives (see table below). The initiatives are a mix of primary, secondary, and tertiary prevention with the aim of building strong, nurturing, and resilient families and communities.

CANP Prevention Initiatives	DOH	DOE	OYS	JUD
Family Resource Centers - Primary and secondary prevention	X	X	X	X
Hawaii Children's Trust Fund Advisory Board, Advisory Committee, and Coalition	X	X	X	X
2020-2024 Child and Family Service Plan Implementation, Zero To Three Family Court -Secondary and Tertiary prevention	X		X	X
Promote Trauma-Informed Care Use in Hawaii -Primary and secondary prevention	X	X	X	X
Support the application of the CANP Framework -Primary and secondary prevention	X	X	X	X

The goal is to develop an integrated prevention continuum of services, policies, and practices across the state and county government offices and programs. This will include strengthening the current collaborations and establishing new partnerships with state offices and programs that address CANP, specifically the Hawaii State Departments of the Attorney General and Public Safety, the Fatherhood Commission, and the Executive Office of Early Learning.

Expanding the collaboration will support policies, practices and services that support children and families and mitigate risks for CANP, such as housing, financial assistance, parent education, substance use and abuse treatment, and domestic violence. The outcomes of this collaboration could include blending or braiding of funding streams; defined policies that align with a shared vision; shared community collaboratives addressing common goals and outcomes; and shared tracking and accountability for outcomes.

The CANP Program will continue to work in collaboration and coordination with the Early Childhood Action Strategy to expand the outreach and offerings of the Aloha at Home initiative, and the Hawaii Children's Trust Fund (HCTF) with its grant-making efforts and the HCTF Coalition to ensure community-level needs, concerns, and solutions are in the forefront in planning and execution of statewide CANP training and activities.

Supporting the public and private collaboration and integration will be carried out in part through statewide CANP activities and training/workforce opportunities. The HCTF Coalition and the individual neighbor island coalitions represent diverse and broad membership involved in the execution of CANP activities. Their work will be supported by the CANP program funds. CANP supported trainings will be made available to these partners.

Strategy 2: Provide training and technical assistance to community-based, prevention-focused programs to strengthening families and prevent child abuse and neglect, and foster appreciation and knowledge of diverse populations.

CANP Program will continue to 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. Opportunities will be implemented using a range of modes from virtual, on-demand/online, and in-person.

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 3: Promoting Health Equity by addressing disparities in confirmed CAN cases.

The data from DHS CWS point to significant disparities among CAN confirmed cases, specifically by race, age, and geography (rural). These variables are not necessarily mutually exclusive. As previously noted, Native Hawaiians are overrepresented in confirmed CAN cases for all age groups.

CANP will expand its collaboration with community organizations such as Papa Ola Lokahi and Native Hawaiian Health Centers that provide medical and enabling services to Native Hawaiians in largely rural areas of the state to better understand the needs and gaps in CANP services and identify actions going forward to address these inequities.

The CBCAP American Rescue Plan funds may be used in part to address disparities associated with geography/rural and race/ethnicity linked 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 COVID that many well-child visits and immunizations were postponed or delayed due to healthcare office closures and COVID 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. Data for FFY 2021 was not available at the time of this report but will be reported next year.

Strategy 1: Collaboration with Pediatric Providers

Once the 2021 campaign was launched, the workgroup did not meet as many providers became busy with the Omicron surge and COVID vaccinations for older children. However, partners were pleased with the success of the campaign and continued collaboration occurred around other child health issues. By working with both the AAP Hawaii Chapter and the Medicaid Medical Director, Title V is using these networks to help promote other maternal and child health issues such as focusing on transition to adult health care for youth, safe sleep, developmental screening, and lead poisoning prevention.

When time and staffing permit, Title V will explore a more comprehensive partnership with Medicaid to collaborate on Title V priorities and other service program concerns.

Strategy 2: Conduct Public Awareness Campaign

Hawaii will continue to work on the second public awareness campaign, focusing on well-child visits and screenings (developmental, behavioral, vision, hearing). The original planning committee was reconvened and agreed to continue to work on the second campaign, using the similar framework and structure as the first campaign. Following the MCH Evidence Center recommendations, more effort will be made to develop concurrent community outreach efforts to reinforce the media messages. Initiatives being discussed include: strengthening the digital/social

media outreach via TikTok, using social influencers, sharing digital messaging with service/agency providers to disseminate to their clients, and meeting with community partners to better reach underserved populations.

Greater attention will also be placed on developing qualitative and quantitative metrics for the messaging 'reach,' to determine how well CWV reached the target population, increasing visit numbers.

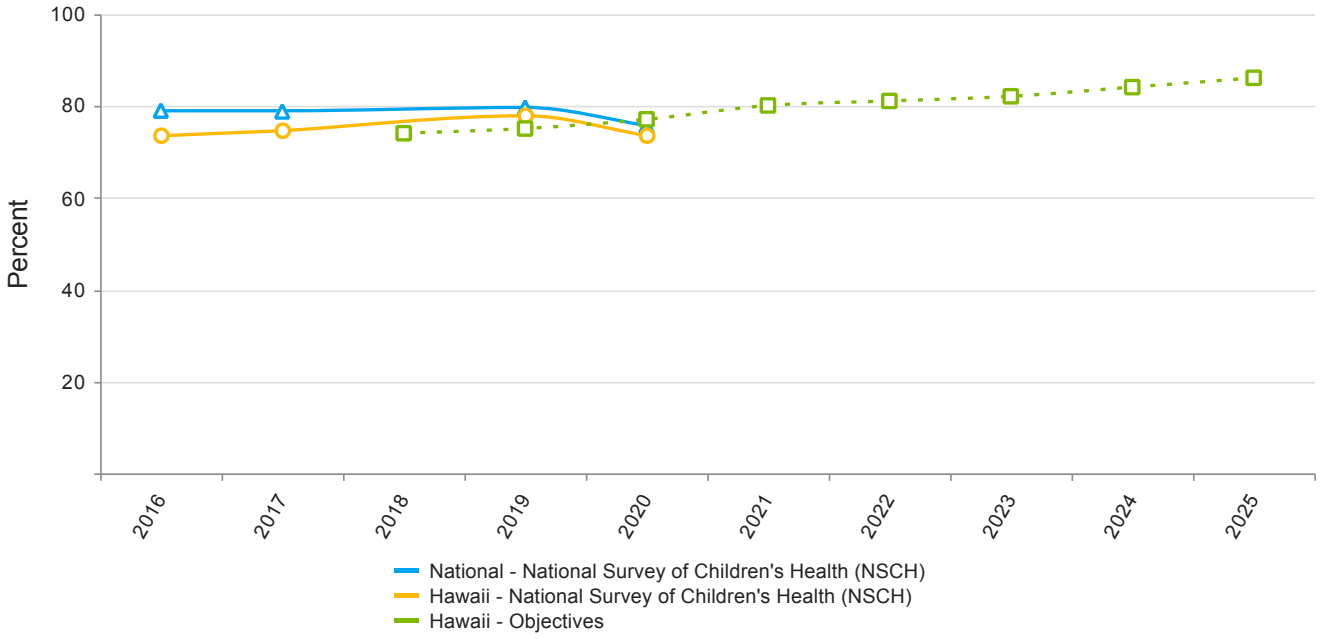
Strategy 3: Build Capacity for Pediatric Champions

Title V continues to work with the AAP Hawaii Chapter and HCAN to help educate and inform the public and policymakers on important child health issues. More pediatric champions are needed to help provide a stronger voice and promote legislation to improve children's health. Hawaii looks forward to continuing to further build capacity for pediatric champions to help advocate on behalf of children and families.

Adolescent Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		74	75	77	80
Annual Indicator	73.5	74.6	74.6	77.7	73.4
Numerator	67,325	74,226	74,226	76,702	71,318
Denominator	91,592	99,470	99,470	98,664	97,099
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	81.0	82.0	84.0	86.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Develop and disseminate a teen-centered Adolescent Informational Resource (AIR) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits

Measure Status:	Active

State Provided Data				
	2018	2019	2020	2021
Annual Objective			18	23
Annual Indicator				
Numerator	9	13	20	26
Denominator	30	30	30	30
Data Source	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	28.0	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 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	
ESMs	**Status**
ESM 10.1 - Develop and disseminate a teen-centered Adolescent Informational Resource (AIR) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits	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 findings of the 2015 five-year needs assessment. The 2025 Title V state objective for NPM 10 is to increase percent of adolescents with a preventive medical visit in the past year to 86.0%.

Data: Aggregated data from the 2019-20 National Survey on Child Health (NSCH) indicates that Hawaii (73.4%) did not meet the 2021 state objective (79.0%) but was close to the national estimate of 75.6%. The Hawaii estimate has met the related Healthy People 2030 Objective (82.0%). Based on 2019-2020 aggregated data, non-Hispanic Asians (66.0%) were less likely to have a preventive medical visit than non-Hispanic Whites (88.6%).

The 2019 Hawaii Youth Risk Behavior Survey (YRBS) indicated that there was a 1.9% decrease in preventive visits of high school teens. For teens in 2017 who reported seeing a doctor for a check-up or preventive physical exam, visits declined from 65.9% in 2017 to 64.0% in 2019. These numbers may be inflated if adolescents defined sports physicals as a wellness visit. Neighbor island disparities remain, with Kauai County high school youth reporting the lowest percentages of adolescent wellness visits followed by Maui County and Hawaii County.

Objectives: Reviewing the baseline data and the HP 2030 objective, the state objectives through 2025 were updated to reflect an approximate 10% improvement over five years.

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 also assists with management of state-funded contracts supporting women's reproductive health. 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 via 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.
- Health Equity. Develop self-help resources, tools, and services for Pacific Islander teens and young adults and all other Hawaii young adults to address health disparities

Research compiled by AMCHP and the MCH Evidence Center were reviewed to identify any additional evidence for Hawaii's strategies. AHU is using several strategies recommended by the National Adolescent and Young Adult Health Information Center, also cited in the evidence-based literature. These include: building collaborative networks with agencies and institutions at the systems level and building capacity in communities to reach youth-serving professionals, parents, guardians, and other caring adults to engage adolescents to share their voice and to better structure how teens access and receive information of interest and of concern to them. The MCH Evidence Center identifies 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 DOH Children with Special Health Needs program to address NPM 12 since it also impacts youth, both with and without special needs, to promote transition planning to adult care and also overlaps with NPM 10 AWV activities.

COVID Impacts: Although the NPM 10 data does not show a significant change in AWV, it includes 2019-2020 aggregated data. National NSCH data does indicate delayed medical visits for all children, and Census Pulse data also shows families delayed medical care during COVID in 2020 through 2021.

Although safety restrictions did ease somewhat in 2021, anecdotally, COVID surges due to the Delta variant may have delayed access to healthcare since families remained cautious about disease spread, providers struggled to implement evolving safety protocols, and families/providers adjusted to telehealth options. Most doctors' offices opened for in-person visits and many offered remote care options in 2021. Conversely, many providers spaced appointments to avoid waiting room congestion and to provide adequate time for cleaning. Thus, routine healthcare and preventive services, such as AWVs and vaccinations, continued to be postponed through 2021. For some families, priorities continued to focus on more immediate daily needs, such as income/housing stability and educational/childcare responsibilities since DOE schools continued remote learning through spring/summer 2021. Existing disparities related in accessing preventive healthcare that existed prior to COVID may have 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 saw a dramatic increase in community partnerships with teens, youth service providers, and other community organizations to promote adolescent health and wellness visits. Existing funds were shifted to devise new ways to reach and address youth needs that emerged as a result of COVID. However, some contracted enabling services were reduced and changed during this period due to COVID restrictions

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 impacts of COVID on their physical, social, emotional, and mental well-being. AHU used the information to develop more effective messaging. The information also provided insight for workforce training ideas that strengthened their relationships with and resources for teens and young adults during COVID.

- 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 healthcare services started to reopen in June.

Coalition for Drug Free Hawaii: CDFH is a critical AWV partner, providing statewide access to youth ambassadors, experienced youth service staff, a well-established statewide website and youth service provider network. CDFH provided adolescents and their families with information on programs and resources via the TeenLink Hawaii (TLH) program, complete with social media links and an interactive website.

YMCA: A new partnership with Atherton YMCA provided AHU with access to a network of 18-to-24-year-old college students to use for input to better inform outreach efforts.

Domestic Violence Action Center (DVAC): The DVAC partnership provides statewide access to Compact of Free

Association migrants (COFA Communities) and an opportunity to gain feedback from this underserved population. The DVAC staff has a successful history of working with COFA Communities in its outreach activities and was beneficial in collecting data/information for developing informational resources for this population.

Media/Marketing firms: FHSD's new Information Specialist expanded the Division's ability to craft and develop media messaging through paid and earned media with a focus on TV, radio, and digital. The Information Specialist negotiated media buys with major state broadcast and cable TV stations and local radio conglomerates to reach the MCH population—particularly young adults/teens and households with children (parenting adults, ages 35-64).

Other Community-Based Organizations: During COVID, AHU expanded and strengthened connections with the state's youth-serving organizations, to promote healthy relationships, adolescent health, and wellness visits, as well as connections with caring adults through virtual meetings and webinars. Partners included: the Hawaii Youth Services Network, Office of Youth Services, Hawaii Partnership to Prevent Underage Drinking, Youth Tobacco Prevention Coalition, DOH Chronic Disease School Health program, Prevent Suicide Hawaii Taskforce (PSHT), Mental Health America of Hawaii, After School Program Alliance, Weed & Seed Hawaii, and Atherton YMCA.

PREP: The AHU PREP service contracts access high-risk youth in residential facilities to provide them information on adolescent wellness, collect youth input to develop relevant resources, and provide workforce training to the PREP providers on the evidence-based Teen Outreach Program® (TOP®) curriculum. Information on AWV was also integrated into the TOP curriculum and program evaluation. The CSHN Branch "Footsteps to Transition" infographic was also incorporated to help initiate conversations about AWV and the importance of scheduling a wellness appointment.

PREP contractors include: the Hawaii National Guard Youth Challenge Academy (YCA) on Hawaii Island and Oahu residential facilities; the Hawaii Youth Correctional Facility, known as the Kawailoa Youth and Family Wellness Center (KYFWC); and RYSE (Residential Youth Services and Empowerment).

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. YCA reports that 94% of their 250 participants,16 to 18 years of age, consistently complete the positive youth development and teen pregnancy prevention TOP curriculum.

KYFWC is administered by 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.

RYSE serves more than 50 18-24-year-old young adults at four sites and assists their residents in obtaining health insurance as well as provides transportation, when possible, to clinic visits.

Because PREP providers are residential programs, services continued throughout COVID with in-person classes.

Women's Health Service Contracts: AHU is administratively located in the MCH Branch Women's Health Section and has partnered with women's health service providers as part of their outreach to teens, young adults, and high-risk populations. When state-funded Perinatal Support Services (PSS) contracts expired in June 2021, MCHB combined PSS and the state funding from the terminated family planning program to issue new service contracts for women's reproductive healthcare (RHC). Most of the contracted providers are FQHCs and several are located on the neighbor islands, where teens have the lowest rates of AWV.

The shelter-in-place and stay-at-home orders diminished outreach efforts of community health workers (CHWs) to

reach youth in the various counties. With school closures and the economic shutdown, healthcare was largely limited to identifying, treating, and mitigating COVID. Many of the PSS program outreach staff were furloughed, leaving the neighbor islands with minimal adolescent health wellness outreach. AHU remained in contact with the adolescent outreach workers via a listserv to keep them informed on self-care, adolescent resources, and tools, as well as adolescent health training opportunities.

CSHN: AHU continued working with the CSHN program to incorporate transition planning into the adolescent health training activities.

YBRS: 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 Youth Risk Behavioral Survey (YRBS), which is administered in odd-numbered years and includes the AWV 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

Developing adolescent informational resources (AIR) online to build knowledge, promote healthy behaviors, and improve skills to access healthcare and community resources continues to be the focus for this strategy. The online resources are also readily available to health educators and outreach staff so that they can 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 health knowledge and attitudes about AWVs.

Only 4.94% of the respondents did not believe an AWV was important, citing barriers like health insurance and additional out-of-pocket costs. The other 95% noted the benefits of an AWV: knowing your health status and learning ways to improve health. Doctors were cited by the teens for identifying health issues/chronic conditions that may need monitoring. When asked about who they seek health advice from, 83% responded with 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. Based on these results, TeenLink youth staff developed resource materials now available on the TeenLink website to address these findings.

The CDFH teen and young adult volunteers recently 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. The website also includes information adapted from the CSHNB transition materials that were designed to increase adolescents’ confidence to access healthcare services and strengthen independent life skills.

PREP: Youth in PREP service sites provided valuable information on their knowledge of AWV, health topics of interest, and preferred methods for receiving key health information. While many teens do have health insurance, most did not know the specific insurer, did not have their insurance card with them, or did not have experience

making a doctor's appointment.

Media Campaign: In Fall 2021, AHU conducted a resiliency media campaign to publicize and refer teens/young adults to the TLH website (teenlinkhawaii.org). The campaign was able to highlight issues identified by teens, including high stress levels, impaired sleep patterns, concerns about school grades, personal eating habits, and effects of their social media behavior. 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 the teen and his parent/s discussing 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 familiarize teens and adults with resiliency messaging.

The reach via TV was projected to be 98.9% of the target audience of households with children. Combined broadcast and cable TV impressions was estimated at more than 2.1 million. For radio, total impressions were estimated at nearly 2.4 million spread across 20 stations that broadcast from Oahu, Maui, Kauai, and Hawaii Island. The PSAs were estimated to reach more than 51,000 teens ages 12 to 17, and more than 316,000 adults 35 to 64.

Digital media buys were incorporated through key outlets including: search, keyword, display, retargeting display, pre-roll before videos, streaming TV, and social media. Digital ads resulted in nearly 2 million impressions/views.

Feedback from TLH teens and families on the PSAs was very positive, with mention of how fun and relatable the spots are because of the humor and use of Hawaiian Pidgin, an English-based creole language spoken locally. TLH program coordinators reported that the website experienced 25,364 visits, compared to the 4,486 for the months prior to the campaign. Interestingly, use of the site extended beyond the state. Of the 25,364 visits, 22K were unique visitors (unduplicated), 22,857 from the US (15K from Hawaii) and the remaining from other countries, ranging from the Philippines, India, the United Kingdom, and the Netherlands.

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 COVID, AHU continued to provide staff development webinars and online training opportunities.

teenLink Hawaii TeenLink Hawaii (TLH) is the "go-to" website for adolescent health and wellness tools and resources, complete with Instagram Posts, IGTV Videos, TikToks, YouTubes, print resources, infographics, and more. It's developed 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 use TLH as their transition to adult healthcare information website. A resiliency media campaign is underway to further 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 increase access to the self-help and self-care tools, resources, and services including acknowledgement of the AWV.

Listserv: The AHU listserv provides information on upcoming webinars and adolescent-centered training opportunities to its youth service providers.

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 Informational Resource (AIR), 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 AIR. 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 COVID, the 2021 indicator was scored at 26 out of 30 points, a 30% increase over 2020. This is credited to major progress being achieved by working directly with youth to assess, revise, and promote the AIR via TeenLink. Objectives were set through 2025. The most current data collection form is below.

A few revisions were made to the ESM checklist that reflect the evolution of the strategy activities over the past 5 years. A physical toolkit for health providers was reworked into a youth driven, developed interactive online website for youth, as well as readily available for caregivers/parents, and health/service providers to use.

ESM 10.2 – Develop and disseminate a teen-centered Adolescent Informational Resource (AIR) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective			N/A	N/A	20.0	23.0	27.0	28.0	29.0	30.0
Annual Indicator			9	13	20	26				

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 AWV 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 infograph 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 AIR/TeenLink.				**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 AIR materials developed by teens and young adults.				**X**
6. Conduct assessments to determine adolescent awareness of the AWV and the perceived barriers to accessing an AWV.			**X**	
7. Assess service provider and informant information to assure the AIR/TeenLink 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 AWV visits, through the AIR.			**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 AWVs.				**X**
10. Assess stakeholders for increased knowledge and comfort level post training.			**X**	
Total Points			**26**	

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

This health equity strategy is focused on addressing the informational/services needs of Pacific Island teens and young adults. AHU solicited bids to work with this community to develop materials that will improve engagement with this population. The Domestic Violence Action Center (DVAC) was awarded the contract, utilizing their networks of Pacific Islander teens and young adults to assess their personal health and wellness needs. These young people will also assist in the development of resources, tools, and services (RTS) and also identify the most effective media platforms, designs, and tools to engage their Pacific Islander peers on health and wellness issues and AWVs. This input will be critical given the continued implementation of COVID 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.

Current Year Highlights for FY 2022 (10/1/2021 – 6/30/2022)

Here are some highlights of current adolescent health activities for FY 2021, including continued impacts and changes due to COVID in Hawaii.

With increased access to COVID vaccinations and reduced severity of COVID cases, the state and county emergency orders were lifted. Public schools resumed in-person learning with mask and other safety precautions in place. COVID vaccinations were offered through some schools, as well as widely in the community.

Physician shortage: Hawaii's continuing physician shortage was also exacerbated by the COVID crisis, which adversely impacted access to AWV providers. A 2020 assessment of primary care physicians by the University of Hawaii (JABSOM) found that COVID disrupted their practices, with temporary and permanent clinic closures, more early retirements, increased telehealth practice, altered operating hours and locations, and reduced patient volume. Primary care doctors represented the largest healthcare workforce shortage on all islands.

PREP: There were some changes in PREP contractors. The Hawaii National Guard Youth Challenge Academy (YCA) and Residential Youth Services and Empowerment (RYSE) ended their contracts due to administrative and staffing shortage issues. Two new contracts were executed with the following agencies.

Parents And Children Together (PACT): PACT provides after school drop-in centers for youth ages 7-18 to promote the development of healthy youth, families, and community with an abundance of positive experiences, including educational, recreational, community-building, and support services. PACT collaborated with the AHU in capacity-building activities and certified four staff as TOP facilitators, beginning in September.

Hawai'i Friends of Restorative Justice (HFRJ): The mission of HFRJ is to train, advocate, develop programs, research, and educate on evidence-based practices that rehabilitate, heal, and give hope to youth residing in Kalihi. HFRJ participated in capacity-building activities to certify four staff as TOP facilitators, beginning in August.

The Kawailoa Family and Youth Wellness Center (KFYWC) continues to participate in PREP. The youth correction officer (YCO) training coordinator reported that there were positive changes in the climate/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 to provide more resources to the healthcare services now provided to the 30 KFYWC teens.

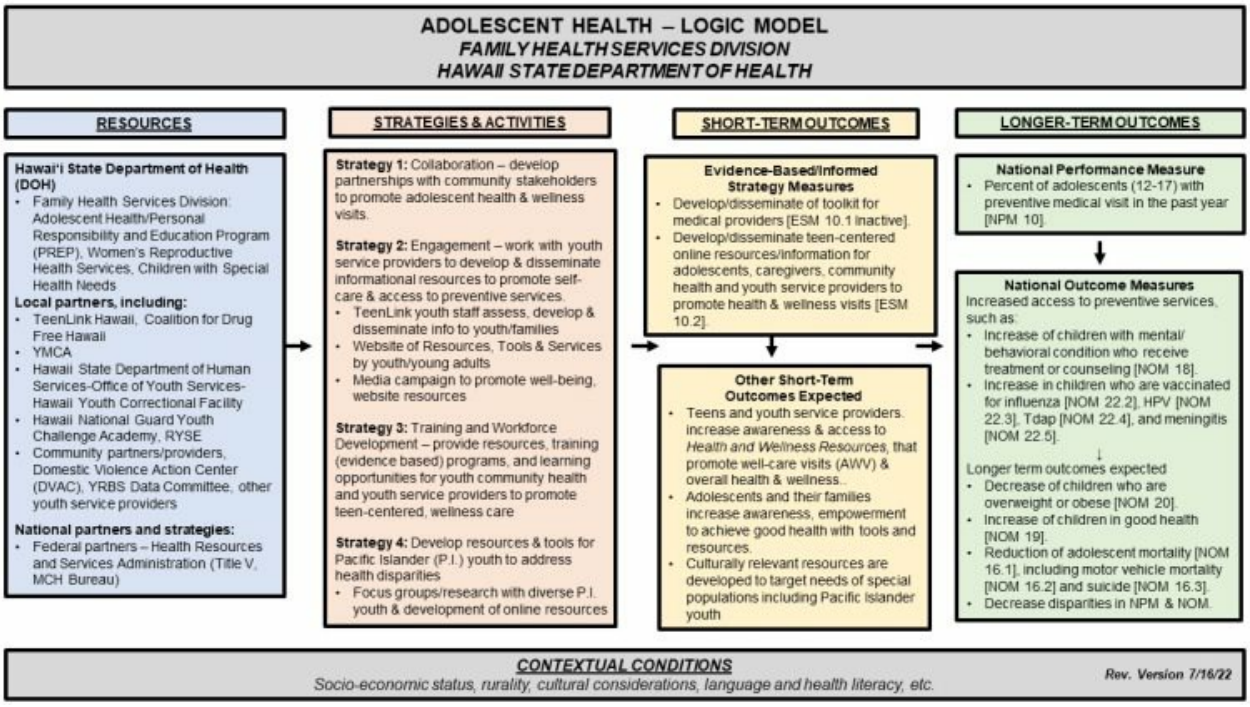
The new and existing PREP programs will include information on adolescent wellness, including active promotion of wellness visits.

TeenLink updates: The TeenLink youth leadership groups continue to maintain and update the TLH website. The website monthly hits have tripled since the February 2021 presentation to promote the new resource. The top topics being accessed include: Coronavirus, Suicide, Mental Health, Health and Wellness Toolkit, Youth Leadership, Sexual Violence, Go Green, Club Drugs, Alcohol, and Runaway.

A new youth survey was conducted in Fall 2021 with a focus on knowledge/skills related to transition to adult healthcare. More information on the survey results and follow-up can be found in the NPM 12 narrative.

Review of the Action Plan

A logic model for NPM 10 was updated to assure alignment among strategies, activities, measures, and desired outcomes. The logic model was revised to add the health equity strategy for engaging and developing new resources.



Challenges, Barriers

AHU's ART seeks 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 needed health services (e.g., AWVs) and resources.

Despite ongoing promotion of AWVs throughout the state, AWVs are not increasing. New challenges were brought on by COVID, including the state's primary care physicians shortage and a shifting of family priorities that led to delayed medical visits. Ongoing beliefs also persist that doctor visits are for illnesses only, preventive visits require out-of-pocket costs, and that sports physicals are the same as an AWV. New players in the healthcare market, such as 'minute clinics' and urgent care centers, also pose challenges to AWVs. Busy families use these convenient, community-based options as a primary source of care, which can undermine the benefits of the more comprehensive AWV provided by a medical home.

Working with specific populations to address health disparities was challenging. While DVAC has Pacific Islander staff who worked to engage youth from their communities, the response has not been robust. It is unclear to what extent the data collection methods are effective in capturing the life experiences and attitudes of Pacific Islander youth. AHU will continue to explore opportunities to collaborate with Pacific Islander youth to increase understanding of both structural and interpersonal barriers to resources/services, their unique needs/concerns, and ideas to help them improve their health outcomes.

Operationally, AHU was adversely impacted by staffing shortages within the Unit, Section and Branch. Vacancies currently include the AHU Supervisor, Reproductive Health Services Manager, and Women's Health Section Supervisor. Efforts to recruit and fill vacancies continue.

Overall Impact

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 AWV and transition messaging, 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 COVID, with projects focused on targeting and Pacific Islanders as well as Native Hawaiian youth.

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, having had 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 with:

- 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 develop relevant information tools, services, and resources needed; provide insight on the ways information is sought and received; assist in promoting self-care; and help with 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.
- Develop self-help resources, tools, and services for Pacific Islander teens and young adults, and all other Hawaii young adults to address health disparities.

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 who 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 Reproductive Health Service contracts. Activities include working with outreach workers to promote AWV and adolescent health through school and community venues, depending on COVID-related circumstances. These activities may be constrained by existing position vacancies.

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 to be incorporated into the TeenLink Hawaii one-stop website and continue the support and promotion of 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 health and behaviors.
- Meet with partners established through the workgroup to promote child wellness visits for young children, including AAP-Hawaii and Medicaid.

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 guidance from teens and young adults. The TeenLink Hawaii (TLH) teen leadership groups will use findings from their peer survey research to further develop and maintain the teen-driven TLH website. The teen groups will continue to develop effective media platforms, designs, and tools to engage peers on health matters and disseminate information on AWVs.

The teen groups will also assist with presenting TLH information to peers, families, and other youth organizations. This will include national and local online information, service resources, and a variety of teen-centered health and wellness materials.

Other activities planned for the coming fiscal year include:

- Engaging other youth groups to utilize and share the TLH materials through other community-based agencies and organizations, including the PREP program sites.
- Collect and analyze evaluation comments on TLH from both adolescents and service providers.
- Develop a young adult section on the TLH website for those young adults, 18 to 24 years of age.

AHU will continue work with the CSHN Branch to engage Youth with Special Health Needs and their families and develop informational resources for this population on the TLH website.

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 contractors, utilizing the evidence-based Teen Outreach Program® (TOP®) curriculum at:

- The Kawailoa Youth and Family Wellness Center (KYFWC)
- Parents And Children Together (PACT)
- Hawai'i Friends of Restorative Justice (HFRJ)

New contracts are being explored with Lanai Community Health Center and the Hawaii National Guard's Youth Challenge Academy (if administrative barriers can be addressed).

Other adolescent health trainings to youth-serving providers will include topics that support healthy relationships, such as adult-to-teen communication skills; 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 TLH website.
- 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 peer support 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 help to identify the most effective media platforms, designs, and tools to engage their Pacific Islander peers on health matters and AWVs. This input will be critical given the continued implementation of COVID 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 will review the 2021 Youth Behavioral Risk Survey results to assess the impacts of COVID as reported by Hawaii's middle and high school students. Special attention will be placed on identifying emerging disparities to better target messaging and service delivery.

Title V Adolescent Health Programs

Adolescent Health programs under the Hawaii Title V program include:

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. This 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 Kawailoa Youth and Family Wellness Center (formerly known as the Hawaii Youth Correctional Facility). Both facilities focus on 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 at 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

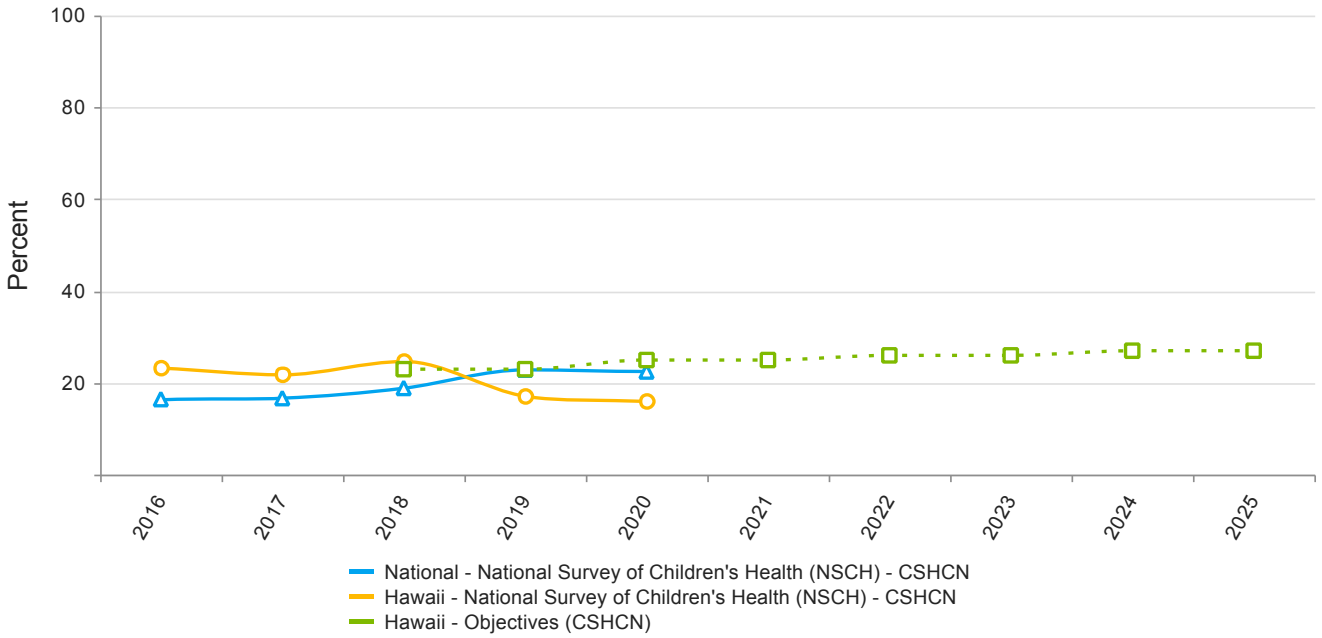
specialized medical care and their families.

Reproductive Health Care & 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. This is achieved through contractual services for uninsured and underinsured pregnant women through pregnancy and six months postpartum. Services include assistance in enrolling for public/private health insurance (Medicaid).

Children with Special Health Care Needs

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		23	23	25	25
Annual Indicator	23.3	21.9	24.7	17.1	15.9
Numerator	4,235	4,457	5,037	3,214	3,171
Denominator	18,144	20,375	20,412	18,758	19,924
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	26.0	26.0	27.0	27.0

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					
	2017	2018	2019	2020	2021
Annual Objective		17	21	24	26
Annual Indicator					
Numerator	13	18	22	25	26
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	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	28.0	30.0	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.	
Develop and expand efforts to address health disparities in transition services for youth	
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 health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

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 DOH needs assessment. By July 2025, the state sought to increase the percentage of youth, with and without special health care needs, who received transition services to 27%.

Data: Although the NPM 12 measure for this indicator reports on transition services received by both youth with and without special needs, the federally available data is reported separately for each group of adolescents. The data for special needs youth was used for this measure since it falls in the CSHCN population domain.

Aggregated 2019-2020 data indicated that Hawaii (at 15.9%) did not meet the 2021 state objective (25.0%) but was not significantly different from the 2020 indicator and the national estimate of 22.5% for youth with special health care needs. The decrease from 2017 (23.3%) was not statistically significant. The related HP 2030 objective for this measure is under development. The sample size was too small for subgroup analysis.

For adolescents with no special health care needs, aggregated 2019-2020 data indicated that the estimate for Hawaii (18.8%) was not statistically different from the nation (17.6%); however, the increase from 2017 (10.4%) was statistically significant. There were no significant differences in reported subgroups by household income poverty level, nativity, sex, and household structure based on the 2019-2020 data provided.

Objectives: The state objectives through 2025 were updated to reflect a 10% improvement over five years (2%/year). The related HP 2030 objective for this measure is under development.

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 of promoting adolescent wellness visits. The team meets monthly via Zoom.

Title V does not directly fund transition activities but funds key CYSHNS staff positions, including the CYSHNS 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 partners in Hawaii that actively support and promote transition to adult life include:

- Title V Adolescent Health Program
- American Academy of Pediatrics-Hawaii Chapter
- Hilopa‘a Family to Family Health Information Center (Hilopa‘a F2FHIC)
- Hawaii State Council on Developmental Disabilities (HSCDD)
- Hawaii State Special Parent Information Network (SPIN)
- Hawaii State Disability and Communication Access Board (DCAB)
- Hawaii State Department of Education (DOE)
- TeenLink Hawaii
- University of Hawaii at Manoa Center on Disability Studies (CDS)
- Kaiser Permanente Hawaii

- Shriners Children's Hawaii
- Special Olympics Hawaii

Strategies: Hawaii has three strategies for transition:

- Incorporate transition planning in service coordination activities for youth enrolled in CYSHNS and their families.
- Provide education and public awareness on transition to adult health care and promote the incorporation of transition services into organizational practices, in collaboration with state and community partners.
- Develop and expand efforts to address health disparities in transition services for youth.

The first strategy is assessed by a scale that monitors progress on the integration of transition planning into the CYSHNS practices/protocol based on *Got Transition's Six Core Elements of Health Care Transition™ 3.0* and serves as the NPM 12 strategy measure (ESM 12.1).

Evidence: Hawaii's first two transition strategies are based on the 2020 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*. A third health equity strategy was added in 2021. Progress on the strategies is described below. The MCH Evidence Center indicates Hawaii's ESM has 'moderate evidence' related to the use of the national core elements for transition.

COVID Impacts: Initially, COVID had dramatic and significant impacts on CYSHNS operations, services, and client needs. All in-person services continued through remote means (telephone or virtual) and in-person CYSHNS neighbor island specialty clinics were canceled since interisland travel was suspended. Nutrition clinics for all islands continued through telehealth visits.

With most Title V staff already familiar with Zoom, the pivot to telehealth was relatively seamless. Some families, however, needed technical support and assistance to access telehealth. Rural families had connectivity issues due to their remote location and low-income families may not have been able to afford reliable internet services. Staff also witnessed a dramatic shift in clients' daily needs toward necessities such as food, diapers, and rent/income assistance. Generally, CYSHNS client services decreased during the pandemic. Engaging families proved challenging, resulting in a significant decline in the provision of transition services. Visits to primary care physician (PCP) and medical specialist office also decreased since in-person visits were limited. In-person clinical services returned midway in FY 2021 due to the rollout of COVID vaccinations.

Staff quickly shifted their focus to promotion, education, and outreach of CYSHNS program services, which could be conducted virtually. New partnerships were made with community organizations that work with youth and young adults. Partnerships with other Department of Health programs and other state and community agencies were strengthened.

Strategy 1: Incorporate transition planning in service coordination activities for youth enrolled in CYSHNS and their families

Core Elements: CYSHNS transition to adult health care efforts are guided by *Got Transition's Six Core Elements of Health Care Transition™ 3.0*. The Core Elements are integrated into CYSHNS policies and procedures for youth and their parents/caregivers receiving CYSHN services.

Core Element 1: Transition and Care Policy/Guide

This element focused on the development of a CYSHNS transition policy that was completed in 2020. The CYSHNS Transition Policy is posted on the CYSHNS website: http://health.hawaii.gov/cshcn/home/communitypage/. All

CYSHNS staff are educated on transition approach, policy, the Six Core Elements, and the roles of CYSHNS, youth/family, and pediatric/adult health care teams in the transition process. Staff are also educated on Title V's overall leadership role to improve MCH population health, including CSHCN. Training content and program guidelines stressed the importance of cultural considerations and decision making. The information is included in all new CYSHNS employee orientation sessions.

Core Element 2: Tracking and Monitoring

This element established a process to track progress in the client database of transition activities for youth enrolled in CYSHNS. Update of the database was completed in 2021.

Core Element 3: Transition Readiness

This core element ensured that CYSHNS staff meet with youth and parents/caregivers at least annually to assess transition readiness and the youth's ability to manage his/her health care starting at age 12-16. Due to COVID, the implementation of transition readiness activities declined in FY 2020-21 because of the widespread shift in family priorities to essential daily needs and COVID-related concerns. Transition readiness activities targeted those being discharged from the program and those who needed to transition to adult services providers.

CYSHNS staff continued to utilize and update transition tools to guide youth and parents/caregivers through the transition process with practitioner, youth, and family input.

Core Element 4: Transition Planning

This core element ensured transition planning is conducted effectively by reviewing and updating individualized transition goals annually with youth/families.

As with Core Element 3, this activity was suspended during FY 2020-21 due to COVID restrictions. Some CYSHNS staff attempted to conduct transition assessments through mail or via virtual visits but reported reluctance from youth to participate. Staff resumed this activity when youth are less stressed by COVID-related concerns. Meanwhile, staff continued to actively share transition information and resources with youth and families.

Core Elements 5 and 6: Transition Transfer of Care and Transition Completion

The above activities culminated with youth and their parents/caregivers successfully transitioning to adult health care providers. Staff provided guidance, resources, and training to help youth apply for health insurance coverage as an adult, select adult health care providers, and learn to manage their adult health care.

CYSHNS staff also assisted with referrals to adult service agencies through the state's *No Wrong Door* program, which is an integrated person-centered system that supports individuals of all ages, disabilities, and payers. *No Wrong Door's* referral system provides a universal intake point for ease in assisting with better access to care.

From the start of the COVID, transition to adult health care was addressed as needed for ongoing medical care and at discharge. CYSHNS staff communicated with youth and families by mail or virtually to ensure that 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 health care 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	26				

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 2021, the ESM 12.1 score was 26 (78.8% completion), meeting the annual target (24).

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 health care 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 2017-21
2. Educate all staff about the approach to transition, policy/statement, Six Core Elements, and roles of CYSHNS, youth/family, and pediatric/adult health care team in the transition process, taking into account cultural preferences.	0 2016	1 2017	2 2018	3 2019-21
Transition tracking and monitoring (core element #2)				
3. Establish criteria and process for identifying and tracking transitioning youth in the CYSHNS database.	0 2016	1 2017-18		3 2019-21
4. Utilize individual flow sheet or database to track youth's transition progress.		1 2016-18	2 2019/20	3 2021
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 health care (self-care).	0 2016	1-1.5 2017-21		
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 2020-21	
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 2017-21		
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 2020-21	
9. Develop and implement referral procedures to adult service agencies.		1 2017	2 2018-19	3 2020-21
Transition transfer of care (core element #5)				
10. Prepare youth and parent/caregiver for transferring to an adult health care provider and planning for health insurance coverage as an adult.		1-1.5 2017-19	2 2020-21	
Transition completion (core element #6)				
11. Contact youth and parent/caregiver, when CYSHNS services end, to confirm having an adult health care provider and health insurance coverage or provide further transition guidance.		1 2017	2 2018-20	2.5 2021
	2021 TOTAL = 26/33 (78.8% completion)			

Strategy 2: 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

This strategy focused on partnership activities to promote transition awareness among youth and their families and on workforce training on transition planning practices for youth-serving organizations and health care providers. The partnership strategy reflected local input from stakeholders and community/agency partners.

Educational/Awareness Events: CYSHNS, along with youth and family members, continued to conduct virtual annual educational transition fairs and events in FY2021 due to COVID restrictions.

The largest event for youth and families of CSHN is the annual Special Parent Information Network (SPIN) statewide conference, which was held in October 2021. SPIN is a statewide parent-to-parent organization that was established to enhance the participation of parents of children with disabilities. SPIN provides information, support, and referral services. 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 key transition information with the 400 family members and service providers who typically attend. Other family events that were canceled due to COVID in 2021 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 continued to collaborate with a broad network of government and community groups that assist with systems coordination and advocacy for transition to adult health care. 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 community organizations.

In FY2021, new partnerships with the Kauai, West Hawaii, and Hilo Legislative Disability Forums provided another opportunity to share key transition messages.

TeenLink Hawaii: In 2021, with MCH Adolescent Health Program's NPM 10, a new partnership was formed with *TeenLink Hawaii*, an organization for youth and by youth that provides information and referral services for youth and young adults. *TeenLink Hawaii* conducted a survey with youth and young adults in 2021 on healthcare issues, including transition planning and helped to identify preferred teen online messaging platforms. One-fourth of survey participants identified as having special health care needs. Survey results included:

- 80% of CYSHN and 85% non-CYSHN stated that they see their doctor and dentist every year for a check-up
- 41% of respondents have had a telehealth appointment
- 73% of respondents stated they know that when they turn 18, they can transfer to a new adult healthcare provider
- 69% of respondents stated that they don't know how to get their own health/dental insurance as an adult
- Respondents were "not confident" or only "somewhat confident" in the following:
    - Finding a new doctor or dentist for themselves (not/somewhat confident 86.2%)
    - Making their own doctor or dentist appointments (not/somewhat confident 65.9%)
    - Filling out a health history form (not/somewhat confident 70.3%)
    - Knowing their medications and to get a refill (not/somewhat confident 70.8%)
    - Knowing when to visit the Emergency Department (not/somewhat confident 64.3%) or Urgent Care (not/somewhat confident 65.2%)
- Respondents were able to obtain PPE, needed medications, and other medical supplies during COVID
- 81% of the respondents have received at least one COVID vaccination, 7% were planning to get vaccinated,

7% were not planning on getting vaccinated, and 5% were unsure
- Due to the COVID, 30% of CYSHN and 35% of non-CYSHN stated that they had missed, canceled, or delayed medical appointments
- For accessing information on social media, respondents prefer YouTube and Instagram, along with TikTok. They do not use Facebook or Twitter.

TeenLink Hawaii's young adult staff used the survey assessment findings to develop transition messaging that were posted on Instagram and TikTok.

Kaiser Permanente: Through a new partnership with the pediatric providers at Kaiser Permanente Hawaii (KPH), transition to adult health care was incorporated into their HMO system of care. With technical assistance from Got Transition and CYSHNS, KPH adopted the *Six Core Elements of Health Care Transition*^{TM} into their pediatric department services and used the Hilopa'a Transition Workbook and CYSHNS TRAC, PATH, and Beach Flyer handouts for transition planning with youth in the KPH health care system. CYSHNS also provided technical assistance to KPH to add transition information to patient after-visit care plans. Also, the KPH Social Worker met with youth and young adults seen in their Genetics Clinic and Behavioral Health Clinic to share the Hilopa'a Transition Workbook and help them to develop transition goals. In 2021, a total of 25 youths received transition services through the KPH clinics. This partnership has expanded transition planning to a potentially larger number of youth and young adults, since KPH is the second-largest health insurer in Hawaii, caring for more than 250,000 members.

Title V Programs: Transition planning was 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 integrated transition planning into the PREP program curriculum for all at-risk and incarcerated youth living in Hawaii residential facilities. The transition tools also assist with planning for employment and education. Because of COVID restrictions, 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 the youth in planning for their future, which included transition to adult health care.

Educational Materials: The CYSHNS Transition workgroup continue to meet monthly to work on outreach materials that can be understood for populations with limited English proficiency or educational level limitations.

In partnership with MCHB Adolescent Health Program, the 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.

Strategy 3: Develop and expand efforts to address health disparities in transition services for youth

A contract was executed to conduct needs assessment analysis with the University of Hawaii Center for Disabilities Studies (UH-CDS) to document the impact of COVID on CSHCN and their clients. The 2018-2019 CSHCN data from the National Survey on Children's Health (NSCH) was analyzed to identify key issues. Since the NSCH does not provide county-level data or detailed Hawaii-based race/ethnicity data, a survey is being designed to reach out youth with special health needs from key underserved populations, to gain more data on these youth. Focus groups will also be conducted statewide to gather more detailed information.

The findings will be used to inform Title V priorities and strategies. Specifically, transition services, messaging, and

outreach may all be revised once the needs assessment process is completed and data analyzed.

CYSHNS will continue to seek and establish new partnerships to address health disparities, including Medicaid and Native Hawaiian/Pacific Islander youth organizations.

Current Year Highlights for FY 2022 (10/1/2021 – 6/30/2022)

Effects of COVID-19: CYSHNS services and activities continued through the COVID pandemic with frequent directives based on vaccination and disease rates. Overall, COVID restrictions have declined, with in-person services returning including public schools. Telework ended in May 2022 for DOH, including CYSHNS staff. While client services can now be provided in-person and based on family preference, remote services continue to be offered.

Many preventive wellness visits were postponed during COVID. In response, Title V partnered with AAP, Medicaid, and community organizations to launch a media campaign in early FY 2022 to encourage the public to institute child wellness visits. Per CYSHNS client feedback, most wellness visits continue to focus on routine health care and maintaining immunization schedules; so transitioning to adult health care was not prioritized for services.

In-person events and clinics which were canceled during the pandemic were reopened in 2021-22, including the Maui Cardiac Clinic, Hilo Neurology Clinic, and Nutrition Clinics.

Outreach Events: The annual SPIN statewide conference was held in virtual format in October 2021. Recordings of informational sessions are available online. One significant benefit of the virtual conference format was greater participation by neighbor island and rural families. CYSHNS was a member of the SPIN advisory board and helped plan this conference.

The Footsteps to Transition Fair held in partnership with the Department of Education was virtually held in February 2022. CYSHNS staff participated on the planning committee and also presented a session on transition to adult health care.

TeenLink Hawaii completed the CYSHN needs assessment survey and messaging campaign on transition to adult health care. They will continue to work on CYSHNS flyers and assessment tools to make them accessible online, as well as attractive for youth. They will also be developing an online toolkit for adult transition information.

The UH CDS completed analysis of the National Survey of Child Health 2018-19 data and is updating the information with the 2019-20 dataset (results in Title V needs assessment summary). Findings from the 2018-2019 NSCH dataset were presented at the Pacific Rim International Conference on Disability and Diversity in February 2022 by CDS and CYSHNS. The YSHNS survey and focus group questions were approved by the University IRB and both the survey and focus groups will be implemented in the summer of 2022. The survey was translated into Tagalog, Ilocano, and Hawaiian to gather better data from ESL and underserved populations. Focus groups will also be conducted to gather more detailed information. As part of the partnership, CYSHNS conducted a training on transition for CDS faculty/staff.

Title V continues to explore the complex process and secure funding for an NSCH oversampling to generate disaggregated race/ethnicity and county-level data for CSHCN.

Other Highlights: Special Olympics Hawaii resumed in-person athletic events, with CYSHNS staff partnering with physicians from Kaiser Permanente Hawaii to provide transition planning information at the January 2022 event. More transition activities are planned for 2022 with Special Olympics Hawaii.

Shriners Children's Hawaii and CYSHNS is partnering to develop a transition program for Shriners youth clients. Meetings have been set to share information and begin to work on transition procedures for their facility to ensure successful transition for their youth and families.

Review of Action Plan

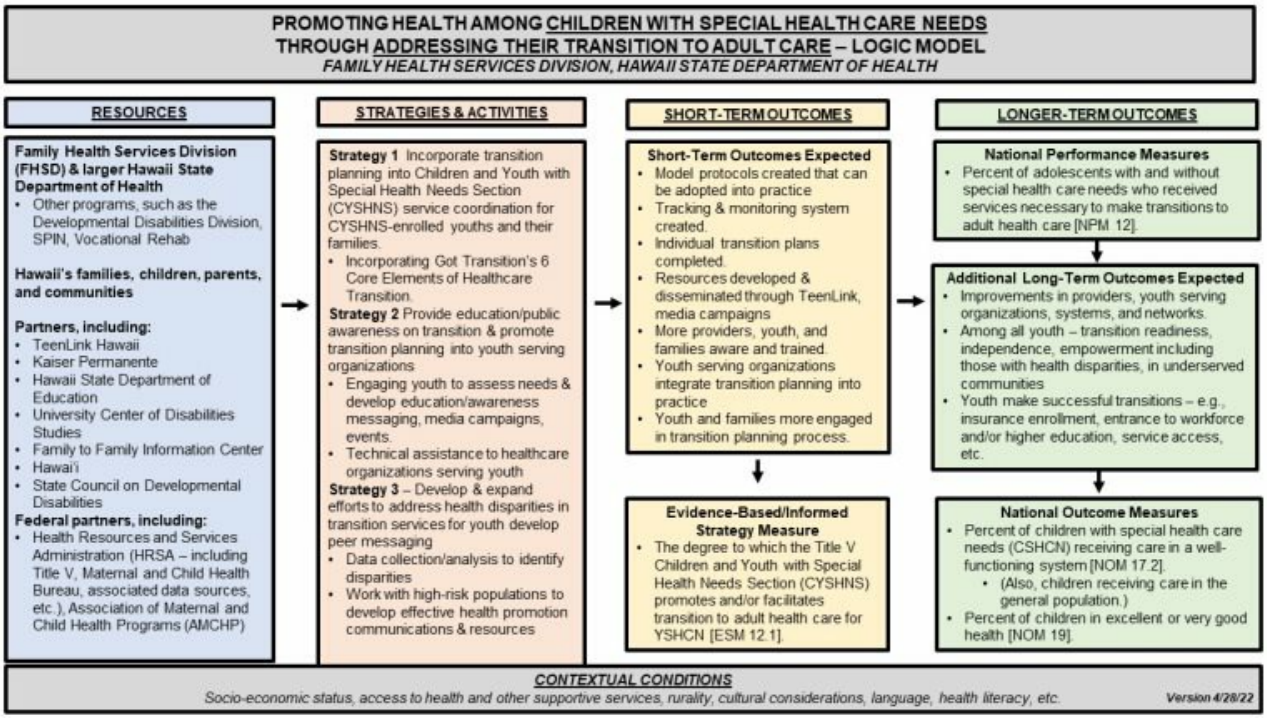
A logic model was developed for NPM 12 to review alignment among the strategies, activities, measures, and desired outcomes. By working on the three strategy areas, Hawaii focused on increasing the percentage of adolescents receiving transition services; however, COVID impacts may have reduced the number of youth 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 CYSHNS and their parents/caregivers prepare for the transition to adult health care.

Strategy 2 focused on public health education and awareness and supporting other youth services organizations to adopt adult transition planning into their services model.

The addition of Strategy 3 in 2021 focused critical attention on health inequities highlighted during the COVID pandemic. Investments in data collection and analysis will help target resources toward under resourced populations and communities with health disparities.

Together, the strategies are designed to improvement in transition services, greater adult transition readiness among youth, and more youth making successful transitions to adult care.



Challenges encountered

The major challenge for 2021 continues to be overcoming barriers to care and addressing more immediate needs

created by COVID. Many families delayed accessing health care during COVID, and the decrease in client-served numbers for direct services provided by CYSHNS and other Title V programs reflects this troubling trend.

CYSHNS experienced challenges with service provision during COVID restrictions. Staff reported that youth were reluctant to participate in transition assessment and planning activities. The hard copy assessments and goal-setting forms did not interest the youth, who were accustomed to electronic media. TeenLink Hawaii is assisting CYSHNS to develop transition materials using preferred digital platforms. The partnership with TeenLink Hawaii is expected to increase effective youth engagement.

For Strategy 2, COVID created enormous challenges to traditional in-person outreach efforts. Event evaluations confirm that participants value ready access to the large array of visible and available services/products in a personal client-centered environment. Many of these events were done in partnership with the state public school system (DOE), which shut down most traditional in-class/school experiences in 2020-2021 and offered only limited services to special education students. Several of the larger events relating to outreach were rescheduled and conducted virtually as a result.

The partnership with UH CDS will provide more recent data during and post-COVID to better understand disparities that impact the YSHCN population in the state to help further develop strategies/partnerships that target those groups and communities of greatest need.

Highlighting the importance of transition planning for all youths, not just those with special health care needs, also remains a challenge; however, partnership with the Title V Adolescent Health Program helped immeasurably.

Overall impact

CYSHNS was successful in developing a system to help youth transition to adulthood. CYSHNS fully integrated transition planning into its standard program services. The program brochure, TRAC, PATH, and Footsteps to Transition flyers were developed by CYSHNS with continuous feedback from youth, families, staff, and partners. Along with the Hilopa‘a Transition Workbook, these tools have been valuable statewide educating, developing, and tracking life goals, as youth transition to adulthood. They are also widely used by system partners, including DOE, pediatricians, and health centers as part of their adult transition planning services. The recent collaboration with Kaiser Permanente Hawaii pediatric services to integrate transition into their system practices demonstrates the utility and ability to replicate CYSHNS protocols and practices. Partnership with the Adolescent Health Program and TeenLink Hawaii is helping to further strengthen youth engagement.

Another major success was 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 health care providers, as well as workforce training events for service providers. The success of many of these events and trainings involve a high level of family and youth engagement.

NPM 12 – 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

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 DOH 5-year needs assessment. By July 2025, the state seeks to increase the percent of youth with (and without) special health care 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 and Transition tracking and monitoring

- Although these policy/tracking/monitoring elements have been achieved, ongoing discussion and education of CYSHNS staff regarding data, policy, and procedures for transition is continuing via monthly transition meetings and new CYSHNS employee orientation.

Transition readiness

- CYSHNS will continue to obtain feedback from youth and parents/caregivers on recommended revisions to transition planning tools and revise as needed.

Transition planning

- CYSHNS will continue to evaluate the effectiveness of transition tools.
- CYSHNS is developing an improved system for receiving referrals into the CYSHNS program for youth and families seeking assistance with transitioning to adult health care.
- CYSHNS will have active participation in the NWD network of agencies.

Transition transfer of care

- CYSHNS will continue to offer support to CYSHNS-enrolled youth and parents/caregivers preparing for adult health care.
- CYSHNS will continue to document and address barriers to transition planning.

Transition completion

- CYSHNS will develop a scorecard or survey for youth and adult health care providers to verify transition completion to improve data collection and analysis.

Strategy 2: Provide education and public awareness on the 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

CYSHNS will continue to work with agency and community partners to modify outreach events and methods for effective youth/family engagement to deliver transition information and services. Although COVID restrictions have eased, in-person gatherings may continue to be restricted as COVID variants continue to spread. Virtual and hybrid means of connecting will continue since it helped broaden participation in CYSHNS events, especially for neighbor islands/rural areas.

CYSHNS will continue to identify new and emerging community partners to promote transition planning, including the *Hawaii Afterschool Alliance*, *No Wrong Door* information and referral system, health insurance plans, adult health care providers and others.

CYSHNS will continue to engage youth to assess and evaluate appropriate adult transition messaging through ongoing partnerships with the Title V Adolescent Health Program and TeenLink Hawaii. CYSHNS will continue to partner with youth agencies and health care providers to distribute/share adult transition information.

CYSHNS will continue to partner with organizations interested in integrating transition planning into their services, including care provider systems such as Kaiser Permanente Hawaii.

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 is documenting the impact of COVID on CSHCN and their families, with a focus on disparity populations at increased risk for poor health outcomes (Native Hawaiians, Pacific Islanders, and Filipinos). Data from the National Survey on Children's Health, coupled with the UHCDS survey and focus groups data, will yield important insights on emerging access issues and key disparities. The findings will be used to help further develop and define Title V priorities and strategies. Specifically, transition services, messaging, and outreach are expected to be revised given the findings of this study.

Title V CSHCN Programs

Children with Special Health Needs Branch (CSHNB) is working to assure that all 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 health care needs, ages 0-21 years, 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	2021
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Hawaii Pediatric Mental Health Care Access grant	Hawaii Pediatric Mental Health Care Access grant
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	20.0	40.0	60.0	80.0

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	2021
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Hawaii Title V Genetics Program	Hawaii Title V Genetics Program
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	9.0	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

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 Access

For the Cross-Cutting domain, Hawaii has added a state priority in 2021 to expand children's mental health services, in response to emerging concerns due to COVID. COVID has highlighted a growing concern over mental well-being, due to pandemic-related social disruptions, disease fears, social isolation, and economic hardships that generated widespread stress, anxiety, and depression. Hawaii received a Pediatric Mental Health Care Access (PMHCA) grant, focusing on developing a pediatric warmline to address mental health concerns of children and youth up to age 21. Community partners also identified mental health as a concern, and government and non-governmental entities are collaborating to address rising mental health needs in the community.

Data: The state measure for this project-focused priority is a process indicator that reports the number of providers receiving training of behavioral health care topics and eventually, data on the tele-consultation model (once established). Since the PMHCA grant was not awarded till late in FY 2021, the indicator is 0, with most activities occurring in the current FY 2022.

However, a review of the National Survey of Children's Health does show a slight increase in children 3-17 years reported to have a mental, emotional, developmental, or behavioral problem from 2018-19 (14.1%) to 2019-20 (15.0%). The latter aggregated data may reflect initial COVID-related effects.

Evidence: The HRSA Pediatric Mental Health Care Access Program promotes behavioral health integration into pediatric primary care, using telehealth delivery. State or regional networks of pediatric mental health teams provide tele-consultation, training, technical assistance, and care coordination, so that pediatric primary care providers can more effectively diagnose, treat, and/or refer children and youth with behavioral health conditions in a timely manner. The overarching goal of the program is to use telehealth modalities to provide timely detection, assessment, treatment, and referral of children and adolescents with behavioral health conditions, using evidence-based practices, such as web-based education and training sessions. The MCH Evidence Center provided ample evidence indicating that telehealth services improve access to healthcare for underserved MCH populations.

Title V lead/funding: The PMHCA grant is administered by FHSD and will fund two staff positions to manage and build the program. Although no Title V funds will be used to support the program directly, Title V-funded staff will assist with data, contractual, and media support. FHSD's Community Health Center Special Fund which will be used as the state's 20% match, as required by the grant. FHSD will support and coordinate community mental health needs for children and youth through this funding.

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's Pacific Basin Telehealth Resource Center. This multi-agency collaboration will strengthen pediatric providers access to 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, coordinated 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 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

COVID Impact Updates: In FY 2021 disruptions from COVID continued throughout the year. Public schools continued, with largely virtual learning, during the 2020-2021 school year and into the summer. In Fall 2021 there was a return to in-person learning, with new safety restrictions (school mask mandates), at a time the Delta variant surge was worsening. Stress from continued isolation and return to in-person learning during prolonged COVID created challenges for most children/adolescents. With COVID continuing in 2022, mental health is an important health concern for children, youth and adults.

Since the grant was awarded at the end September 2021, the report for FY 2021 largely reflects multi-agency efforts to develop and submit the grant application.

Strategy 1: Initiate and develop pediatric mental health care program and systems model

PMHCA grant: FHSD was awarded the PHMCA grant in September 2021 to establish a state system of behavioral health teleconsultation and care coordination for children, especially those in underserved areas and rural communities. These areas suffer from chronic severe shortages of behavioral health providers and have other barriers to care. Overall, the goal of the grant is to promote integration of primary care and behavioral health to improve and increase services to children, youth, and their families in their communities.

Activities for FFY 2021 largely focused on completing the grant and developing plans for the three key strategies.

The first strategy focused on the infrastructure to support a model that provides pediatric provider's mental health consultation before client needs escalate into a crisis and/or need for prolonged treatment. The activities were based on guidance from HRSA and included:

- Hire a Project Coordinator and Assistant to coordinate the project activities within FHSD.
- Convene an Advisory Group, to meet quarterly, to help advise on implementation of project.
- Execute contracts for services to be rendered.
- Review existing PMHCA models and develop a state model for implementation.

Upon receipt of the grant award, FHSD staff prepared administrative requests needed to secure approvals to establish program accounts, budgets, new position descriptions, as well as procurement for vendor contracts.

Strategy 2: Promote Workforce development and training on pediatric mental health care

This strategy focused on identifying providers and providing trainings on pediatric mental health care to address shortages of both pediatric and behavioral health providers and enhance knowledge and skills of existing providers. The activities for this strategy included:

- 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 ongoing professional development use in community

Since FHSD had an existing Project ECHO pediatric program, activities were initiated to conduct a pediatric mental health series. Project ECHO Hawaii had developed a training needs assessment of providers in the summer of

2021 to develop a plan for training on mental health topics. Guidance from HRSA on training topics was aligned with the needs assessment, anticipating that Hawaii would receive the requested federal funding.

Strategy 3: Support services and linkages in the community

Through the process of writing the grant application, FHSD addressed the service capacity issues and linkages needed to support children's mental health. Hawaii reviewed existing data and resources available in the community, given existing access and availability issues for mental health services across the state. Key stakeholder interviews were conducted with providers, to better understand the provider perspectives of challenges within the system of care in Hawaii. FHSD also met with community groups, such as the Community Children's Councils, to announce its intention to address the mental health needs of children and youth. It received positive feedback and commitments from community and providers alike to work collaboratively and serve on the grant's Advisory Committee.

Hawaii continues to look at a coordinated intake and referral system to help promote the coordination of services to ensure that there are no gaps between intakes and referrals and services. There is the recognition, however, that not all communities have mental health services and treatment options available.

This strategy focused on assuring mental health service availability and access for families throughout the state. Activities for this strategy included:

- Identify family groups to begin to work with families receiving behavioral health services to help evaluate their experience
- Meet with key stakeholders to better assess the mental health system in addressing the service needs of communities

Current Year Highlights for FY 2022 (10/1/2021 – 6/30/2022)

This section highlights the Year 1 startup work for the PMHA grant.

Strategy 1: Refine, develop, and implement pediatric mental health care access model

The first strategy focuses on the systemic infrastructure to support the PMHCA grant. The PMHCA grant deliverable is the development of a pediatric mental health care access model that pediatric providers will access to work with behavioral health providers. Activities included:

- FHSD issued a press release in October to announce the PMHA grant award, to let community partners know of DOH's plans to further support the mental health needs of children and youth in the community.
- FHSD met with the University of Hawaii John A. Burns School of Medicine (JABSOM) Department of Psychiatry faculty and the Med-QUEST Division to discuss plans to develop and implement a fully staffed, interdisciplinary warmline. More resources are needed to implement this costly model, and FHSD is looking to partner with public and private funders to pilot the proposed warmline.
- Informational handouts were developed to inform and network with community partners about the proposed project.
- Advisory Committee members were recruited and three meetings held to gain provider input and guidance for the grant activities. Members include representatives from:
    - Medicaid-DHS
    - American Academy of Pediatrics-Hawaii Chapter
    - John A Burns School of Medicine-Dept. of Psychiatry
    - Hawaii Primary Care Association
    - Pacific Basin Telehealth Resource Center
    - Hawaii Rural Health Association
    - Hawaii Families as Allies (local chapter of the Federation of Families)

- Several years ago, Hawaii tried to implement a similar warmline model for pediatric providers to be staffed by behavioral health professionals. Presentations on the previous efforts, challenges, and lessons learned were featured at one of the Advisory Committee meetings to better inform planning for the current model.
- FHSD continued work on establishing position for a Project Coordinator and Assistant to coordinate the grant activities.
- Contracts were executed for marketing services and conducting of an environmental scan to develop a systems overview of available mental health resources/services.
- Regular meetings with the HRSA program officer, technical assistance specialists, and other state grantees have enabled continued progress, while sharing valuable perspectives and resources to inform Hawaii's planning efforts.

Strategy 2: Promote Workforce development and training on pediatric mental health care

Like most of the nation, Hawaii has a workforce shortage of behavioral health and primary care providers. There are currently 216.1 FTE pediatricians and 342.2 FTE family medicine and general practice providers statewide (as of November 2020), with an estimated workforce shortage of 412 FTEs across all islands (AHEC).

COVID exacerbated the workforce provider shortage: Out of the 989 medical provider offices surveyed, many reported:

- Temporary and permanent clinic closures
- Early retirements
- Increased telehealth practices
- Altered operating hours and locations
- Reduced patient volume

The loss of providers and workforce shortage increases exist in every Hawaii county. Moreover, staff shortages due to provider burnout and employees contracting COVID has caused some of the mental health facilities and treatment centers to close, further reducing treatment options.

Because of the workforce shortages, FHSD opted to focus on offering providers access to timely mental health training. This strategy focuses on workforce training efforts. Highlights of activities include:

- FHSD met with Project ECHO Hawaii to discuss tele-education training to both pediatric and behavioral health providers. An agreement was reached for Project ECHO to develop a mental health curriculum and provide training to providers.
- Hawaii's Project ECHO began its pediatric series, which will have 9 topics including: Integrated Behavioral Health in the Primary Care Office; Overview of CAMHD; Depression; Disruptive Behaviors/Parent Management, ADHD; PTSD; Pediatric Anxiety; Setting Up and Maintaining Integrated Behavioral Health in the Primary Care Office; and Mental Health Needs of Sexual and Gender Minority Children and Adolescents.
- FHSD met with the John A. Burns School of Medicine (JABSOM) to see if mental health topics can be added to the Grand Round sessions in order to reach more pediatric and family practice providers.

Strategy 3: Support services and linkages in the community

To coordinate and align project efforts with existing resources, FHSD surveyed providers about the needs and challenges in the community. Networking activities, focus groups, and key informant interviews increased partnerships and yielded findings that changed the focus of this strategy away from families to more systems building efforts.

- There is validation that mental health needs among children are increasing due to COVID.
- There is strong interest among mental health providers to have access to pediatric mental health consultative service for diverse medical, educational, and community providers that work with youth.
- There is a need for increased coordination and information sharing among service providers.
- Federal COVID relief funding is resulting in new mental health initiatives (including the PMHA grant).

FHSD contracted with the University of Hawaii Center on Disability Studies to conduct an environmental scan of existing services and programs that support children and youth mental health. The report will include key findings and recommendations to strengthen Hawaii's system of behavioral health services.

Several key partners offered help to fund/develop the pediatric mental health consultative services, including Medicaid-DHS and a local private foundation.

As part of the PMHCA grant, state matching funds will come from the State Community Health Center special funds, which will help address the role of Federally Qualified Health Centers in supporting mental health needs of children and youth who are uninsured and underinsured.

To assure availability of critical mental health surveillance data, FHSD contracted with the University of Hawaii Office of Public Health Studies to develop a mental health data dashboard to monitor mental health status of all residents and identify mental health disparities and needs in the community statewide.

Challenges Encountered

Some of the major challenges for this priority measure include:

- Capacity issues due to the lengthy state system process to establish and fill staffing positions for the PMHCA grant means that existing program staff must add to their current workload to help address grant deliverables.
- Hawaii, like many other states, saw an increase of children and youth mental health needs exacerbated by COVID. Providers confirmed an increase in mental health needs for children and youth due to anxiety and depression caused by COVID; social distancing and lack of socialization of youth; increased social media and cyberbullying; and family stress due to economic concerns.
- Pediatric and behavioral health workforce shortages were exacerbated due to COVID. Delayed well-child visits are hampering efforts to screen and intervene early, as behavioral concerns emerge. Mental health indicators will be closely monitored, including emergency room data, youth survey data, and reports from service providers.
- There are limited mental health services and treatment options currently available, which often means that children and youth in rural communities and neighbor islands must fly in or drive to central Honolulu for services. This is true for both intensive treatment options as well as for preventive services.
- The stigma of mental health impedes assessment and provision of needed care. While COVID helped to normalize discussion around these issues, many families may still be resistant to mental health-related care.
- Cultural understanding and responses to mental health needs more research and evidence for best practices as an effective option to traditional western therapy and mental health treatment.

Overall Impact

Child mental health is a relatively new area for FHSD, although FHSD promoted maternal depression screening and completed some work around infant mental health. The PMHCA grant affords FHSD the opportunity to expand efforts to address critical mental health needs of children, which have been intensified by COVID.

Networking meetings and interviews resulted in substantial data/information collection. Across many sectors of

services for children/youth, mental health is an urgent concern. Key findings from these meetings led to refocus some of the grant activities into systems building. Funds were redirected to contract for an environmental scan to systematically collect/organize the information. The scan will serve as the basis for a resource directory and will include specific recommendations to inform future grant planning.

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.

The pandemic highlighted the health and digital inequity experienced by many underserved communities and families. Some people 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 set up 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 postpartum 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 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.

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

The report for FY 2021 reflects the grant plans and initial startup activities.

Strategy 1: Telehealth Library Access Project Infrastructure Development

Activities for FFY 2021 began with formulating the project plans, securing key partnerships, developing plans for the three key strategies, and completing the grant proposal.

The funding for the new project was awarded to DOH on June 1, 2021. Grant activities for FY 2021-22 included:

- Hire Librarian Project Coordinator to coordinate the project activities.
- Execute contract with the Research Corporation of the University of Hawaii to cover hiring of the island program coordinators and digital navigators.
- Protocols for the telehealth services will be developed and tested.
- Develop schedule of libraries for implementation of project.
- Procure telehealth equipment for each library as it is implementing the project.
- Set up the private room for telehealth for the two libraries on the Hawaii Island that don't have any.
- Execute contracts for services.
- Implement pilot phases at each library until procedures are finalized before full implementation begins at the library.

By September 30, 2021, FHSD staff completed the initial paperwork to set up the project; get approvals from the Governor and Director of Health; create the Librarian V (project coordinator) position description; and set up the collaboration with the State Public Library, UH, community-based organizations, and families in the communities near the libraries.

Strategy 2: Workforce Development

This strategy focused on actions needed to develop training for project staff. Activities for FY 2021-22 are:

- Identify and develop training for the digital navigators.
- Hire project coordinators on each island as each island enters the project.
- Hire individuals from each community as health/digital navigators for each library as each library implements the project.
- Provide training to staff.
- Develop and implement evaluation of activities.

Strategy 3: Service Provision

This strategy focused on the activities for actual provision of telehealth services. Activities for FY 2021-22 are:

- 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.

Current Year Highlights for FY 2022 (10/1/2021 – 6/30/2022)

The major work on the project is focused on procurement of the $7M to implement the project. Several avenues to expedite procurement were identified and considered. All contracts are now being administered through the Research Corporation of the University of Hawaii (RCUH).

Challenges Encountered

Some of the major challenges for the grant include:

- The quantity of paperwork and approvals necessary to implement project activities.
- Difficulty recruiting appropriate staff during the pandemic.
- Individualized nature and schedule for the public libraries, needing more customization of the project activities.

Overall Impact

The exponential use of telehealth due to the pandemic created a tremendous need to expanded access and digital equity to rural communities throughout the state. This grant project is creating public access with support for families in underserved areas to use telehealth. This project allows families to go to a safe public space and overcome the lack of devices, internet connection, and digital literacy to use telehealth to obtain health information and services they most likely would not have received without telehealth.

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 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 aligned with the work of the Title V Pediatric Mental Health Care Access (PMHCA) grant. Plans for the three strategies and activities are presented below.

Strategy 1: Refine, develop, and implement pediatric mental health care access model

This strategy focuses on the infrastructure to support the PMHCA grant, which will lead to the development of the mental health care warmline and systems model.

- The two grant staff positions will be filled.
- The PMHCA Advisory Group will meet quarterly to discuss the grant activities and develop the systems model, with input from key stakeholders.
- Hawaii will continue working with the federal project officer and key partners in Hawaii to design a systems model for that is effective and sustainable.

Strategy 2: Promote Workforce development and training on pediatric mental health care

This strategy focuses on workforce training efforts and Hawaii will continue to build capacity through training efforts.

- FHSD will work with Project ECHO Hawaii to provide workforce training, using the ECHO model on mental health topics as well as the early identification and referral system.
- Evaluation of the first training series will help implement efforts to improve the training.
- FHSD will partner with public and private agencies to provide opportunities for training on mental health and trauma informed care topics to healthcare providers, schools, and early childhood providers and families.

Strategy 3: Support services and linkages in the community

FHSD recognizes the need to support and develop linkages around children's mental health. The need for mental health services spans across healthcare, schools, and community settings. To better service children and youth, it is important for there to be linkages in the community to diagnose, treat, and connect children and families.

- FHSD will work with the University of Hawaii Center on Disability Studies to conduct an environmental scan of existing services and programs that support children and youth mental health.
- FHSD will work with Hawaii's Medicaid-DHS program to support existing services and providers with the systems model, warmline, and other needs.
- FHSD is working with community health centers (FQHCs) to identify resources in the community to help address rural community needs.
- To assure availability of mental health surveillance data, FHSD will work the University of Hawaii Office of Public Health Studies to develop a mental health data dashboard to monitor mental health status of all residents and identify mental health disparities and needs in the community statewide. Stakeholder input will be used for the selection of indictors and dashboard design to ensure the website is user friendly and easy to navigate. The dashboard is planned for completion in June 2023.

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.

Plans focus on implementation of the grant strategies/activities for the $7 million project.

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.

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 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 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, 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 COVID outbreak. As engaging families became challenging during the COVID shutdowns, FHSD was able to divert funding toward television/radio media campaigns coupled with digital media promotion to support health messaging, online resources, and service programs to address needs during the pandemic. Collecting family input through focus groups or surveys shifted to remote/online methods.

Although family engagement became more difficult, program managers reported increased partnerships with community programs and agencies. During COVID, programs and services have mobilized and coordinated efforts in response to the changing service needs of families. Modifications were made to plans, activities, public events, service contracts, and meetings. There was exponential growth in the number of virtual webinars and meetings 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 are shared.

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 Pre/Inter-Conception Workgroup co-chaired by the state Medicaid agency continued remote meetings to address access to contraception and reproductive life planning. New PRAMS data and other data sources are being reviewed that may serve as a new strategy measure for NPM 1.

NPM 6 Developmental Screening. The Developmental Screening program organized a diverse statewide network of partners to gather ongoing feedback on the state developmental screening guidelines, which were reviewed to ensure the practices remained appropriate with the change to virtual/telephonic provider visits. Title V programs supported purchase and utilization of remote/online developmental screening tools for service providers since in-person visits remained challenging through much of FY 2021. Title V increased parent input/partnerships to improve outreach efforts for developmental screening. The *Learn the Signs Act Early* project used parent social influencers to develop and promote messaging on the importance of developmental screening using their social media platforms on Facebook, Instagram, and Facebook Live.

Kakou for Keiki (All Together for Children), Maui county's early childhood ECCS grant team, used input from parent leaders to identify outreach methods, messaging, and assess/respond to family needs during COVID. Outreach was expanded using Facebook and Instagram to promote the CDC Developmental Milestone VROOM App. Parents also suggested combining developmental screening information with materials to promote selfcare for parents. Thus, health/wellness kits were also offered at medical offices and food distribution sites.

NPM 10 Adolescent Health. The Adolescent Health Unit (AHU) continued to collect input from youth throughout COVID, working with TeenLink Hawaii, a youth empowerment, outreach, and education program that provides information and referral services for youth and young adults. 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. Youth also appear to use multiple sources for information/learning; thus, a multipronged approach from which teens are able to utilize may be needed. The survey data is being used to update the TeenLink Hawaii resources and a future TeenLink media campaign.

NPM 12 Transition to Adult Care The CSHN Branch continued to collect input from youth and families on transition information and planning tools. CSHNB and the Title V Adolescent Health program worked with TeenLink Hawaii to conduct a second youth survey to:

- Assess knowledge of their own health and ability to access health care.
- Assess the continuing effects of COVID-19 on their lives.
- Assess their preferred sources for healthcare information and planning tools.

TeenLink Hawaii's young adult staff used the assessment findings to develop transition messaging that was posted on Instagram and TikTok. Also based on the survey results, CSHNB will revise the transition planning printed materials and PDFs to interactive digital apps and formats.

SPM 1 Child Abuse and Neglect CAN prevention has two primary mechanisms for community input including: 1) The Hawaii Children's Trust Fund (HCTF) Advisory Committee (11 private and public members) and 2) The HCTF Coalition (30 active members representing key community partners working to prevent child maltreatment across the islands). These groups serve a range of consumers and provide an important voice for their communities. Based on input, the Title V CAN Prevention programs diverted funding toward a network of community-based programs and services to address/support immediate needs of the most vulnerable, under-resourced populations and areas in the state.

SPM 2 Food Insecurity & WIC. To improve WIC services, a new community advisory workgroup was formed. Members include WIC staff from the state WIC office, WIC community clinics (including those located in Federally Qualified Health Centers), university researchers, the Native Hawaiian healthcare organization, advocates, and current WIC recipient mothers.

The participation of WIC clients in the working group provided an invaluable perspective, helping members understand how WIC works – and does not work – for its clients. For example, WIC clients emphasized that they were employed and were unaware that they could qualify for WIC benefits. It was suggested that outreach via workplaces could be especially effective. Another client said that it was difficult to track the expiration of WIC benefits (that need to be continuously renewed). She suggested regular reminders via text or a smartphone app would help clients better utilize their benefits. This input is being incorporated to service recommendations/plans.

SPM 3: Child Mental Health Access. The major aim for this project funding was to develop a real-time consulting service, staffed by mental health professionals, to support pediatric primary care providers address the behavioral needs of their clients. Since Hawaii is a small state, FHSD wanted to ensure community and agency partners were supportive of the project and the effort could align/enhance existing services. After extensive outreach/meetings with healthcare and service providers across sectors several themes emerged:

- Mental health is a serious concern for all children, not just adolescents and for their families.
- There is support for the consulting service not only for use by pediatric providers, but also by other healthcare/service providers (school nurses, counselors).
- There is a need for improved systems building and coordination. With millions in federal funding entering the state for mental health programs, services are ever-expanding with new start-ups including schools. Information sharing and coordination is one of the key concerns repeated by all providers.

With this input the project revised its focus on systems building as a priority and is contracting for an environmental scan to document service availability and develop recommendations to improve service system coordination.

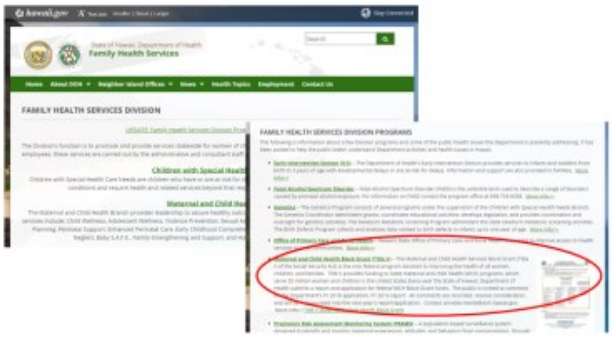
SPM 4: Telehealth Expansion to Underserved Communities. Supported by $7M in Centers for Disease Control Health Equity grant funding, the project will establish 15 new telehealth access points in public libraries located in underserved communities statewide. Staffing includes health and digital navigators recruited from the community or island.

The need and support for projects that support digital equity throughout the state are enormous since the COVID shutdowns. This project emerged from partnerships developed in the state broadband workgroup, convened during the pandemic to coordinate efforts to expand access to remote services with the closure of schools, healthcare services, and businesses. The 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.

SPM 5: Child Wellness Visits. The selection of this priority emerged from Title V programs and other service providers that saw many families delaying care for children during COVID. A media campaign to promote pediatric office visits was designed with input from partners in a workgroup that included the American Academy of Pediatrics-Hawaii Chapter (AAP-H), State Medicaid program, and the Hawaii Children's Action Network (HCAN). Messaging was developed and tested with parent focus groups conducted remotely through the Home Visiting program and the Parent Leadership Training Institute (PLTI). Parents for the TV spot were also recruited from PLTI.

Public Access to the Title V Report/Application

The FHSD Title V reports are posted on the Hawaii website (https://health.hawaii.gov/fhsd/home/title-v-maternal-child-health-block-grant/) once the report has been submitted. The Hawaii Title V website also archives the presentations and videos used during past years' block grant reviews.



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 2021 with the exception of a research inquiry and several solicitations from national companies interested in marketing their services. The information was shared with appropriate agencies.

III.G. Technical Assistance

Hawaii relies on national and local technical assistance (TA) to develop leadership and core public health skills and competencies, particularly since the University of Hawaii does not have an MCH specialist or MCH program.

However, FHSD's key need is filling of vacancies, including MCH epidemiologists.

To address limited local MCH expertise/training resources, Hawaii would like to explore MCH Bureau opportunities to reestablish an MCH certificate program at the University of Hawaii that could benefit both existing staff but also help recruit and develop the future MCH workforce and next generation of MCH leaders. An MCH program could also benefit Title V programs in the Pacific jurisdictions as many students from the jurisdictions enroll at the university for college.

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 and FHSD related Statutes and Policies.pdf

Supporting Document #02 - NPM_NOM Summaries.pdf

Supporting Document #03 - FHSD Program Description and Programs by Domain.pdf

Supporting Document #04 - Logic Models.pdf

Supporting Document #05 - Glossary of Terms.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FHSD Program Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Hawaii

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,138,833	
A. Preventive and Primary Care for Children	$ 699,363	(32.6%)
B. Children with Special Health Care Needs	$ 1,030,127	(48.1%)
C. Title V Administrative Costs	$ 70,508	(3.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,799,998	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,962,854	
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)	$ 48,437,773	
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)	$ 50,576,606	
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)	$ 41,413,149	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 91,989,755	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
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) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 40,000
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
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) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 427,273
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 283,913
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 2,369,091
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) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	$ 486,403
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
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 23,902,329
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 1,009,550

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
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) > Pediatric Mental Health Care Access Program	$ 445,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Office of 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) > Office of Adolescent Health > Coronavirus State Hospital Improvement Program	$ 843,170
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SHIP Covid Testing and Mitigation	$ 2,583,760
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > AMCHP Cares Act: MCH Telehealth	$ 275,000
US Department of Education > Office of Special Education Programs > IDEA Part C (ARP)	$ 1,218,273
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Hawaii Newborn Screening Data Project	$ 160,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > CBCAP - ARPA	$ 1,000,179

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,083,027 (FY 21 Federal Award: $ 2,138,833)		$ 2,021,007	
A. Preventive and Primary Care for Children	$ 634,665	(30.5%)	$ 641,295	(31.7%)
B. Children with Special Health Care Needs	$ 802,000	(38.5%)	$ 918,079	(45.4%)
C. Title V Administrative Costs	$ 94,134	(4.5%)	$ 100,813	(5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,530,799		$ 1,660,187	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 31,499,929		$ 26,180,239	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 18,439,145		$ 19,530,529	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 49,939,074		$ 45,710,768	
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)	$ 52,022,101		$ 47,731,775	
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)	$ 37,230,305		$ 37,566,837	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 89,252,406		$ 85,298,612	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	$ 426,600	$ 491,979
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,500	$ 148,522
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 250,000	$ 357,340
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 165,389	$ 164,131
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 116,205
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	$ 600,000	$ 558,641
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	$ 515,082
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 238,913	$ 288,657
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 2,301,492	$ 2,400,153
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,678,058	$ 4,726,867
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	$ 415,271	$ 291,005
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 251,394

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 297,297	$ 345,331
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 26,161,881	$ 25,905,551
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Office of Rural Health	$ 230,000	$ 241,659
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility Program	$ 446,074	$ 356,398
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	$ 118,660	$ 56,716
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program	$ 150,000	$ 36,191
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Coronavirus State Hospital Improvement Program	$ 843,170	$ 315,015

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: FY2023 budgeted reflects the actual FY2021 Title V award received. This federal allocation methodology will remain consistent moving forward.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: FHSD has been making a concerted effort to reduce the Title V administrative costs. This category will likely zero out by FY2024.	
3.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: From FY 2023 the state general fund budget appropriation will increase by nearly $4M, primarily for Early Intervention purchase of services contracts. Note that the Hawaii Legislature has been supportive of the Early Intervention Program's budgeting needs meeting budget requests for the past few sessions.	
4.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This number represents the legal appropriation spending limit (ceiling) for FY 2023	
5.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: FY 2021 actual Title V expenditures as reported by the state's DataMart accounting system.	
6.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**

	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures were greater than budgeted due to position vacancies when the FY21 budget was forecasted. Actual expenditures account for payroll expenditures allocated towards CSHCN efforts.	
7.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: FY 2021 actual expenditures.	
8.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Actual FY 2021 expenditures as reported in DataMart. Expenditures are usually lower than the budgeted amount due to position vacancies and changes or reduction in contractual execution and performance. In FY 2021 expenditures were $5,319,690 below what was budgeted due to both vacancies and timing of expenditures.	
9.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: FY 2021 Program Income expenditures were higher than usual due to the legislature re-appropriating $10M for a one-time need to address economic uncertainties related to the COVID-19 global pandemic.	
10.	**Field Name:**	**7. TOTAL STATE MATCH**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are usually lower than the budgeted amount which is a reflection of the legislative ceiling for general and special funds. Actual expenditures take into account position vacancies and contract performance and the timing of expenditures in relation to the Title V reporting period.	
11.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)**
	Fiscal Year:	**2023**

	Column Name:	**Application Budgeted**
	Field Note: The budget reflects the anticipated federal award for FY2023.	
12.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: The Preventive Health and Health Services Block Grant resides with another Hawaii DOH Division who provides funding from year to year based on the availability of funds. The FY2023 budget reflects a decreased budget level from previous years as a reallocation of funding priorities, not a decrease in the overall block grant.	
13.	**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) American Rescue Plan (ARP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: New ARPA grant.	
14.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: New federal grant awarded to the Hawaii DOH Family Health Services Division. Grant project period expected to run 9/30/2021 - 9/29/2026. Annual award anticipated is $445,000.	
15.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SHIP Covid Testing and Mitigation**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: COVID-19 related new grant's project period: 7/1/2021 - 12/31/2022.	

16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > AMCHP Cares Act: MCH Telehealth**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: New AMCHP CARES Act award with project period 10/1/2020 - 4/30/2021.	
17.	**Field Name:**	**Other Federal Funds, US Department of Education > Office of Special Education Programs > IDEA Part C (ARP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: IDEA Part C ARPA supplemental award project period 7/1/2021 - 9/30/2023.	
18.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Hawaii Newborn Screening Data Project**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: New award with an anticipated project period of 7/1/2020 - 6/30/2024. $160,000 anticipated annually.	
19.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > CBCAP - ARPA**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: CBCAP ARPA award project/budget period: 10/1/2020 - 9/30/2025. Total award: $1,000,179.	
20.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: FY2021 expenditures exceeded the FY2023 budget primarily because FY2020's unspent carryover funds were made available and expended during FY2021.	

21.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The Preventive Health and Health Services Block Grant (PHHSBG) contributions to the Family Health Services Division fluctuate depending on the availability of funds. The amount budgeted in FY2021 was lower than the actual amount of PHHSBG received which explains the variance in expended vs. budgeted.	
22.	**Field Name:**	**Other Federal Funds, 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)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The difference in FY2021 budgeted vs. actual expenditures was the result of FY2020 contract encumbrance expenditures processed in FY2021.	
23.	**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:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: FY2021 expenditures exceeding FY2021 budgeted was the result of FY2020 contract encumbrances liquidating and booked as FY2021 expenditures.	
24.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: CBCAP FY2021 contracts were executed late resulting in fewer FY2021 expenditures. Consequently, FY2022 expenditures will likely exceed FY2022 CBCAP budget.	
25.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program**

	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The disparity between expenditures and budget is due to the Small Rural Hospital Improvement Program's contracts and encumbrances starting late in FY2021's reporting period. This is an annual occurrence reported on the Title V application.	
26.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The Newborn Screening State Evaluation Program's budget period was from 9/1/2020 - 8/31/2021. The variance in expenditures vs. budget is simply a timing issue related to executing contracts, encumbering the funds and processing expenditures.	
27.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Adolescent Health > Coronavirus State Hospital Improvement Program**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The Coronavirus State Hospital Improvement Program's $843,170 budget was a supplemental award for COVID-19 related activities. The contracted activities were not fully expended in FY2021 due to the timing of the grant's project/budget period.	

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 128,841	$ 137,554
2. Infants < 1 year	$ 128,841	$ 137,554
3. Children 1 through 21 Years	$ 699,363	$ 641,295
4. CSHCN	$ 1,030,127	$ 918,079
5. All Others	$ 81,153	$ 85,712
Federal Total of Individuals Served	$ 2,068,325	$ 1,920,194

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 2,997,675	$ 3,225,191
2. Infants < 1 year	$ 2,997,675	$ 3,225,191
3. Children 1 through 21 Years	$ 16,956,107	$ 16,100,798
4. CSHCN	$ 23,488,791	$ 20,992,963
5. All Others	$ 1,997,525	$ 2,166,625
Non-Federal Total of Individuals Served	$ 48,437,773	$ 45,710,768
Federal State MCH Block Grant Partnership Total	$ 50,506,098	$ 47,630,962

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**FEDERAL-STATE MCH BLOCK GRANT PARTNERSHIP TOTAL**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

Field Note:
The budgeted amount takes into account the legislative authorized ceiling for state general and special funds. The budgeted amount will likely always exceed 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 23 Application Budgeted	FY 21 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	$ 76,562	$ 112,083
3. Public Health Services and Systems	$ 2,062,271	$ 1,908,924
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	$ 2,138,833	$ 2,021,007

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 25,875,733	$ 16,874,698
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 5,111,411	$ 2,450,867
B. Preventive and Primary Care Services for Children	$ 2,555,705	$ 1,225,434
C. Services for CSHCN	$ 18,208,617	$ 13,198,397
2. Enabling Services	$ 12,409,122	$ 15,859,838
3. Public Health Services and Systems	$ 10,152,918	$ 12,976,231
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		$ 1,003,835
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 1,054,300
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Primary and Urgent Care in Hana		$ 1,253,266
Waianae Coast Emergency Room Services		$ 1,590,333
Early Intervention Services (POS)		$ 11,972,964
Direct Services Line 4 Expended Total		$ 16,874,698
Non-Federal Total	$ 48,437,773	$ 45,710,767

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: The FY 2023 budget for Non-Federal MCH Block Grant direct services is nearly $9,001,035 more than was expended in FY 2021. The large variance can primarily be attributed to the budget reflecting the legislative authorized ceiling whereas expenditures are actual as reported by DataMart.	
2.	**Field Name:**	**IIB. - Other - Primary and Urgent Care in Hana**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Actual expenditures reported in FY2021 as reported in DataMart.	
3.	**Field Name:**	**IIB. - Other - Waianae Coast Emergency Room Services**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Actual expenditures reported in FY2021 as reported in DataMart.	
4.	**Field Name:**	**IIB. - Other - Early Intervention Services (POS)**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Actual expenditures reported in FY2021 as reported in DataMart.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Hawaii

Total Births by Occurrence: 15,608 **Data Source Year: 2021**

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	15,429 (98.9%)	1,378	50	50 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric 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, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-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 2021

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	1,237	35.0	0.0	62.0	3.0	0.0
2. Infants < 1 Year of Age	671	35.0	0.0	62.0	3.0	0.0
3. Children 1 through 21 Years of Age	10,034	30.0	0.0	66.0	4.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	8,217	29.0	0.0	69.0	2.0	0.0
4. Others	15,981	13.0	0.0	83.0	4.0	0.0
Total	27,923					

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	15,785	No	15,608	99.0	15,452	1,237
2. Infants < 1 Year of Age	15,783	No	15,608	99.0	15,452	671
3. Children 1 through 21 Years of Age	342,510	Yes	342,510	66.0	226,057	10,034
3a. Children with Special Health Care Needs 0 through 21 years of age^	52,019	Yes	52,019	24.0	12,485	8,217
4. Others	1,048,252	Yes	1,048,252	42.0	440,266	15,981

^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:	**2021**

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; 837); and 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; 400). The percentages of primary source of coverage are based on 2020 National Vital Statistics System for Pregnant Women/Infants.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**

Field Note:
Programs that contributed to this count of infants < 1 year of age include 2021 Primary Care Contracts (265). 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. Another program that contributed to this count include 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; 406). Note. The percentages of primary source of coverage are based on 2020 National Vital Statistics System for Pregnant Women/Infants.

Note that the increase in 2021 number (671) compared to 2020 (339) is due to the reporting of Safe Sleep program (400) that was not reported in 2020 for this age category. Also note that Home Reach program reported in 2020 (provides in-home parent education and support services to promote the five protective factors which have been shown to strengthen families; 34) no longer exists in 2021.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**

Field Note:
Programs that contributed to this count include 2021 Primary Care Contracts (983). 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; 834), Women's Reproductive Health (463); and Children with Special Health Care Needs in 3a (8,217). The percentages of primary source of coverage are based on 2019 American Community Survey for Children 1-21.

Note the decline in total number served in this age category in 2021 (10,034) from 2020 (12,519) is mainly due to the contract ending for Family Planning Services in June 2021, so the count (834) only accounts for half a year, from January-June 2021. This program is replaced by Women's Reproductive Health after June. (June-December 2021; 463). Also note that contracts for the two Family Strengthening Programs [Community Based Parenting Education and Home Reach] ended in 2021.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**

Field Note:
2021 data for the number of children serviced contributed by CSHNB (8,217). Children with Special Health Needs Section (provides care coordination and other services for children age 0-21 with chronic medical conditions; 945); genetics, metabolic, hemoglobinopathy, Neighbor Island genetics,
telemedicine clinics (provides provides genetic services, information, and education; 1,520); Newborn Metabolic Screening Program follow-up (detect rare disorders that can cause serious health and development problems; 1,375); Newborn Hearing Screening Program follow-up (identify hearing loss early so children can receive timely early intervention services; 636); Early Intervention Section (provides care coordination, family training, etc for children age 0-3 with developmental delay or at biological risk; 3,527); Hi‘ilei Developmental Screening Program (provides developmental screening via mail or online, and activities to help in children's development; 33); Hawaii Childhood Lead Poisoning Prevention follow-up (aims to reduce children's exposure to lead by strengthening blood lead testing; 144). Another program that contributed to the count include Kauai District Health Office (37). The distribution of source of coverage is based on National Survey of Children’s Health – CSHCN, 2019-2020

5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**

Field Note:
Programs that contributed to this count of others include 2021 Primary Care Contracts (7,615). 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; January-June 2021; 4,071), Women's Reproductive Health (June-December 2021; 2,026); 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=1,449)], Kauai District Health Office (COVID vaccination and testing; 350), and Maui District Health Office (COVID vaccination and testing; 470). Note that the contract for Family Planning Services ended in June 2021, so the count (4,071) is from January-June 2021. This program is replaced by Women's Reproductive Health after June. (June-December 2021). The percentages of primary source of coverage are based on 2019 American Community Survey for adults 22+.

Note the decline in 2021 primary care contracts number (7,615) when compared to 2020 (12,839). Also, the decline in 2021 Family Planning Services (4,071) from 2020 (8,069) is due to the contract ending for Family Planning Services in June 2021, so the count (4,071) only accounts for half a year, from January-June 2021. This program is replaced by Women's Reproductive Health after June (June-December 2021; 2,026). The contracts for the two Family Strengthening Programs [Community Based Parenting Education and Home Reach] also ended so there is no reporting for these programs in 2021. All these contributed to the decline in 2021 total number (15,511) from 2020 (23,042).

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**

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 (1,237), number of brochures distributed to pregnant women (5,686; may be duplicated as each woman may receive more than one brochure), women who receive mailout resources from PRAMS program (2400), WIC Program (5,533), 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; 55), Early Childhood Comprehensive Systems (promote developmental screening, primary caregiver support and trauma informed care to improve healthy development and maternal health systems for our prenatal to five year old population in Maui County and statewide; 8) and Kauai District Health Office (developed a flyer and provided COVID vaccines in Kauai locations for pregnant women, 400) .

2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2021**

Field Note:
Denominator is based on 2021 birth data obtained from Vital Statistics.

3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**

	Field Note: Estimated by 2020 percentage of newborn metabolic screening (98.9%). Note. Other programs that served infants included Kauai District Health Office (outreach activities, 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; 239), the Parent Line (Line provides comprehensive parenting education, training, and support through a telephone warmline, a website, and printed and electronic educational resources, 22), Early Childhood Comprehensive Systems (promote developmental screening, primary caregiver support and trauma informed care to improve healthy development and maternal health systems for our prenatal to five year old population in Maui County and statewide; 24) and WIC (10,641).	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2021**
	Field Note: Denominator is based on 2021 birth data obtained from Vital Statistics.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: Numerator: Programs contributed to the numerator (226,042) included 5a number (1,817), Parent Line (Line provides comprehensive parenting education, training, and support through a telephone warmline, a website, and printed and electronic educational resources; 798), Participation in WIC Program (state provided administrative support, 17,911), Adolescent Health (serves 11-24 years old in programs such as Youth Challenge Academy, Personal Responsibility Education Program etc; 419), 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; 158), 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; 337), Early Childhood Comprehensive System (970), Sexual Violence Prevention Program (provides primary prevention services through statewide partnerships to prevent all forms of sexual violence and promote healthy, respectful relationships; 2,499), and Children with Special Health Care Needs (12,555). Note. The large decline in the Sexual Violence Prevention Program in 2021 (2,499) compared to 2020 data (103,977) was due to the “[Respect]” episode created by the Honolulu Theatre in 2020 but not in 2021. Also note that media campaign reported the number of children served (183,306) from the TeenLink Resiliency Campaign, which was not in 2020 report. This contributed to the increase in percentage served in 2021 (66%) compared to 2020 (43%)	
6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
Programs that contributed to the count include 5a number (8,217). An estimated total of 4,338 of the CYSHCN population 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.

7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**

Field Note:
Numerator: Programs contributed to the numerator (437,958) included 5a number (15,981); Sexual Violence Prevention Program (meetings and trainings;1,369), Adolescent Health (training for teen-serving staffs; 1,671), WIC services for postpartum women (5,267); Hawaii Public Health Training Hui (education to promote health and well-being; 832), Parent Leadership Training Institute (PLTI) Hawaii (increases the number and skill level of parents and community leaders; 21), Kauai District Health Office (outreach activities; 4,000), Hawaii Medicare Rural Hospital Flexibility Program (Clinical Quality and Financial Improvement Training to critical access hospital staff; 52), Oral Health (oral health meetings, 50), Domestic Violence Prevention Program (workforce trainings, 4370), Child Abuse/Neglect Prevention (events on raising awareness of child abuse and neglect prevention; 2824), and Parenting Support/Safe Sleep (162), Home Visiting Network (outreach campaigns; 507), CMV brochures distributed to adults by the Perinatal program (752), Early Childhood Comprehensive Systems (outreach activities, 9218), Media Campaigns (New releases: Lead Poisoning Prevention Week, WIC Cash Value Benefit Increase, TeenLink Hawaii Resiliency Campaign Launch, Pediatric Mental Health Care Access Grant, Telehealth and Digital Navigators at Public Libraries Statewide, Integrated Infant and Early Childhood Behavioral Health Plan, 390,882),
Denominator: 2020 Census Estimate (1,048,252).

Note that the decrease in percentage total served in 2021 (42%) from 2020 (47%) is mainly due to the decline in number in media campaign in 2021 (390,882) compared to 2020 (447,587).

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Hawaii

Annual Report Year 2021

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	15,315	3,879	320	2,624	12	3,752	1,345	3,177	206
Title V Served	15,146	3,836	316	2,595	12	3,711	1,330	3,142	204
Eligible for Title XIX	9,083	1,079	140	685	214	3,015	2,156	0	1,794
2. Total Infants in State	16,244	2,408	252	2,753	29	3,497	2,051	5,254	0
Title V Served	16,066	2,382	249	2,723	29	3,459	2,028	5,196	0
Eligible for Title XIX	15,288	235	72	362	66	717	233	0	13,603

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Information obtained from maternal race as reported in 2021 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:	**2021**
	Column Name:	**Total**
	Field Note: Used overall estimate of newborn metabolic screening percentage (98.9%) in 2021 applied to overall total and each race group.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Data Sauce: Data from Hawaii Medicaid program in 2021 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.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Total number of infants based on 2020 CDC, NCHS, Bridged-Race population estimates from https://wonder.cdc.gov. 2021 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**

	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Used overall estimate of newborn metabolic screening percentage (98.9%) in 2021 applied to overall total and each race group.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Data Sauce: Data from Hawaii Medicaid program in 2021 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 of infants exceeds the number of pregnant women. This is because infants are defined as all children <1 year old in 2021, 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	2023 Application Year	2021 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"	Eydie McNicoll	Eydie McNicoll
4. Contact Person's Telephone Number	(808) 681-1520	(808) 681-1520
5. Number of Calls Received on the State MCH "Hotline"		1,449

B. Other Appropriate Methods	2023 Application Year	2021 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"		3,389
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		1,966
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 2023

No.	Priority Need
1.	Promote reproductive life planning
2.	Increase the rate of infants sleeping in safe conditions
3.	Improve the percentage of children screened early and continuously ages 0-5 years for developmental delay
4.	Reduce the rate of confirmed child abuse and neglect cases per 1,000 with special attention to children ages 0-5 years.
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
6.	Improve the healthy development, health, safety, and well-being of adolescents
7.	Reduce food insecurity for pregnant women and infants through WIC program promotion and partnerships
8.	Promote child wellness visits and immunizations among young children ages 0-5 years.
9.	Address health equity and disparities by expanding pediatric mental health care access in rural and under-served communities
10.	Address health and digital equity by expanding access to telehealth information and services in state public libraries located in underserved communities.

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 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
2020	73.0 %	0.4 %	10,790	14,785
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
2019	104.8	8.7	146	13,934
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
2016_2020	12.9	3.9	11	85,130
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	
	2021
Annual Indicator	16.9
Numerator	14
Denominator	82,744
Data Source	Vital Statistics
Data Source Year	2017-2021

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
2020	8.1 %	0.2 %	1,281	15,783
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**
2020	10.0 %	0.2 %	1,582	15,775
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
2020	28.7 %	0.4 %	4,531	15,775
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
2020/Q3-2021/Q2	1.0 %			
2019/Q4-2020/Q3	1.0 %			
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
2019	4.3	0.5	72	16,825
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
2019	5.1	0.6	86	16,797
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
2019	3.3	0.4	55	16,797
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**
2019	1.8	0.3	31	16,797
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**
2019	214.3	35.8	36	16,797
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
2019	NR	NR	NR	NR
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
2020	6.6 %	0.9 %	1,006	15,321
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
2019	1.1 ϟ	0.3 ϟ	15 ϟ	14,226 ϟ
2018	1.3 ϟ	0.3 ϟ	19 ϟ	14,468 ϟ
2017	2.2	0.4	32	14,879
2016	1.1 ϟ	0.3 ϟ	16 ϟ	15,111 ϟ
2015	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2014	1.4	0.3	22	15,358
2013	0.8 ϟ	0.2 ϟ	12 ϟ	15,722 ϟ
2012	0.8 ϟ	0.2 ϟ	13 ϟ	15,869 ϟ
2011	0.8 ϟ	0.2 ϟ	13 ϟ	15,757 ϟ
2010	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2009	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2008	0.8 ϟ	0.2 ϟ	13 ϟ	16,419 ϟ

Legends:

⚑ Indicator has a numerator ≤10 and is not reportable

ϟ 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
2019_2020	14.1 %	1.6 %	40,887	289,222
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
2020	10.3 ϟ	2.6 ϟ	16 ϟ	155,351 ϟ
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 ϟ	2.7 ϟ	17 ϟ	155,558 ϟ
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

ϟ 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
2020	20.9	3.7	32	153,398
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
2018_2020	6.1	1.6	14	229,290
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
2018_2020	10.5	2.1	24	229,290
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
2019_2020	14.5 %	1.3 %	43,575	300,175
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
2019_2020	18.6 %	3.8 %	8,114	43,575
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
2019_2020	1.8 %	0.5 %	4,589	249,409
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
2019_2020	5.4 %	0.9 %	13,161	245,922
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
2019_2020	46.8 %	6.7 %	9,730	20,781
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
2019_2020	92.1 %	1.1 %	276,238	299,934
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
2019_2020	15.5 %	2.1 %	20,313	131,281
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
2017	67.2 %	4.0 %	11,000	17,000
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
2020_2021	59.5 %	2.1 %	164,292	276,121
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
2020	84.9 %	2.5 %	66,589	78,453
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
2020	83.7 %	2.7 %	65,660	78,453
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
2020	86.0 %	2.4 %	67,501	78,453
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
2020	13.0	0.6	470	36,031
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
2020	13.7 %	1.3 %	2,067	15,102
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
2019_2020	2.1 %	0.5 %	6,336	298,701
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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				77	79
Annual Indicator			76.6	78.1	81.1
Numerator			184,106	185,323	191,337
Denominator			240,287	237,398	235,933
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

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

Annual Objectives				
2022	**2023**	**2024**	**2025**	
Annual Objective	81.0	83.0	85.0	87.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	79	80	82	82	85
Annual Indicator	81.5	81.5	81.5	84.0	80.1
Numerator	14,376	14,376	14,376	6,895	12,016
Denominator	17,634	17,634	17,634	8,212	15,003
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2015	2015	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	86.0	87.0	87.0	88.0

Field Level Notes for Form 10 NPMs:

None

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	**2021**
Annual Objective	21	29
Annual Indicator	28.7	24.7
Numerator	2,245	3,565
Denominator	7,829	14,455
Data Source	PRAMS	PRAMS
Data Source Year	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			1	21	29
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				
	2022	**2023**	**2024**	**2025**
Annual Objective	30.0	30.0	31.0	31.0

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.	

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	**2021**
Annual Objective	33	49
Annual Indicator	48.1	45.9
Numerator	3,755	6,633
Denominator	7,801	14,447
Data Source	PRAMS	PRAMS
Data Source Year	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			1	33	49
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				
	2022	**2023**	**2024**	**2025**
Annual Objective	49.0	50.0	50.0	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.	

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		33	39	40	40
Annual Indicator	32.0	39.1	36.5	31.6	41.2
Numerator	12,946	14,121	13,201	12,899	16,334
Denominator	40,486	36,113	36,145	40,832	39,621
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	40.0	41.0	41.0	42.0

Field Level Notes for Form 10 NPMs:

None

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		74	75	77	80
Annual Indicator	73.5	74.6	74.6	77.7	73.4
Numerator	67,325	74,226	74,226	76,702	71,318
Denominator	91,592	99,470	99,470	98,664	97,099
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	81.0	82.0	84.0	86.0

Field Level Notes for Form 10 NPMs:

None

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		23	23	25	25
Annual Indicator	23.3	21.9	24.7	17.1	15.9
Numerator	4,235	4,457	5,037	3,214	3,171
Denominator	18,144	20,375	20,412	18,758	19,924
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	26.0	26.0	27.0	27.0

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**	**2021**
Annual Objective			5.9	5.5	5.4
Annual Indicator		5.9	5.5	5.7	5
Numerator		635	584	591	508
Denominator		108,119	105,815	104,141	101,271
Data Source		DHS CAN annual report	DHS CAN annual report	DHS CAN annual report	DHS CAN annual report
Data Source Year		2017	2018	2019	2020
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	5.0	4.9	4.9	4.8

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:	**State Provided Data**
	Field Note: Baseline Data from 2020 DHS CAN annual report (p.8) http://humanservices.hawaii.gov/reports/child-abuse-and-neglect-reports/ represents a rate of 5.0 per 1,000 children 0-5 years of age (Numerator: 508 unique children confirmed victims; Denominator: 2020 Census Estimate 0-5 years: 101,271)	
5.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Objectives for 2022-2025 were updated 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	2021
Annual Objective		
Annual Indicator	25,584	25,907
Numerator		
Denominator		
Data Source	Hawaii WIC Services	Hawaii WIC Services
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

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

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:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Indicator is number of WIC enrollments for 2021	

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	2021
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Hawaii Pediatric Mental Health Care Access grant	Hawaii Pediatric Mental Health Care Access grant
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	20.0	40.0	60.0	80.0

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:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The number of pediatric/mental health providers trained on Pediatric Mental Health Care is 0 for 2021.	

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	2021
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Hawaii Title V Genetics Program	Hawaii Title V Genetics Program
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	9.0	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:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: his is a new measure. The number of telehealth access point in 2021 is 0.	

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	2021
Annual Objective		
Annual Indicator	73.2	63.8
Numerator		
Denominator		
Data Source	Hawaii Med-QUEST	Hawaii Med-QUEST
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	76.0	77.0	78.0

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:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Only annual indicator is available. Numerator and denominator are not available for this measure.	
3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: 2022-2025 objectives have been updated based on 2021 indicator. Objectives reflect a 1% increase between 2022-2025.	

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	34	31	31	31	31
Annual Indicator	31.7	31.9	30.9	32.4	33.3
Numerator	2,849	2,773	2,661	2,558	2,614
Denominator	8,974	8,693	8,599	7,903	7,851
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	31.0	31.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Estimate based on 2017 final vital statistics data file	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Estimate based on 2018 final vital statistics data	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Estimate based on 2019 final vital statistics data file	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Estimate based on 2020 final vital statistics data file.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Estimate based on 2021 provisional vital statistics data file as final 2019 data file not available	

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	2021
Annual Objective			11	11
Annual Indicator			0	11
Numerator				
Denominator				
Data Source			Hawaii Safe Sleep Program	Hawaii Safe Sleep Program
Data Source Year			2020	2021
Provisional or Final ?			Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The completion of the translations, dissemination plan, coupled with the launch of a media campaign in FY 2022 largely finishes the work for ESM 5.2. Thus, the FY 2021 indicator is 11 out of 11. A new ESM will be developed next year with the addition of new a strategy.	

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**	**2021**
Annual Objective			12	18	24
Annual Indicator					
Numerator	9	19	23	26	26
Denominator	30	30	30	30	30
Data Source	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	27.0	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:	**State Provided Data**
	Field Note: The measure is a scale and the annual indicator for 2021 is 26. Converting to percentage 26/30 = 86.7%	

ESM 10.1 - Develop and disseminate a teen-centered Adolescent Informational Resource (AIR) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits

Measure Status:	Active

State Provided Data				
	2018	2019	2020	2021
Annual Objective			18	23
Annual Indicator				
Numerator	9	13	20	26
Denominator	30	30	30	30
Data Source	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	28.0	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 20/30 = 66.7%	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Converting to percentage 26/30 = 86.7%	

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		17	21	24	26
Annual Indicator					
Numerator	13	18	22	25	26
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	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	28.0	30.0	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 24.5. Converting into percentage 24.5/33 = 74.2%	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The measure is a scale and the annual indicator for 2021 is 26. Converting into percentage 26/33 = 78.8%	

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:	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. 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.

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 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To support reproductive life planning and healthy birth outcomes by increasing intervals of birth spacing (births spaced from 18 month to next conception).</td></tr>
<tr><td>Definition:</td><td>
<table>
<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>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data source is vital statistics, Office of Health Status Monitoring.
Calculation of interval is based on birth certificate data with valid clinical estimate of gestational age of index birth and prior live birth.
Pregnancy Interval = ConceptionDate – Last Live Birth (following HRSA CoIIN to reduce infant mortality outcome measure).</td></tr>
<tr><td>Significance:</td><td>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 Medicaid Services, CMCS Informational Bulletin, April 8, 2016, State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception; Augustin Conde Agueldo, 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®.</td></tr>
</table>

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Expand outreach to Non-English-speaking families and care givers through translation of educational and general awareness safe sleep messages.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>20</td></tr>
<tr><td>Numerator:</td><td>Number of languages Departments of Health (DOH) & Human Services (DHS) safe sleep are available for Hawaii's communities</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of children receiving developmental screening and referred and receiving services among Hawaii Title V direct service programs.</td></tr>
<tr><td>Definition:</td><td>
<table>
<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>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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

Systems Development
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.
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.
4. Develop website to house materials, information and resources on developmental screening.

Data Collection and Integration
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

Policy and Public Health Coordination
7. Develop Policy and Public Health Coordination Scale.
8. Conduct process for annual assessment of rating scale.</td></tr>
</table>

	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 Informational Resource (AIR) 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:	**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:	This is a summary of the Data Collection Form that lists 10 strategy components organized by the following domains: • Collaboration • Engagement to Develop the Adolescent Resource Toolkit • Workforce Development Training for Community Stakeholders 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.
Significance:	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: • 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. 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.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for YSHCN.</td></tr>
<tr><td>Definition:</td><td><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></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>This is a summary of the Data Collection Form that lists 11 strategy components organized by the Six Core Elements of Health Care Transition:
• Transition policy
• Transition tracking and monitoring
• Transition readiness
• Transition planning
• Transfer of care
• Transition completion.
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.</td></tr>
<tr><td>Significance:</td><td>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.

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.

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.</td></tr>
</table>

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 2021

	Access				Linkages	
Data Sources	(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	09	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:	**6) Newborn Hearing 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 Laulima Data Alliance. The Laulima 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.