Maternal and Child Health Services Title V Block Grant

Hawaii

FY 2024 Application/ FY 2022 Annual Report

Created on 9/28/2023 at 9:39 AM

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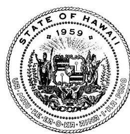
I. General Requirements

I.A. Letter of Transmittal

JOSH GREEN, M.D.
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI



KENNETH S. FINK, MD, MGA, MPH
DIRECTOR OF HEALTH
KA LUNA HOʻOKELE

STATE OF HAWAIʻI
DEPARTMENT OF HEALTH
KA ʻOIHANA OLAKINO
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

July 31, 2023

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) 2024 (October 1, 2023 – September 30, 2024). The FY 2024 application and FY 2022 annual report are 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 annette.mente@doh.hawaii.gov.

Sincerely,

Kenneth Fink

Kenneth S. Fink, MD, MGA, MPH
Director of Health

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

II. Logic Model

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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

Hawaii is one of the most ethnically diverse states with no single majority race (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) administers 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. The four guiding pillars of MCH are: 1) delivery of services using the ten Essential Public Health Services framework; 2) data-driven performance accountability; 3) partnerships with agencies, community providers, and individual families/youth; and 4) health equity for all MCH populations to achieve their full health potential. To help expand its capacity and reach, FHSD leverages state and federal grant funds with community partners.

To set priorities for the state MCH program, a comprehensive needs assessment is conducted every five years. For FY 2022, Hawaii identified ten Title V priorities, adding four additional state priorities in 2021 based on assessment efforts during 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	Promote food security through WIC services
	Reduce infant safe sleep conditions
Child Health	Improve the percentage of children age 0-5 years screened early and continuously for developmental delay
	Reduce the rate of child abuse and neglect, with special attention to children ages 0-5 years
	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 Emergency Response 2020-2022

Hawaii managed the COVID-19 pandemic better than many other states. This was reflected in consistently low COVID case numbers, hospitalizations, and deaths. Aptly, the Commonwealth Fund ranked Hawaii number one among states in

managing COVID response in 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 restrictions. Over the course of the pandemic, Hawaii's governor issued over 20 COVID-related emergency proclamations that included 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 to reduce disease spread. With community partners, the State also implemented active COVID-19 testing, contact tracing, and systematic vaccination rollout. The State cautiously relaxed COVID restrictions to reopen the economy lifting all COVID restrictions in March 2022, making Hawaii the last state to end an indoor mask mandate.

COVID: The community spread of COVID-19 remains low yet steady through June 2023 with 296,454 cumulative cases and 1,884 deaths since the beginning of the pandemic. Positive case numbers are considered an underestimate since many residents now test from home. Fatalities are largely among the elderly (80%). COVID disparities continue with Native Hawaiians, Filipinos, and Pacific Islanders experiencing higher rates of infection and death. Roughly 25% of the state's population has not contracted COVID (43.5% among those 65 and older).

Vaccinations: As of June 2023, 78.8% of Hawaii's population was fully vaccinated, a relatively high vaccination rate. Those receiving a booster or bivalent shots is 23%, like the national average.

Disease Management. In 2022, the State transitioned from a COVID emergency response to disease management. HDOH continues to collect and publicly release COVID data weekly, although the CDC discontinued reporting, making national comparisons more difficult. HDOH continues to issue advisories on current COVID-19 recommendations and works with key partners to ensure the most accurate guidance and information is being shared.

As Hawaii transitions to a new pandemic phase, surveys show Hawaii residents are becoming more confident that the worse of the pandemic is over, perhaps keeping COVID-19 booster uptake low. However, significant health consequences of the pandemic remain including long COVID, mental health issues, and other comorbidities which pose significant healthcare challenges.

Economic Impact of COVID: The COVID shutdown saw an unprecedented contraction of the state's economy in 2020:

- A 98.8% decrease in travelers to the state.
- An unemployment rate that rose from 2.1 % to 21.9% in one month (the lowest to the highest unemployment rate in the U.S).
- Food banks reported a 60% increase in services.
- Enrollments for government assistance soared.

Recovery. After Hawaii's cataclysmic fiscal collapse, the economy made an equally astounding turn around in 2021 driven by an unexpected rebound in domestic tourism, with visitor arrivals returning pre-pandemic levels in 2022. Unemployment returned to 3.5% in 2022, although businesses still report hiring challenges.

An unprecedented level of federal spending also 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 rent/mortgage subsidies helped maintain personal income through 2020-21. Although 2022 saw the end of many federal supports, there was a slight increase in average earnings reflected in real income recovery to near pre-pandemic levels. In 2023, economists report Hawaii's inflation appears to be decreasing faster than for the U.S.

Despite these bright spots, affordability remains an enormous challenge for many residents. Data for 2021 shows that Hawaii goods and services were 13% higher than the U.S. average, making Hawaii the most expensive state in the country. Home prices rose by 40% in April 2022. Affording a single-family home now takes twice the income compared to a decade

ago ($190,000 annually). During the same period, median household income increased by only 27%. Hawaii's job market continues to be dominated by low-wage, service industry jobs.

Increased domestic out-migration over the past five years may be due in part to the state's high cost of living as well as greater job opportunities in other western states.

New Governor: In November 2022, Hawaii elected a new democratic governor, Josh Green M.D., who ran on a bold, progressive, action-oriented platform to address the state's most difficult problems. He promised to address Hawaii's housing crisis, homelessness, affordability issues through tax reform, and expand subsidized pre-schools while protecting the state's natural resources. As an emergency room doctor from Hawaii County, Governor Green is keenly aware of the needs of rural/neighbor island communities and committed to strengthen the state healthcare workforce and infrastructure. His agenda was bolstered by a substantial budget surplus.

Title V Programs/Services: Through 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 as the state moved out of the public health emergency. Although hampered by vacancies, FHSD staff soldiered on, creating new partnerships to address service shortfalls.
Programs increased focus on addressing health disparities highlighted by COVID. FHSD also acknowledged existing public health and healthcare workforce needs to minimize burnout.

In 2022, 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. The major decrease resulted from the loss of federal 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 promote services and health messaging.

5-Year Plan Highlights for 2021-2025

FY 2023 marks the third year of the Title V 5-year project period. Four new state priorities were added in 2021 in response to COVID needs and new federal funding opportunities: Food Insecurity through WIC services, Telehealth expansion to underserved communities, Pediatric Mental Health Access and Child Wellness Visits/Immunizations. Some planned activities experienced delays or changes due to COVID including workforce turnover and vacancies. 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 access to Long-Acting Reversible Contraception (LARC). More than 1,000 health care providers statewide were trained on OKQ. Hawaii birthing hospitals now stock LARC for same-day insertion after delivery.

DOMAIN: PERINATAL/INFANT HEALTH

Promote safe sleep practices

- Media messaging campaigns continued using TV, radio, and digital ads to promote safe sleep messaging and resources available through the statewide The Parent Line (TPL). Safe sleep information materials are now available in 11 languages to reach those with limited English proficiency. Families may also access safe sleep online workshops.

Address Food Insecurity through Improving WIC services

- In partnership with the Hawaii Children's Action Network, work was completed on a Partnership for Children grant to help identify improvements in WIC services. A Community Advisory Committee was convened comprised of community/agency partners, university researchers, and WIC parents to develop recommendations. Additional grant funding was secured to implement the committee's recommendations.

DOMAIN: CHILD HEALTH

Improve early and continuous screening for developmental delay

- In partnership with the American Academy of Pediatrics on a Centers for Disease Control Act Early grant to promote

developmental screening through trainings of pediatric and family service providers. Projects included training of WIC clinical staff to pilot a developmental checklist, launching a social media campaign with parent social media influencers, translating education information to reach Pacific Islander populations, and complete service maps for each county.

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, establishment of DOE Family Resource Centers (FRC), the formation of a statewide FRC network, and joined Native Hawaiian organizations to address over-representation of Hawaiians in the foster care system.
- Issued over $800,000 in state/federal funding to community-culturally based programs to provide critical services for family and parenting support.

Increase Child Wellness Visits

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

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 website using popular social media 'influencers.'
- Developed a scope of work to partner with the Micronesian Pacific Islander community to identify needs/resources to support well-being of Micronesian 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 are now conducted virtually or use hybrid formats as more events are returning to in-person.

DOMAIN: CROSS-CUTTING/SYSTEMS BUILDING

Expand telehealth services to underserved rural communities

- Implementation continues on a $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. Locations have been established, training of personnel began, and piloting of the healthcare hub model was completed.

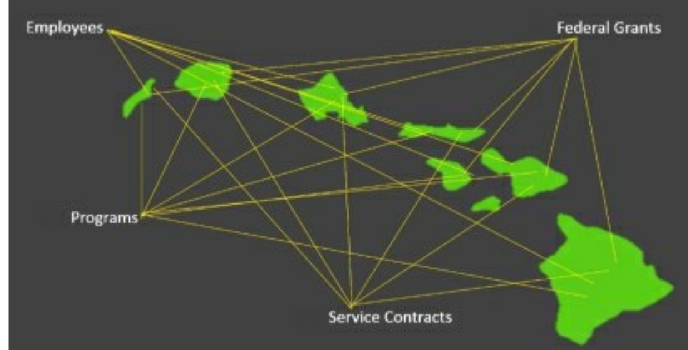
Expand pediatric mental health care access to underserved rural communities

- 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 HDOH, 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, 25 federal grants, and approximately 150 service contracts with community-based organizations totaling roughly $55 million—all with 265 FTE positions statewide.

Title V funds played a critical role in supporting the state's overall MCH efforts. In 2022, the FHSD budget was $95.5M million. Nearly $2.0 million was provided by Title V, with $34.6 million state matching funds and an additional $40.4 million in other federal funds. Of the state's overall population, FHSD programs reached an estimated 99% of pregnant women; 100% of all infants; 99.3% of children 1-21 years of age, including 99.3% of children with special health needs; and 62.6% 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 (17 FTE). Positions included: critical data analytics staff (epidemiologists and research statisticians); administrative, fiscal, and program management for MCH and CSHN; Public Information Officer; and 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

Over the course of the COVID-19 pandemic, there was a period of time hospitals, clinics, and doctors' offices were only seeing patients that required emergency services. This had a significant impact on well-child visits, immunizations, and other healthcare screenings for children. FHSD was motivated to assist Hawaii families through TV, radio, and digital media by encouraging parents and caregivers to call their child's pediatrician or healthcare provider to resume regular, in-person checkups. Through the Call Your Pediatrician campaign, FHSD partnered with the American Academy of Pediatrics – Hawaii Chapter (AAP Hawaii Chapter), Med-Quest (state Medicaid program), and Hawaii Children's Action Network (HCAN) to craft and distribute appropriate messaging.

Click to play TV spot – Time For a Checkup!

A 30-second TV spot was created utilizing pediatricians from AAP Hawaii Chapter and a real local family in a doctor's office setting. The objective was to increase well-child visits by helping to alleviate fears of COVID-19 exposure from in-person checkups with healthcare providers and to remind parents and caregivers about the importance of preventative screenings. For these reasons, the TV spot highlighted COVID safety precautions and showed the doctors and family interacting and smiling.

The initial campaign ran from November 2021–January 2022. A news 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 TV spot ran on major broadcast and cable TV stations, including KITV4 (ABC affiliate), Hawaii News Now (NBC and CBS affiliate), and Spectrum. Through TV, there was a reach of 99.6% of adults 25-54 with over 3.91 million impressions. A companion radio spot ran through Pacific Media Group's 20+ stations broadcasting across the state from four of the major islands (Oahu, Maui, Hawaii Island, Kauai). The radio spot reached 61.8% of adults 25-54 with over 1.68 million impressions.

Digital ads included display, pre-roll, programmatic, and over-the-top (OTT). These placements served over 1.52 million impressions with 3,668 clicks to the accompanying website that was created as a resource for the campaign: KeikiCheckup.com.

A second phase of the campaign ran from June–September 2022 using the same creative with some minor tweaks to the messaging. A new TV spot was produced to encourage parents and caregivers to resume regular, in-person visits to their child's pediatrician or healthcare provider and to ask about recommended screenings.

Click to play TV spot – Keiki Screening

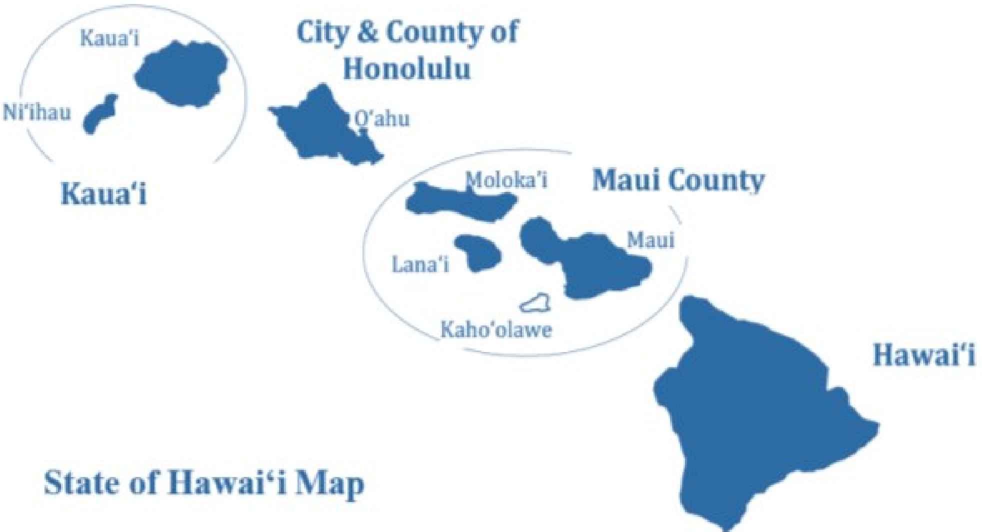
With even more funding available, the second phase broadened its reach. The new TV spot ran on KIT4, Hawaii News Now, and also KHON2 (Fox affiliate). The broadcast TV reach was 99.3% of adults 25-54 with over 5.95 million impressions. For radio, iHeartMedia's 20+ stations statewide reached 52.4% of Oahu adults 25-54 years old and 30.9% of neighbor island adults 25-54 years old for over 2.03 million impressions. Additionally, KNDI Radio 1270AM, an ethnic station, was added to better reach specific populations of concern by running translated versions of the spot in Ilocano, Tagalog, Marshallese, Samoan, Tongan, Pohnpeian, and Chuukese.

Digital ads included social media (Facebook, Instagram, TikTok), display, pre-roll, OTT, and streaming audio. These placements served over 3.11 million impressions with 3,957 clicks to the website. Additionally, Screenvision was added to the media buy to reach moviegoers at Hawaii's largest chain Consolidated Theatres, with 10 theatres across Oahu and Maui. Over 1.12 million impressions were served with a statewide reach of 69% of 25-39-year-olds; 67% of 40-49-year-olds; and 61% of 50-54-year-olds.

III.B. Overview of the State

GEOGRAPHY

Situated in the Pacific Ocean's center, 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 are performed by cities or towns in other states. The state government is responsible for functions usually performed by counties or cities in other states. For example, Hawaii is the only state 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 urban 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. Oahu 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 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 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

using helicopters or fixed-wing aircrafts.

DEMOGRAPHICS

The estimated 2021 state population is 1,441,553 residents, the 30th most populous state in the U.S. Oahu is home to 69.4% (1,000,890 residents) of the state's population, while 14.1% (202,906 residents) live on Hawaii Island, 11.4% (164,268 residents) in Maui County, and 5.1% (73,454 residents) in Kauai County. Compared to 2019 (1,415,872),[1] There was a 25,681 (1.8%) population increase in the state.

ETHNIC DIVERSITY

Hawaii is the most ethnically diverse state in the nation.[2] According to the 2021 American Community Survey (ACS) data, 26.3% of the population reported two or more races and the following single race proportions: White=22.2%; Asian=37.2%; and Native Hawaiian or Other Pacific Islander (NHOPI)=10.1%. The largest Asian single-race subgroups were Filipino (14.8%) and Japanese (11.6%), and the largest NHOPI single-race subgroup was the indigenous Native Hawaiians (6.3%). The individual Asian and NHOPI subgroups from the U.S. Census are listed in the table below, showing 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 with two or more race groups. They are not included in the single-race groups commonly reported. Hawaii State 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 26.4% of the state population when reported as “Alone or in Combination,” compared to just 6.3% when reported singly. There is also variation among race subgroups with an overall estimate of 34.2% of those in the “Asian Alone or in Combination” reporting another race. Variation in the three largest Asian subgroups ranges from 36.3% Filipino to 60.6% Chinese. The other Asian subgroups are likely newer immigrants compared to these three and have smaller numbers reporting more than one race.

Race	Resident Population in the State (N)	Percent of State Population (%)	Proportion Reporting at least one other Race (5)
White Alone	319,677	22.2%	0
White Alone or in Combination	617,903	42.9%	48.2%
Native Hawaiian or Other Pacific Islander (NHOPI) Alone	145,556	10.1%	0
NHOPI Alone or in Combination	380,825	26.4%	61.8%
Native Hawaiian Alone	90,370	6.3%	0
Native Hawaiian Alone or in Combination	309,807	21.5%	69.3%
Asian Alone	536,161	37.2%	0
Asian Alone or in Combination	814,349	56.5%	34.2%
Filipino Alone	213,337	14.8%	0
Filipino Alone or in Combination	370,594	25.7%	36.3%
Japanese Alone	166,881	11.6%	0
Japanese Alone or in Combination	314,102	21.8%	37.2%
Chinese Alone	86,861	6.0%	0
Chinese Alone or in Combination	*220,460*	*15.3%*	*60.6%*
Source: U.S. Census Bureau. 2021. ACS Calculations by Hawaii DOH, FHSD.			

Immigration

Hawaii is a gateway to the U.S. for immigrants from Asia and the Pacific and has a sizeable immigrant community. Based on the 2021 ACS, there were 270,345 immigrants in Hawaii, or nearly one in five (18.8%) residents. This is the 6th highest of all states. Hawaii immigrants were 56.2% women and 5.6% children (under 18 years old). The largest ethnic group of immigrants comprised of Asians (75.1%), followed by NHOPI (9.1%) and White (7.6%).

Most immigrants in Hawaii (81.7%) speak a language other than English, and 47.4% speak English less than "very well." About 19.5% had a bachelor's degree; 9.3% had a graduate or professional degree. Approximately 62.2% of immigrants 16 years and over were employed in the labor force in 2021.

Undocumented Immigrant Estimates

According to the Pew Research Center, in 2016, an estimated 45,000 undocumented immigrants were in Hawaii (3.3.% of the population).[3] The majority were from the Philippines. Hawaii was the only state where undocumented women (55%) outnumbered 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 undocumented	17.0%	24.0%
Proportion of adults 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 & 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.[4] As of 2019, 11% of those DACA-eligible immigrants in Hawaii 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 live, work, and study in the U.S. indefinitely without a VISA or green card. This status was negotiated in exchange for exclusive U.S. military control of 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.

Among COFA migrants, there are reports of high morbidity rates due to chronic diseases, communicable diseases (tuberculosis), and other medical concerns (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 to 28,000.[5] COFA migrants are consistently overrepresented among homeless surveys 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.[6]

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 the ethnic diversity in Hawaii, limited English proficiency may impact access to healthcare for immigrant communities and poses a challenge to service organizations targeting these populations. According to the 2021 ACS, an estimated 25.8% of Hawaii residents ages 5 years and over spoke a language other than English at home, compared to 21.6% nationally. An estimated 11.1% of Hawaii residents reported limited English proficiency (4th highest state ranking) compared to 8.3% nationally.

In School Year 2019-20, an estimated 18.0% (32,044) 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

Hawaii has areas with a growing Hispanic population. Anecdotally, recent Hispanic workers to the state helped address labor shortages in agriculture (coffee and pineapple farms) and the service and construction industries, primarily in Maui and Hawaii counties. Service organizations report that 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 policies and programs that are culturally/linguistically accessible. Further, differences in culture and language are important considerations when implementing Evidenced-Based Interventions, 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. In 2021, Active Duty, National Guard, and Reserve Personnel comprised an estimated 3.6% of the state's population (51,575 people).[9] There are several major military health facilities to serve this population on Oahu. The Tripler Army Medical Center is the federal tertiary care hospital for 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 clinics for active-duty members and their family members.

Homeless

The 2022 Hawaii Point-in-Time homeless study estimates the number of *sheltered* homeless in the state was 2,224 (1,896 on Oahu and 628 on the neighbor islands).[10] Data for *unsheltered* homeless was 2,355 for Oahu and 1,224 on the neighbor islands. There was a 13.8% decrease in sheltered homeless compared to 2021 for Oahu and a 1.3% decrease for sheltered homeless for neighbor islands. Compared to other states, Hawaii had the fourth highest homeless rate in the U.S. (41 per 10,000 residents), more than twice the national rate (18 per 10,000).[11]

Maternal and Child Population

Based on 2021 ACS data, the estimates show that there were 264,324 women of reproductive age (15-44 years old), a 1.6% decline from 2015 (268,648), representing 18.3% of the entire state population. Vital statistics data show the number of births continued to decrease between 2019 (16,810), 2020 (15,780), 2021 (15,608), and 2022 (15,354).

Estimates show there were 164,877 children 9 years of age or younger in Hawaii, representing a 7.1% decrease from 2015. This group represents 11.4% of the state population. There were 168,774 children 10-19 years of age in Hawaii, representing a 3.4% increase from 2015. This group represents 11.7% of the state population.

Based on the 2020-2021 National Survey of Children's Health, there are an estimated 39,320 Children with Special Health Care Needs (CSHCN), 13.2% of all children ages 0-17 years. This is significantly below the national estimate of 19.5%. The 2020-2021 Hawaii estimate was slightly lower, though not statically significant, compared to the 2019-2020 estimate (14.5%).

Older Population

Hawaii's population is aging. Based on 2021 population estimates, persons aged 65 years and over comprised

19.6% of the population, compared to 16.6% in 2015. Nationwide, this population comprised 16.8% in 2021 compared to 14.9% in 2015. There are more older people in proportion to younger ones.

ECONOMY

Tourism, real estate, construction sectors, and military spending largely drive the economy in Hawaii. Initial COVID shutdowns in 2020 resulted in the virtual closure of the Hawaii 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. According to the Hawaii Department of Business, Economic Development and Tourism (DBEDT),[12] in 2023 the state's major economic indicators were largely positive in the fourth quarter of 2022. Visitor arrivals, wage and salary jobs, state general fund tax revenues, and private building authorizations increased in 2022 compared to 2021.

Tourism

In 2020, during the COVID-19 pandemic, total visitor arrivals decreased by 7,556,762, or 73.8%. 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 international visitor arrivals both increased.

Tourism continued to recover in 2022. Total visitor arrivals by air increased by 2,374,674 or 35.0 % compared to 2021 (a 7.7 % increase in domestic flights and a 295.1 % increase in international flights).[13] Visitor expenditures also increased. In 2022, visitor expenditures totaled $19.2 million, an increase of 46.7 % from the previous year.

Unemployment

The unemployment rate in Hawaii 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. The 2020 average annual unemployment rate was 11.6% but decreased to 5.7% in 2021 as the economy rebounded. The unemployment rate decreased to 3.5% in 2022 compared to the U.S. average of 3.6%[14] ranking Hawaii the 27th lowest among the 50 states.

Job Market

Labor market conditions were mainly positive in 2022: Hawaii averaged 625,200 non-agricultural jobs, an increase of 25,600 jobs or 4.3 % over 2021. The job increase in 2022 was due to increases in both the private and government sectors. The largest increases were in Food Services and Drinking Places, which added 9,500 jobs (16.2% increase), followed by Accommodation, which added 6,300 jobs (19.0%).[15] Natural Resources, Mining, and Construction increased by 1,600 jobs (4.4%), and the Government sector added 2,200 jobs (1.8%) compared to 2021.

Wages

According to 2020 data from the U.S. Bureau of Labor Statistics, the average annual wage for employees in Hawaii was $57,934, roughly a 10% increase over 2019 despite COVID shutdowns. Economists believed this was largely due to direct federal stimulus payments/supports, including supplemental unemployment insurance benefits.

In 2021, wages overall continued to increase to a smaller extent. The U.S. Bureau of Labor Statistics reported that the 2021 average annual wage in Hawaii was $59,644, 11.8% lower than the U.S. average.[16] However, this is about a 3.0% ($1,710) increase compared to the 2020 average annual wage ($57,934). Hawaii ranked 24th among the 50 states.

Income

Per capita, personal income for Hawaii also increased in 2021 ($60,947) from 2020 by 6.7% ($57,109).[17]As noted, income loss from the economic shutdown was offset by government stimulus/relief supports.[18] Federal income and housing support programs were crucial in preventing economic collapse for some families and communities.

Per capita income in Hawaii was 5% lower than the national average. After adjusting for cost of living, the per capital income was 12% lower than the unadjusted level.[19] Aggregated income wages do not measure the disparate effect on high- and low-income workers. During the pandemic, professional workers continued to work safely and remotely through 2021, while many lower-income households were dependent on face-to-face service jobs, the hardest hit by COVID. This led to disproportionate economic hardship for these families. This divergence in economic impacts (social and health) reflected preexisting structural inequalities.

State Budget/Revenues

The state general fund revenue for 2022 ($9.44M) increased by 16.0% over 2021 ($8.13M), and 47.2% over 2020 ($6.42M).[20] This reflected robust tax collections from tourism's rapid recovery, renewed consumer spending, and additional tax collections due to inflation. The transient accommodations tax on visitors reflected the largest increase.

Based on this, the State Council on Revenues (which sets the state's budget ceiling) lowered its forecast on revenue growth from 5.5% to 2.0% for fiscal year (FY) 2023.[21] Also, it lowered its forecast from 5.0% to 4.0% for FY 2024. The 3.5% decrease in the FY 2023 revision is due to a legislatively mandated taxpayer refund, expected to reduce revenues by $334 million in FY 2023 and lower estimated taxes from individual filers. Lower capital gains income due to poor performance in the stock market and a cooling real estate market is likely to cause lower estimated tax payments.

The council acknowledged the risks that may inhibit the economic recovery include new variants of the COVID-19 virus: inflation and the response from the Federal Reserve, high oil and commodity prices, economic disruptions from the war in Ukraine, severe labor shortages, supply chain disruptions, sustained travel hesitancy from Asian markets, and the reduction in Federal stimulus spending.

Poverty

Based on 2021 ACS estimates, the poverty rate in Hawaii was 11.2% (all ages in poverty), 1.6% lower than the U.S. rate (12.8%). This represents an estimated 156,735 individuals living in poverty in the state. Over 40,502 (13.6%) of those under 18 years old live in households below the Federal Poverty Level (FPL). Poverty rates were variable across counties: Honolulu 10.2%; Maui 12.1%; Kauai 11.7%; and Hawaii 14.8%. Poverty rates were higher among Native Hawaiians/Other Pacific Islanders (16.5%) and Blacks/African Americans (14.3%), compared to Whites (11.9%) or Asians (7.6%).

The official FPL obscures many families' struggles 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 3-year average (2019-2021) poverty rate was 10.5% in Hawaii using the supplemental poverty measure, 0.4% higher than the official poverty rate (10.1%).[22]

ALICE Report

The Hawaii United Way agency tracks working residents living just above the poverty level who cannot afford basic necessities through a survey titled Asset Limited, Income Constrained, Employed (ALICE).[23] The most recent Hawaii ALICE study in 2022 found that more Hawaii households fell below the ALICE threshold compared to 2018 before COVID. An estimated 44% of ALICE households lived in Hawaii (compared to 42% in 2018) and struggled to

meet housing, childcare, food, transportation, and healthcare expenses. These were in addition to the 11% of households below the FPL. Additionally, the percentage of households with income below the FPL increased from 9% in 2018.[24] This suggests hardship deepened for many island residents during the pandemic, and the post-pandemic inflation made it more difficult to cover everyday expenses. A majority of Native Hawaiian (60%) and Filipino (59%) residents fell below the ALICE threshold, along with households with children (54%).

The report cites the major reasons 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 paying less than $15 per hour. It is difficult for ALICE households in Hawaii to find affordable housing, job opportunities, and community resources. Although public and private assistance helps, it does not provide financial stability. ALICE households are often forced to make difficult financial choices with limited resources, such as forgoing healthcare, childcare, healthy food, or car insurance.

The report also confirmed that in addition to financial challenges, mental health issues (anxiety, depression) emerged as one of the major concerns for ALICE households.

HIGH COST OF LIVING

Data for 2021 shows that in Hawaii, the price level of goods and services was about 13% higher than the U.S. average, making it the most expensive state in the country.[25]

Housing Costs

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

In April 2023, the median housing cost for a single-family dwelling on Oahu was $999,995, and for a condominium was $500,000.[26] Based on ACS 2021 one-year estimates, the median monthly owner mortgage cost in 2021 was $2,584, 54.5% higher than the U.S. average. Among these homeowners, 33.9% spent *35% or more of their household income* on housing, higher than the U.S. average of 21.0%. Hawaii ranked the highest in the nation for this indicator. Not surprisingly, the homeownership rate in Hawaii in 2021 was one of the lowest in the U.S. (46th among the 50 states) at 62.6%, which was lower than the U.S. average of 65.4%.

Rental Costs

The high cost of fair market rent may be out of reach for working families. Based on the ACS 2021 estimate, 37.4% of occupied housing units in Hawaii were renter-occupied (compared to 34.6% nationally). The median monthly gross rent for the renter-occupied units was $1,774, 49.0% higher than the U.S. average of $1,191. 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 2021 ACS estimates, the percentage of multigenerational family households among all family households in Hawaii was 8.2% (40,229 out of 490,080 households), which was higher than the U.S. average of 3.8% (4,858,150 out of 127,544,730 households). 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 complicated COVID-19 social distancing/isolation efforts and contributed to disparities in

infection rates for these groups.

Cost of Health Insurance

Overall, the cost of private employer-based health in Hawaii steadily increased for a family plan between 2013 and 2021 ($14,382 to $18,539).[27] Hawaii health plans offered through the federal marketplace also increased slightly from $330 for the average premium to $484 in 2022.[28]

Health Services Infrastructure

There are about 100 health facilities in Hawaii.[29] Of the state's 29 hospitals, 12 are labor and delivery hospitals. Three pediatric hospitals have Neonatal Intensive Care Units on Oahu, while other hospitals have fewer acute pediatric services. Hawaii has 15 federally qualified health centers, 15 rural health clinics, and seven Native Hawaiian health system sites. Most healthcare services, particularly specialty care providers/facilities, are concentrated in urban Honolulu on Oahu. Neighborhood island residents commonly fly to Oahu to access medical, dental, and behavioral services. Maps of these facilities are in the Supporting Documents.

Healthcare Workforce

The state has 300 family and general practitioners, 210 obstetricians and gynecologists, and 230 pediatricians.[30] Based on the 2021 population estimate, there are 14.6 per 100,000 obstetricians and gynecologists, which is higher than the national rate (6.5 per 100,000 population), though non-significant. There are 16.0 pediatricians per 100,000 population, which is similar to the national estimate (10.1). The rate for family/general practitioners (20.8 per 100,000 population) is similar to the national rate (31.0). Despite the 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.

The COVID pandemic worsened healthcare workforce needs in the state. The Hawaii Physician Workforce Assessment Project reported that the state is short 776 doctors, with the greatest need in primary care specialties. The greatest need is on the neighbor islands, with Maui and Hawaii County experiencing a physician shortage of 40%.[31] In 2022, nearly 3,900 position vacancies were reported across 89 patient-facing professions, an average job vacancy rate of 17% compared to 10% in 2019.[32] The state's smallest islands, Lanai and Molokai, have the highest percentage of job vacancies.

Healthcare Shortage Designations

Shortage Designations represent an area's or population's needs based on several factors, including health professional presence, socioeconomic and demographic data, language barriers, health indicators, access to health care, and travel time to the nearest available provider. As described previously, most shortage areas populate the rural neighbor islands and rural/low-income urban areas on Oahu. The entire state is designated a mental health shortage area. Maps of shortage areas in Hawaii 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. HPSA designations cover nearly all major islands and the rural northern half of Oahu. 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 with insufficient health resources (staffing/facilities/services) to meet the population's medical needs. MUAs include Kauai, Molokai, Hawaii Island,

rural/high-poverty areas on Oahu, and the East area of Maui.

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 (personnel, facilities, services) or a population group having a shortage of such services. MUPs include Lanai, West Maui, and a part of Oahu that includes the community of Wahiawa. Not all these populations overlap with MUA or professional shortage areas.

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 from 18,938 in 2017 to 22,327 in 2022.[33]

Under 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.[34] 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 several components of the ACA into the PHCA to ensure the benefits remained available under Hawaii law: including dependent coverage for children until 26 years and prohibiting a preexisting condition exclusion and the use of gender to determine premiums.

Through these efforts, Hawaii consistently reports low uninsured rates:3.9% in 2021.

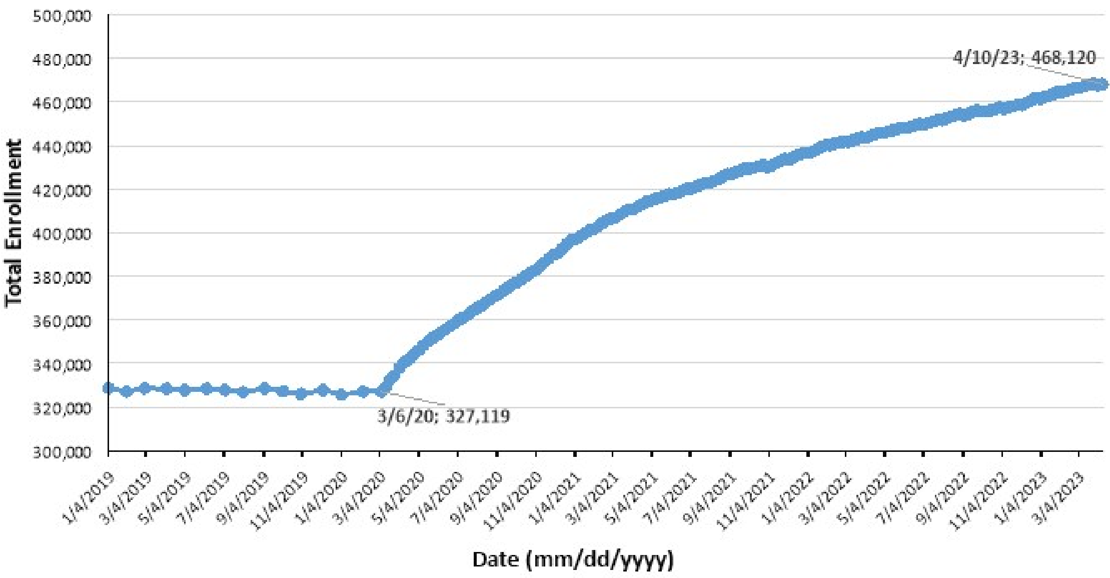
MEDICAID

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 **T**ransform the way healthcare is provided to recipients. QUEST's objectives are: to expand medical coverage to populations previously ineligible for Medicaid and to contain costs by shifting to a managed care delivery system. Savings realized would be used to expand coverage. Under this waiver, Medicaid beneficiaries, excluding those with disabilities and over 65, received their services through managed care.

Medicaid eligibility levels for children in Hawaii 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 individuals from coverage. Hawaii Medicaid enrollments increased by 37.0% for the duration of the pandemic, with over 448,193 enrollees statewide from March 2020 to July 2023. The County of Maui had the largest increase (41.2%) in enrollment compared to Kauai County (37.8%), Honolulu County (38.1%), and Hawaii County (31.3%).



Of the 448,193 individuals enrolled in Medicaid, 157,386 are children.[35] The Medicaid Program also provided coverage for 3,397 pregnant women. Additionally, the program continues to support medically needy children who require nursing home level of care.

Adult COFA who make up a large proportion of the Pacific Islander population in Hawaii were ineligible for federal Medicaid coverage since 1996. In December 2020, federal Medicaid eligibility was finally restored to COFA migrants. As of February 7, 2022, there were 9,257 COFA adults enrolled with Med-QUEST.

The state'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 can choose 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 the Kaiser Foundation Health Plan, which operates only on the islands of Oahu and Maui.

Medicaid Unwinding. The state Medicaid program has launched a media campaign to ensure all eligible Medicaid enrollees stay covered: *Stay Well, Stay Covered*, which includes a website with information available in 14 languages. Eligibility redeterminations began April 1, 2023, and will continue into 2024. Enrollees can keep their coverage until their renewal date but must be found eligible to keep coverage any further. The first renewal notices began in April for people whose renewal is scheduled for May. The first round of disenrollments begins in June for those who were either found to be no longer eligible or who failed to respond to a renewal notice.

Unhoused enrollee renewals will be processed at the end of the unwinding period. And dual-eligible enrollees (eligible for Medicare and Medicaid) who become eligible for Medicare between April and September 2023 will not go through a Medicaid eligibility redetermination until six months after their Medicare begins.

For those no longer eligible for Medicaid, a 16-month special enrollment period is available on HealthCare.gov.

GOVERNMENT

The state's Executive Branch of government is organized into 16 cabinet-level agencies. The major health programs are administered by DOH and by 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 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), responsible for administrating 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.

Hawaii remains a strong Democratic state with very few Republicans that hold public office. Hawaii elected a new democratic Governor, Josh Green, MD, in 2022. Green served as the Lt. Governor in the past administration during COVID. The new DOH Director is Kenneth S. Fink, MD, MGA, MPH; Debbie Kim Morikawa is the new Deputy Director for HRA. Matthew J. Shim, PhD, MPH, remains 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 a listing of statutes pertaining to the division programs, see the Supporting Documents.

Legislature

In 2022, the legislature used a $2B surplus to appropriate funds toward alleviating financial hardships for resident families, including:

- $1B for affordable housing
- Raised the minimum wage
- Passed several tax credits to help low-income and working families: Earned Income, Child/Dependent Care, Food/Excise tax credits
- Extended Medicaid coverage for postpartum care to 12 months and restored comprehensive adult dental care
- Increased preschool subsidies and funds for public preschool classrooms.

With another $1.7B surplus, the 2023 Legislature expanded supports for residents, including:

- Funds to expand emergency housing and wrap-around services for homeless
- Funds to support housing for teachers and those with disabilities
- Funds to upgrade/expand neighbor island hospitals
- $30M in loan forgiveness to recruit/retain healthcare workers
- Expansion of preschool and childcare supports and workforce training
- Doubling the earned income tax credit (although other key tax credits, paid family, and sick leave policies

failed).

The Legislature also strengthened and expanded protections for reproductive healthcare access and abortion services, as well as gun safety laws, in response to recent Supreme Court rulings.

Despite these bright spots, this year's legislature saw members openly criticize the session for a lack of transparency and the underfunding of food security programs and education while funding salary raises for legislators.

COVID-19 and Response

Hawaii managed the COVID-19 pandemic better than many other states. This was reflected in consistently low COVID case numbers, hospitalizations, and deaths. The state'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 restrictions. The governor issued over 20 COVID-related emergency proclamations that mandated 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 to reduce disease spread. With community partners, the state also implemented COVID-19 testing, contact tracing, and systematic vaccination rollout. The state cautiously relaxed COVID restrictions in March 2022, making Hawaii the last state to end an indoor mask mandate.

The community spread of COVID-19 remains low yet steady through June 2023, with 296,454 cumulative cases and 1,884 deaths since the beginning of the pandemic. Positive case numbers are considered underestimated since many residents now test from home. Fatalities are largely among the elderly now (80%). COVID disparities continue with Native Hawaiians, Filipinos, and Pacific Islanders experiencing higher infection and death rates. Roughly 25% of the state's population has not contracted COVID (43.5% for those 65 and older).

As of June 2023, 78.8% of the state's population was fully vaccinated, a relatively high vaccination rate. Those receiving a booster or bivalent shots are 23%, similar to the U.S. average. In 2022, the state transitioned from a COVID emergency response to disease management. DOH collects and publicly releases COVID data weekly, although the CDC discontinued reporting, making national comparisons more difficult. DOH continues to issue advisories on current COVID-19 recommendations and works with key partners to ensure that accurate guidance and culturally tailored messaging are shared.

Hawaii continues to monitor significant consequences of the pandemic, including long COVID, mental health issues, other comorbidities, and socioeconomic determinants that pose healthcare challenges.

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[1] Due to the impact of COVID-19, 2020 Census data for population estimates is unavailable. Instead of providing the standard 1-year data products, the Census Bureau released experimental estimates from the 1-year data. Therefore, population comparison with 2019 will be provided here.

[2] with no single-race majority.
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III.C. Needs Assessment
FY 2024 Application/FY 2022 Annual Report Update

C.1 Needs Assessment Update Background and Context

The Needs Assessment (NA) update

The COVID-19 pandemic is unprecedented in this generation and has far-ranging impacts across the health, economic, education, and employment sectors in Hawaii. Ongoing needs assessment builds upon the 2020 Title V Five-Year Needs Assessment (NA) and continues with data collection and analysis.

In addition to reviewing primary and secondary data sources, NA efforts involved collecting input from staff/programs and external stakeholders to understand changing needs and priorities as the state moves into a new phase of the pandemic. The information collected informs Hawaii 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 reviewed the FAD dataset and completed a summary that highlights trends, national comparisons, and disparities. The summary can be found in the Supporting Documents.

C.1.a. Ongoing Needs Assessment Activities

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

- Title V data support for this annual report was secured through the University of Alabama Birmingham (UAB) MCH and Evaluation/Assessment Collaborative. UAB developed the FAD summary found in this section.
- 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.
- Hawaii Children's Action Network is completing a survey for the Early Childhood Comprehensive System (ECCS) grant of pregnant women and families with young children to help inform the ECCS strategic plan activities.
- The University of Hawaii Center on the Family is completing a series of county profiles of WIC clients, part of an ongoing analysis of Hawaii's WIC data.
- deBeaumont Foundation, Public Health Workforce Interests and Needs Survey (PH WINS) epidemiologist is conducting analysis of the workforce data for FHSD planning
- Data from the 2019-2020 Pregnancy Risk Assessment Survey (PRAMS) Hawaii emergency preparedness (EP) module was shared with the DOH Emergency Preparedness program.

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 in each

population domain that suggest worsening health in certain key areas. These trends are highlighted by domain in this section. There are challenges with relying on the FAD and its source data for an overview of MCH health, particularly for the state of Hawaii. Race and ethnic groups used in the FAD combine several categories, namely Asian, Native Hawaiian, and Pacific Islander, which are important to disaggregate in Hawaii to accurately describe the population and key health inequities. From state-collected data, it is apparent that persistent racial and ethnic disparities continue. In general, White, Japanese, and Chinese groups fare better on most health outcomes than Filipino, Native Hawaiian, or Other Pacific Islander races 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.

Methodology

For all NPMs and NOMs associated with each population domain, the most recent values, comparison to the nation, and trend over time were gathered from the 6-26-2023 federally available data (FAD) update. Indicators were sorted into categories: maintained trends better than or comparable to the nation, changing trends or needing improvement, and no comparison or trends available.

The comparisons and trends presented in the tables for each domain align with the statistical analysis provided in the FAD. Due to the limitations of the source data, it is important to recognize that while differences in data may not be statistically significant, it may have substantive significance and represent trends that are important to monitor related to overall progress and identification of disparities. Any indicator that did not have analysis to determine a national comparison or state trend is noted as "Not Provided."

Disaggregated data were analyzed for each indicator to identify disparities and inequities that could inform program planning. Disparities are described in summaries beneath each domain indicator table. Four categories are used in the "Disparities Identified" column to describe disparities in disaggregated data:

Label	Definition
Yes	Disaggregated data were available and indicated statistically significant differences between stratifier subgroups.
No	Disaggregated data were available and did not indicate statistically significant differences between stratifier subgroups.
N/A*	Disaggregated data were available but due to small sample size and broad confidence limits most subgroup data carried interpretation warnings or were suppressed, limiting ability to determine statistically significant differences.
N/A**	Disaggregated data were unavailable.

For indicators where the age range spans the Child and Adolescent domains, the original data source was used to determine the estimate that reflects that age range appropriate for the specific domain. These values are italicized and indented under the indicator total value.

Maternal/Women's Health Domain

An estimated 304,948 women of reproductive age (WRA), aged 15-49 years, live in Hawaii, making up 42.6% of the female population in the state (ACS, 2021). Most WRA in Hawaii are White (25.7%), followed by Native Hawaiian (19.8%), Filipino (17.0%), and Japanese (17.0%), with all other groups under 11%, respectively (BRFSS, 2021). Compared to the state's population, the proportion of WRA is consistent with those that are not WRA. Most WRA are married (52.2%), heterosexual (93.1%), a high school (30%) or college graduate (32.6%) and employed (53.4%) with an annual household income of $75,000 or more (42.8%).

For the following maternal health indicators, Hawaii either performs similar to the U.S. or comparisons cannot be determined from available data. State trends could not be determined for all indicators in the table below.

Maternal/Women's Health Indicators	Most Recent Value	Comparison to U.S.	State Trend	Disparities Indicated
NPM 13.1: Preventive dental visit – during pregnancy	44.6%	Not provided	Not provided	Yes
NPM 14.1: Smoking – during pregnancy	1.7%	Better	Trending better	Yes
NOM 3: Maternal mortality	16.1 per 100,000	About the same	Not provided	N/A**
NOM 7: Early elective delivery	1.0%	Not provided	Not provided	N/A**
NOM 24: Postpartum depression	14.4%	Not provided	Not provided	No

***Disaggregated data unavailable*

- NPM 13.1: Preventive dental visit during pregnancy: While Hawaii performs better than the U.S. on this measure, examining disaggregated data from 2021 highlighted disparities according to marital status and WIC participation. Of unmarried individuals, 35.6% attended this visit. Of WIC participants, 32.6% attended this visit.

- NPM 14.1: Smoking during pregnancy – Hawaii performs better than the U.S. and demonstrates improvement on this measure. Examining disaggregated data from 2021 highlighted the following disparities.

Stratifier	Stratifier Subgroup	Most Recent Value
Educational Attainment	High school graduate	4.8%
Health Insurance	Medicaid	3.7%
Marital Status	Unmarried	3.2%
Nativity	Born in U.S.	2.1%
Race/Ethnicity	Hispanic	2.5%
	Non-Hispanic Multiple Race	2.8%
WIC Participation	Yes	2.4%

The following table presents worse performance compared to the nation or worsening trends within the state.

Maternal/Women's Health Indicators	Most Recent Value	Comparison to U.S.	State Trend	Disparities Indicated
NPM 1: Well-woman visit	69.5%	About the same	Not provided	No
NPM 2: Low-risk cesarean delivery (first births)	22.8%	Better	Trending worse	Yes
NOM 1: Early prenatal care	71.6%	Worse	Trending worse	Yes
NOM 6: Early-term birth	29.0%	About the same	Trending worse	Yes

***Disaggregated data unavailable*

- NPM 2: Low-risk cesarean delivery (first birth) – Examining disaggregated data from 2021, 25.9% deliveries to individuals born outside the U.S. were cesarean deliveries for low-risk first births. Of individuals older than 35 years, 32.6% deliveries were cesarean for low-risk first births.

- NOM 1: Early prenatal care: Hawaii performs worse than the U.S. and demonstrates a worsening trend on this measure.

Stratifier	Stratifier Subgroup	Most Recent Value
Educational Attainment	Less than high school	50.4%
Health Insurance	Medicaid	59.7%
	Uninsured	57.6%
Marital Status	Unmarried	63.7%
Maternal Age	<20 years	60.8%
Nativity	Born outside U.S.	64.7%
Race/Ethnicity	Non-Hispanic Native Hawaiian/Other Pacific Islander	43.9%
Urban-Rural Residence	Non-Metro	69.0%
WIC Participation	Yes	67.0%

- NOM 6: Early term birth: Hawaii performs similarly to the U.S. and demonstrates a worsening trend on this measure.

Stratifier	Stratifier Subgroup	Most Recent Value
Educational Attainment	Less than high school	32.3%
Health Insurance	Medicaid	30.7%
	Private	30.5%
Race/Ethnicity	Non-Hispanic Asian	34.8%
WIC Participation	Yes	31.3%

Perinatal/Infant Health Domain

In 2021, there were 15,637 births to Hawaii residents. In 2021, the fertility rate was 58.8 per 1,000 for women aged 15-44 years. Hawaii fertility rates declined from 2019 to 2021 (63.5, 58.8, 58.8, respectively). Among teen mothers 15-19 years, the birth rate is 12.3 per 1,000, similar to the U.S. rate of 15.4, and is highest among NHOPIs. Despite significant decreases in perinatal deaths, the increase in severe maternal morbidity (SMM) is an emerging concern.

For many perinatal health indicators, Hawaii performs similar to or better than the U.S. and demonstrates consistency in these indicators over time. Indicators demonstrating consistent overall maternal health trends include:

Perinatal/Infant Health Indicators	Most Recent Value	Comparison to U.S.	State Trend	Disparities Indicated
NPM 4A: Breastfeeding – initiation	90.1%	Better	Consistent	N/A**
NPM 4B: Breastfeeding – exclusively through 6 months	27.7%	About the same	Consistent	N/A**
NPM 5A: Safe sleep – infant placed on back	83.0%	About the same	Consistent	No
NOM 4: Low birth weight	8.8%	About the same	Consistent	Yes
NOM 5: Preterm birth	10.2%	About the same	Consistent	Yes
NOM 8: Perinatal mortality	5.2 per 1,000	About the same	Consistent	Yes
NOM 9.1: Infant mortality	4.9 per 1,000	About the same	Consistent	Yes
NOM 9.2: Neonatal mortality	2.9 per 1,000	About the same	Consistent	Yes
NOM 9.3: Postneonatal mortality	2 per 1,000	About the same	Consistent	No
NOM 9.4: Preterm-related mortality	145.7 per 100,000	About the same	Consistent	Yes
NOM 9.5: SUID mortality	63.4 per 100,000	About the same	Consistent	N/A**
NOM 11: Neonatal abstinence syndrome	1.4 per 1,000	Better	Not provided	N/A**

***Disaggregated data unavailable*

- NOM 4: Low birth weight – While Hawaii performs comparably to the U.S. and demonstrates a stable trend on this measure, examining disaggregated data from 2021, 11.6% of individuals with less than high school education delivered infants with low birth weight. Of individuals 35 years or older, 11.0% delivered infants with low birth weight. Although maternal age is not amenable to intervention, awareness of age-related risks is critical for conversations and collaborations with clinical providers.
- NOM 5: Preterm birth – While Hawaii performs comparably to the U.S. and demonstrates a stable trend on this measure, examining disaggregated data from 2021, 13.7% of individuals with less than high school education had a preterm birth. Of individuals 35 years or older, 12.4% had a preterm birth. Although maternal age is not amenable to intervention, awareness of age-related risks is critical for conversations and collaborations with clinical providers.
- NOM 8: Perinatal mortality – While Hawaii performs comparably to the U.S. and demonstrates a stable trend on this measure, examining disaggregated data from 2018 - 2020, individuals not participating in WIC demonstrated a perinatal mortality rate of 4.8 fetal deaths per 1,000 live births. Multiple births had a perinatal mortality rate of 20.9 fetal deaths per 1,000 live births.
- NOM 9.1: Infant mortality – While Hawaii performs better than the U.S. and demonstrates a stable trend on this measure, examining disaggregated data from 2018 - 2020, individuals younger than 20 years old had an infant mortality rate of 12.3 infant deaths per 1,000 live births.
- NOM 9.2: Neonatal mortality – While Hawaii performs better than the U.S. and demonstrates a stable trend on this measure, examining disaggregated data from 2018 – 2020, individuals not participating in WIC

demonstrated a neonatal mortality rate of 3.9 infant deaths per 1,000 live births.

- NOM 9.4: Preterm-related mortality – While Hawaii performs better than the U.S. and demonstrates a stable trend on this measure, examining disaggregated data from 2018 – 2020, individuals with other public health insurance coverage (not Medicaid) demonstrated a preterm-related mortality rate of 346.3 infant deaths per 100,000 live births. Of note, data were suppressed for individuals without any health insurance.

The following table presents areas where Hawaii performs similarly or worse than the nation, and state trends cannot be determined from the available data.

Perinatal/Infant Health Indicators	Most Recent Value	Comparison to U.S.	State Trend	Disparities Indicated
NPM: 5B: Safe sleep- separate approved sleep surface	27.7%	Worse	Not provided	Yes
NPM 5C: Safe sleep- no soft bedding	52.0%	About the same	Not provided	Yes

- NPM 5B: Safe sleep – separate approved sleep surface – Examining disaggregated data from 2021, 21.0% of unmarried individuals put their infant to sleep on a separate approved sleep surface.
- NPM 5C: Safe sleep – no soft bedding

Stratifier	Stratifier Subgroup	Most Recent Value
Health Insurance	Medicaid	41.1%
Marital Status	Unmarried	41.4%
Urban/Rural Residence	Non-Metro	39.8 %
WIC Participation	Yes	38.5%

Child Health Domain

According to 2023 KIDS Count data, the state has 304,399 children under 18 years old, roughly 21% of the total population. Since 2012, there has been a steady decline in the percentage of children under 18 years old, explained by declining birth rates and the growing aging population. Compared to the overall state population, children in Hawaii are more likely to be of two or more races (32% vs. 26.3%), Hispanic or Latino (20% vs. 11.1%), or NHOPI (12% vs. 10.1%), and less likely to be Asian (22% vs 37.2%) or White (13% vs 22.2%). Prior to the COVID outbreak, the economic well-being of Hawaii's children, in general, had been improving since 2010 (14%); however, the proportion of children in poverty in 2021 increased (11.2%). A smaller percentage of children in Hawaii (22%) live in single-parent households compared to all U.S. children (26.8%).

For many child health indicators, Hawaii performs similar to or better than the U.S. and demonstrates consistency or improving trends in these indicators over time. Indicators demonstrating consistent overall child health trends include:

Child Health Indicators	Most Recent Value	Comparison to U.S.	State Trend	Disparities Indicated
NPM 6: Developmental screening	41.0%	About the same	Consistent	No
NPM 7.1: Non-fatal injury hospitalizations	62.4 per 100,000	Better	Trending better	No
NPM 11: Children (0-17) with a medical home *NPM 11: Children (0-11) with a medical home*	48.5% *49.9%*	About the same	Consistent	Yes
NPM 13.2: Preventive dental visit (1 – 17 years) *NPM 13.2: Preventive dental visit (1 – 11 years)*	84.9% *82.6%*	Better	Consistent	Yes
NPM 14.2: Someone living in the household smokes (0 – 17 years) *NPM 14.2 Someone living in the household smokes (0 – 11 years)*	14.7% *13.7%*	About the same	Consistent	Yes
NPM 15: Adequate and continuous insurance (3-17 years) *NPM 15: Adequate and continuous insurance (3 – 11 years)*	81.0% *83.2%*	Better	Consistent	No
NOM 14: Children (1-17 years) with decayed teeth or cavities *NOM 14: Children (1 – 11 years) with decayed teeth or cavities*	10.6% *12.4%*	About the same	Consistent	No
NOM 15: Child mortality	7.7 per 100,000	Better	Consistent	No
NOM 18: Children (3-17) with mental health treatment *NOM 18: Children (6-11 years) with mental health treatment*	45.4% *38.5%*	About the same	Consistent	No

NOM 19: Children (0-17) in very good or excellent health *NOM 19: Children (0-11 years) in very good or excellent health*	92.5% *95.0%*	Better	Consistent	No
NOM 20: Obesity – (2-4 years)	10.7%	Better	Consistent	Yes
NOM 22.1: Child vaccination – 7-vaccine series by 24 months	79.2%	Better	Consistent	No
NOM 25: Children (0-17 years) not able to obtain health care in the last year *NOM 25: Children (0-11 years) not able to obtain health care in the last year*	3.1% *2.6%*	About the same	Consistent	No

- General Health and Well-Being:
  - NPM 14.2: Someone living in the household smokes – While Hawaii performs better than the U.S. and demonstrates a stable trend for this measure, examining disaggregated data from 2020 – 2021, 27.3% of children in a home where the highest education attainment of an adult in the house is high school and 19.2% where an adult attended some college live in a household where someone smokes.
  - NOM 20: Obesity (2 – 4 years) – While Hawaii performs better than the U.S. and demonstrates a stable trend for this measure, examining disaggregated data from 2020, 11.9% of male children were obese.
- Oral Health
  - NPM 13.2: Preventive dental visit (1 – 17 years) – While Hawaii performs better than the U.S. and demonstrates a stable trend for this measure, examining disaggregated data from 2020 – 2021, 27.9% of children in a home where the primary household language is not English did not receive a preventive dental visit.
- Health Care Access
  - NPM 11:Children (Non-CSHCN) with a medical home – While Hawaii performs comparably to the U.S. and demonstrates a stable trend on this measure, examining disaggregated data from 2020-2021, only 30.7% of children in homes where the primary household language is not English receive care that meets medical home criteria.

The following table presents worse performance compared to the nation or worsening trends within the state.

Child Health Indicators	Value	Comparison to U.S.	State Trend	Disparities Indicated
NPM 8.1: Physical activity (everyday)	21.4%	Worse	Consistent	No
NOM 17.4: Children (3-17) diagnosed with ADD/ADHD *NOM 17.4: Children (3-11 years) diagnosed with ADD/ADHD*	9.5% *4.8%*	Worse	Consistent	Yes
NOM 22.2: Children (6 mos.- 17 years) with annual flu vaccination *NOM 22.2: Children (6 mos.- 12 years) with annual flu vaccination*	57.5% *60.1%*	About the same	Trending worse	No

- NOM 17.4: Children (3-17) diagnosed with ADD/ADHD: Examining disaggregated data from 2020 – 2021, 8.0% of male children currently have a diagnosis of ADD/ADHD.

Adolescent Health Domain

There are an estimated 213,100 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.

For many adolescent health indicators, Hawaii performs similarly to or better than the U.S. and demonstrates consistency in these indicators over time. Indicators demonstrating consistent overall child health trends include:

Adolescent Health Indicators	Most Recent Value	Comparison to U.S.	State Trend	Disparities Indicated
NPM 7.2: Non-fatal injury hospitalizations	164.9 per 100,000	Better	Trending better	Yes
NPM 8.2: Physical activity (everyday)	13.3%	About the same	Consistent	N/A*
NPM 9: Bullying (victimization)	22.7%	Better	Trending better	Yes
NPM 9: Bullying (perpetration)	9.2%	About the same	Consistent	Yes
NPM 10: Adolescent well-visit	66.3%	About the same	Consistent	N/A*
NOM 16.1: Adolescent mortality	26.3 per 100,000	Better	Consistent	Yes
NOM 16.2: Adolescent motor vehicle death	6.1 per 100,000	Better	Consistent	N/A*
NOM 16.3 Adolescent suicide	12.1 per 100,000	About the same	Consistent	N/A*
NOM 22.3: HPV vaccination	83.8%	Better	Trending better	Yes
NOM 22.4: Tdap vaccination	88.6%	About the same	Trending better	Yes
NOM 22.5: Meningitis vaccination	88.0%	About the same	Trending better	Yes
NOM 23: Teen births	12.3 per 1,000	Better	Trending better	Yes

**Disaggregated data were available, but small sample sizes and broad confidence intervals limited ability to identify statistically significant disparities.*

- NPM 7.2: Injury hospitalizations – Hawaii performs better than the nation and has improved in injury-related hospitalizations. Disparities are present in these data. More adolescents aged 15-19 years (233.9 per 100,000) are hospitalized compared to adolescents aged 10-14 years (99.3 per 100,000). More males (197.5 per 100,000) are hospitalized compared to female adolescents (130.4 per 100,000).
- NPM 9: Bullied, age 12-17 years – While Hawaii trends better than the U.S. and has been trending better, disparities are present. Data from 2020-2021 shows that more females (27.5%) are bullied in Hawaii than males (18.9%). Non-Hispanic adolescents are also more likely to be bullied compared to other races.
- NPM 9: Bullied others, ages 12-17 – Hawaii performs worse compared to the national percentage of adolescents who bully others and has trended consistently over time. Data from 2020-2021 shows that more males (10.9%) bully compared to female adolescents (7.1%). Non-Hispanic adolescents are more likely to bully compared to other races.
- NOM 16.1: Adolescent mortality – Hawaii performs better than the nation in adolescent mortality but has been trending consistently. Data from 2019-2021 shows that 15–19-year-olds (38.2%) are more likely to die than 10–14-year-olds (14.7%). Males (35.6%) are also more likely to die than female adolescents (16.1%).
- NOM 22.3: HPV vaccination – Hawaii performs better than the nation and has improved over time. Data from

2019-2021 shows that those with private insurance (85.7%) are more likely to be vaccinated than those with other public insurance (69.1%). White adolescents (71.5%) are also less likely to be vaccinated than Asian adolescents (89.0%).

- NOM 23: Teen births – Hawaii performs better than the nation and continues improving around teen births. Disparities are present in maternal age. Adolescents aged 18-19 years (26.2 per 1,000) have higher rates of teen births compared to those aged 15-17 years (3.8 per 1,000). FAD data shows that the percentages of Asians (2.9%) and Whites (8.8%) were lower than Hispanics (19.8%), Native Hawaiians/Other Pacific Islanders (19.6%), and Multiple Races (15.9%).
- NOM 22.4: Tdap vaccination of adolescents – Hawaii performs consistently with the nation but has been trending better. More adolescents with private insurance (90.4%) are vaccinated compared to those with Medicaid (79.2%) and other public insurance (81.3%).
- NOM 22.5: Meningitis vaccination of adolescents – Hawaii performs consistently with the nation but has been trending better. Disparities are present in these data. More adolescents with private insurance (90.4%) get vaccinated compared to Medicaid (82.5%) and other public insurance (74.9%).

The adolescent health indicator for which Hawaii performs similarly to the U.S. with a worsening trend over time identified in the following chart:

Adolescent Health Indicators	Most Recent Value	Comparison to U.S.	State Trend	Disparities Indicated
NOM 20: Obesity – ages 10-17	17.1%	About the same	Trending worse	Yes

- NOM 20: Obesity, age 10-17 years – Hawaii is consistent with the national average for obesity but has been trending worse. More males (23.2%) are obese compared to female adolescents (10.4%).

CSHCN Domain

The population of CSHCN in Hawaii is estimated to be 39,320. According to data from 2020-2021 (NSCH), 13.2% of children ages 0-17 years in Hawaii have special needs, significantly lower than the national estimate (19.5%). This difference may be due to the small sample size of CSHCN in Hawaii (N=316). About 16.0% are identified as "other, non-Hispanic" race, followed by Asian (10.5%), White (11.3%), and 12.2% Hispanic/Latino (data on race/ethnicity was missing for about 3% of CSHCN in Hawaii). Among CSHCN, there are more males (15.8%) than females (10.3%), a trend that was also observed nationally. Adolescents (19.5%) were more likely to have special health care needs compared to 0-5 years (7.3%) and 6-11 years (13.3%). Other non-Hispanic children (16.0%) were more likely to have a special health care need compared to Hispanic (12.2%), White (11.3%), and Asian (10.5%).

For many CSHCN indicators, Hawaii performs similarly to or better than the U.S. and demonstrates consistent trends over time. These indicators are highlighted in the table below.

CSHCN Indicators	Most Recent Value	Comparison to U.S.	State Trend	Disparities Indicated
NPM 11: Medical home	43.7%	About the same	Consistent	N/A*
NPM 12: Transition	21.9%	About the same	Consistent	N/A*
NPM 15: Adequate insurance	81.0%	Better	Consistent	N/A*
NOM 17.2: CYSHCN systems of care (received all components of a well-functioning system: family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition)	20.1%	Better	Consistent	N/A*

**Disaggregated data were available, but small sample sizes and broad confidence intervals limited ability to identify statistically significant disparities.*

Federally available data (FAD) identifies the following indicators in which Hawaii has lower values than the nation and maintains a consistent trend (this does not indicate “worse” performance given the nature of these indicators). Hawaii has statistically significantly lower rates of these diagnoses compared to the nation.

CSHCN Indicators	Most Recent Value	Comparison to U.S.	State Trend	Disparities Indicated
NOM 17.1: Children (0-17) with special health care needs	13.2%	Lower	Consistent	Yes
NOM 17.3: Children (3-17) diagnosed with autism spectrum disorder	1.7%	Lower	Consistent	N/A*
NOM 17.4: Children (3-17) diagnosed with ADD/ADHD	5.9%	Lower	Consistent	Yes

**Disaggregated data were available, but small sample sizes and broad confidence intervals limited ability to identify statistically significant disparities.*

- NOM 17.1: Children with special health care needs – While Hawaii performs better than the nation and is trending consistently, disparities are present in available data. Males are also more likely to have special health care needs (15.8%) compared to female children (10.3%).
- NOM 17.4: Children aged 3-17 years diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) – Hawaii performs worse than the nation in this measure but has been consistent over time. Disparities are present based on sex of child. More males (8.0%) currently have ADD/ADHD compared to female children (3.7%).

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 265 FTE staff, of which 17 FTE are Title V-funded, and 37 FTE are located on neighbor islands.

	Total FTE	Title V FTE*	Hawaii FTE	Maui FTE	Kauai FTE
FHSD	29.5	2.5	2.0	2.0	2.0
MCH Branch	34	6.5	1.0	0	0
CSHN Branch	133.5	8	4.0	3.0	2.0
WIC Branch	68.0	0	12.0	6.0	4.0
TOTAL	**265.0**	**17**	**18.0**	**11.0**	**8.0**

**Includes vacant positions.*

FHSD's staffing decreased overall by 12 FTE, including 2.5 Title V funded FTE. Most positions were lost due to long-standing vacancies. However, the Division did receive several new positions for Lead and Newborn Metabolic Screening programs and Early Intervention Services (including a clinical psychologist). Although the number fluctuates, the Division vacancies numbered roughly 60 positions.

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 (Hawaii Maternal Infant Health Coalition, 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/funding, and community input. Staff often 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. The priorities address health equity and social determinants of health:

- 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 guidance and in collaboration with community partners.

Other Plan Changes: Many planned FY 2022 activities were delayed or revised due to COVID-related changes or consequences such as staffing shortages. The lack of epidemiology staff hindered more detailed data analysis and also evaluation initiatives. All Title V programs continue ongoing assessment activities through collaboration with university researchers and private consultants.

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 changed with the election of a new Governor. New DOH leadership is reflected in the revised org chart, including new DOH Director and Health Resources Administration Deputy. This change did not impact the FHSD leadership.

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[1] The Title V federally available dataset (FAD) includes all Title V National Performance and Outcome Measures data. States have the option to utilize other local data sources to provide more timely and disaggregated analyses.

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

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,077,106	$2,055,426	$2,083,027	$2,021,007
State Funds	$31,499,929	$26,944,383	$31,499,929	$26,180,239
Local Funds	$0	$0	$0	$0
Other Funds	$203,441	$49,934	$0	$0
Program Funds	$13,584,510	$8,622,714	$18,439,145	$19,530,529
SubTotal	$47,364,986	$37,672,457	$52,022,101	$47,731,775
Other Federal Funds	$45,765,848	$30,928,565	$37,230,305	$37,566,837
Total	$93,130,834	$68,601,022	$89,252,406	$85,298,612

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,319,160	$1,587,890	$2,138,833	
State Funds	$29,759,413	$28,217,762	$29,962,854	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$18,474,919	$5,837,054	$18,474,919	
SubTotal	$50,553,492	$35,642,706	$50,576,606	
Other Federal Funds	$40,729,830	$35,299,951	$41,413,149	
Total	$91,283,322	$70,942,657	$91,989,755	

	2024	
	Budgeted	**Expended**
Federal Allocation	$2,195,700	
State Funds	$34,554,745	
Local Funds	$0	
Other Funds	$0	
Program Funds	$18,334,030	
SubTotal	$55,084,475	
Other Federal Funds	$40,373,086	
Total	$95,457,561	

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 2022 Expenditures as reported on the FY 2024 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 265 full and part-time employees in FY 2024, 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. Thus, unlike most states, FHSD must provide all levels of service delivery: direct, enabling, population-based, 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 – together addressed this need with a FY 2022 Program Income budget of $18.3M with same year expenditures of $5,837,054. 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)

Form 2 also notes that expenditures from other federal funds administered through the various FHSD programs in FY 2022 totaled $36,887,841. These other federal fund expenditures include programs such as WIC ($22.3M), Home Visiting (MIECHV) ($3M), Early Intervention (Part C) ($2.2M), Genetic Services ($655K), and 20 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 31,592 broken out as follows:

Pregnant Women: 962
Infants < 1 Years of Age: 1,002
Children 1 through 21 Years of Age: 9,384
Children with Special Health Care Needs: 6,768
Others: 20,244

Form 5b estimates FHSD programs using all funding sources were able to reach: 99% of the Pregnant Women, 100% of all Infants < 1 year of age, 99.3% of Children 1-21 years of age, 99.3% of Children with Special Health Needs (0-21 years of age) and 62.6% of Others.

Use of Title V Funds. To support the infrastructure needed to administer FHSD programs statewide in FY 2022, Title V funds were used for key staff positions (17 FTE out of a total of 265 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 and 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.

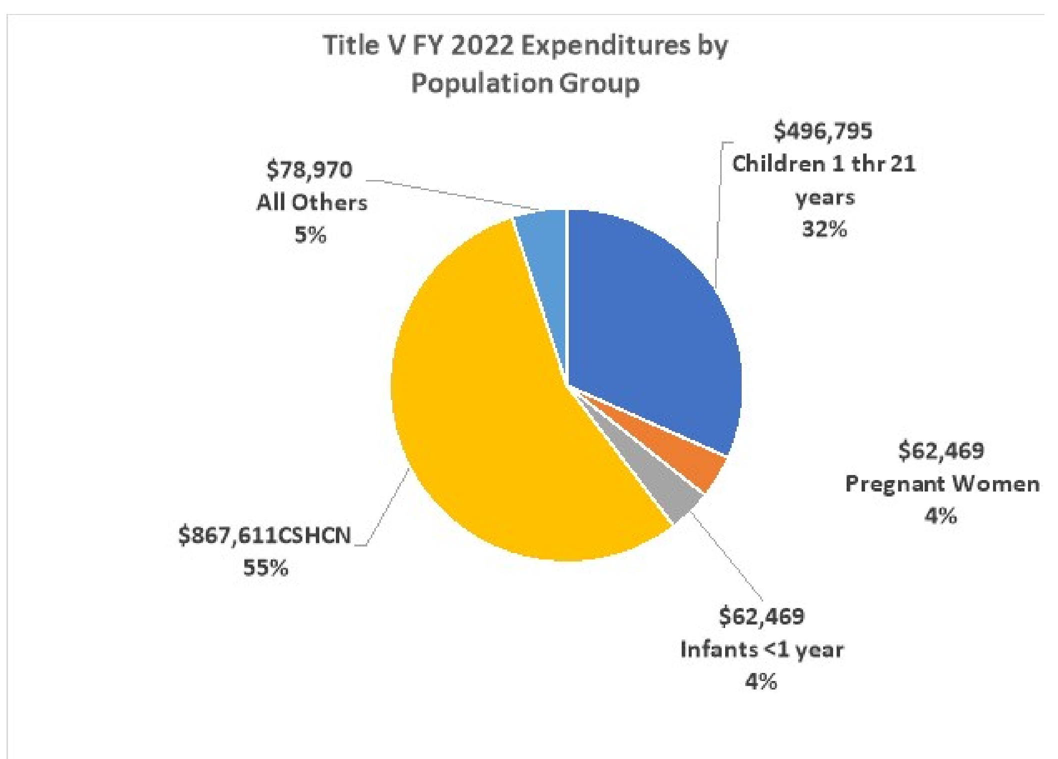
Legislative Requirements Met. The State maintains expenditure and budget documentation for all MCH Block Grant funding allocations for tracking and reporting. Consistent with the requirements in the Title V legislation, expenses are tracked through the state accounting system, *Datamart*, and carefully 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 administrative purposes. Form 2 reports that Hawaii met these requirements for FY 2022 expenditures. The table below outlines the FY 2024 budget and FY 2022 expenditures across these categories. Preventive/Primary care for children was 32.1% of FY 2022 Title V expenditures, while CSHCN received 54.8% of Title V funds in the same year. Hawaii kept administrative costs relatively low (0.2%) because HDOH waives all indirect costs for the Title V grant. For all other federal grants, the HDOH charges 22.0% in SFY23.

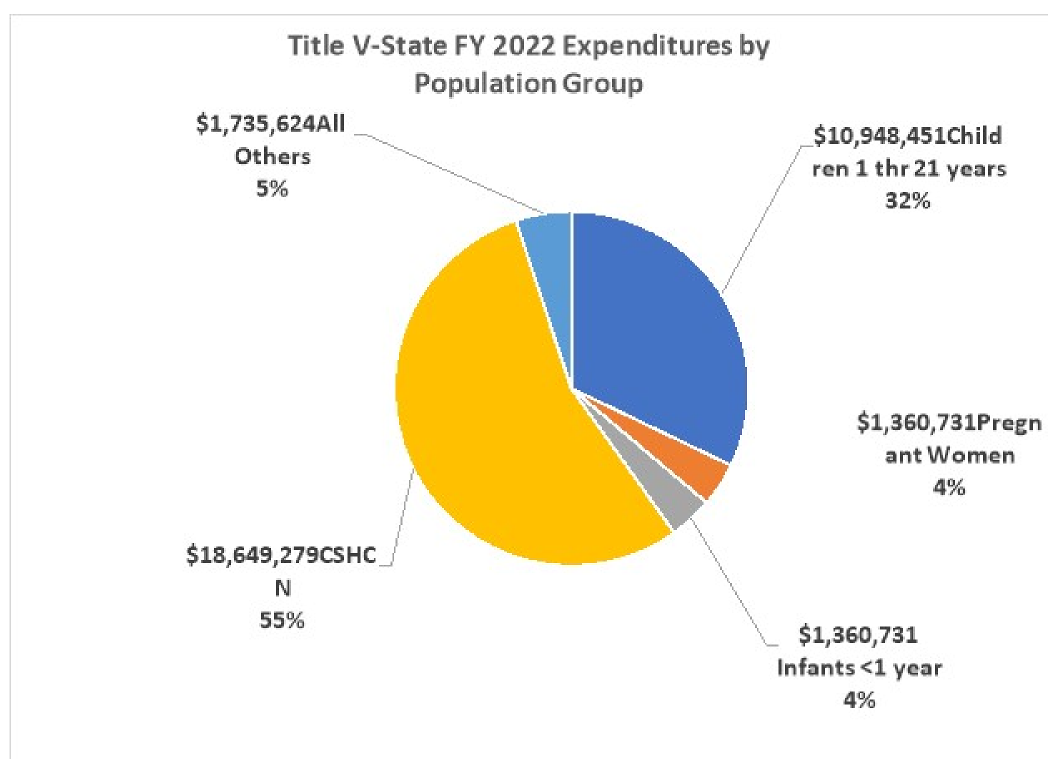
Category	FY 2024 Budgeted		FY 2022 Expended	
Preventive and Primary Care for Children	$774,693	**33.9%**	$496,795	**31.3%**
Children with Special Health Care Needs	$1,171,244	**53.3%**	$867,611	**54.6%**
Title V Administrative Costs	$3,973	**0.2%**	$19,577	**1.2%**

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 2022 state expenditure match of $34.1M far exceeds the match requirement.

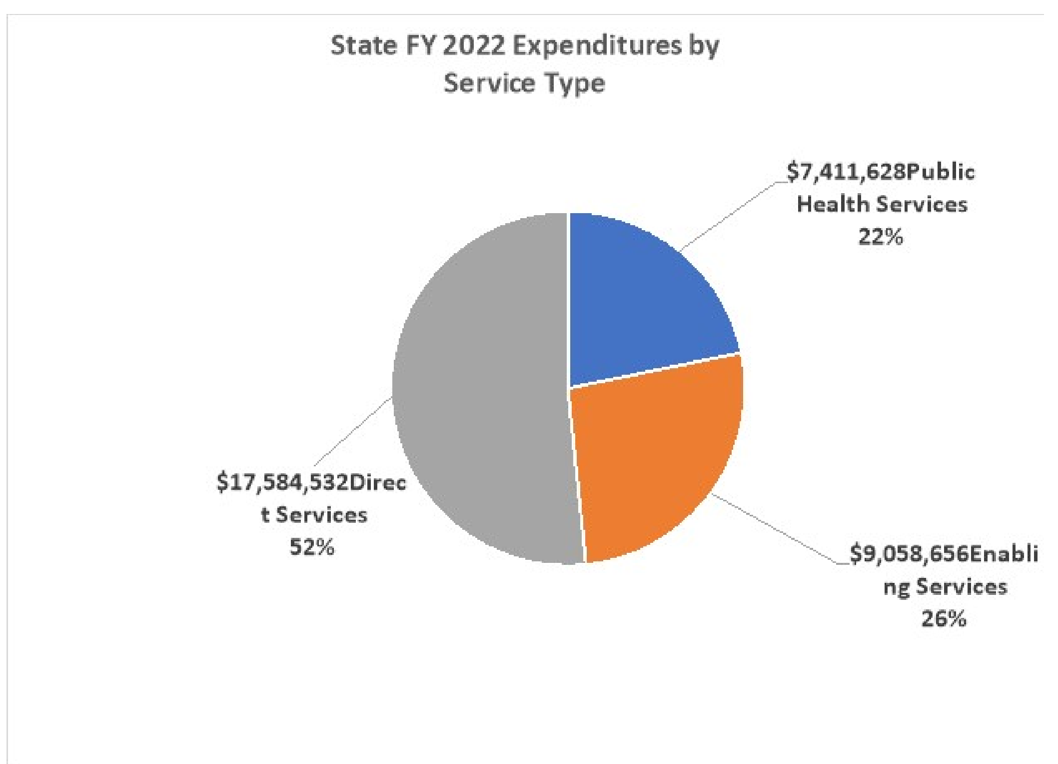
Expenditures by Population Group. The chart below shows how the FY 2022 $1.6M Title V funds were expended to serve the five Title V population groups. The amounts reflect expenditures for FHSD Title V funded personnel (17 FTE in 2022) who support FHSD programs across the state. No Title V funds were used for direct services. The breakouts confirm Hawaii expended over 55% for CSHCN, 32% for Children 1 through 21 Years, 4% for Infants < 1 year, 4% for Pregnant Women, and 5% for All Others.



The chart below shows how the FY 2022 $34.1M 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 (55%). 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 state matching funds in FY 2022 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 52% of all expenditures. The remaining state expenditures were divided between enabling (26%) and public health services (22%). Analysis of these expenditures show Hawaii clearly leveraged Title V funding to advantageously provide infrastructure support for its MCH programs.



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

Service Type	Program
Direct	Community Health Services Family Planning Perinatal Support Services Early Intervention* Primary Care Services for Uninsured Children & Youth with Special Health Needs*
Enabling	Early Intervention* Children & Youth with Special Health Needs* Hawaii Home Visiting Program & Network Hi'ilei Developmental Screening Parenting Support Program Sexual Violence Prevention Teen Pregnancy Prevention WIC Services/ Breastfeeding Support
Public Health Services & Systems	PRAMS Birth Defects Monitoring Newborn Hearing Screening Newborn Metabolic Screening Child, Maternal, Domestic Violence Fatality Review Early Childhood Comprehensive 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 Care Access State Primary Care State Rural Health Small & Medicare Rural Hospitals Flexibility program

Significant Variations – Form 2 and Form 3 (Federal Fiscal Year 2022) – Expenditures

Form 2, Item 1. A. Preventative and Primary Care for Children. There were $344,071 less in expenditures than was budgeted in FY 2022. The variance is directly related to position vacancies after the budget was forecast vs. actual expenditures attributed to CSHCN.

Form 2, Item 3. State MCH Funds. Actual FY 2022 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 2022, expenditures were only 5.18% lower than budgeted. This variance is an improvement from years past.

Form 2, Item 6. Program Income. In FY 2022, the budgeted amount for program income was $18,474,919 but expenditures were $12,637,865 less than budgeted. 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 re-appropriated $10M for a one-time need to address economic uncertainties related to the COVID-19 global pandemic but expenditure returned to normal levels in 2022. 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.

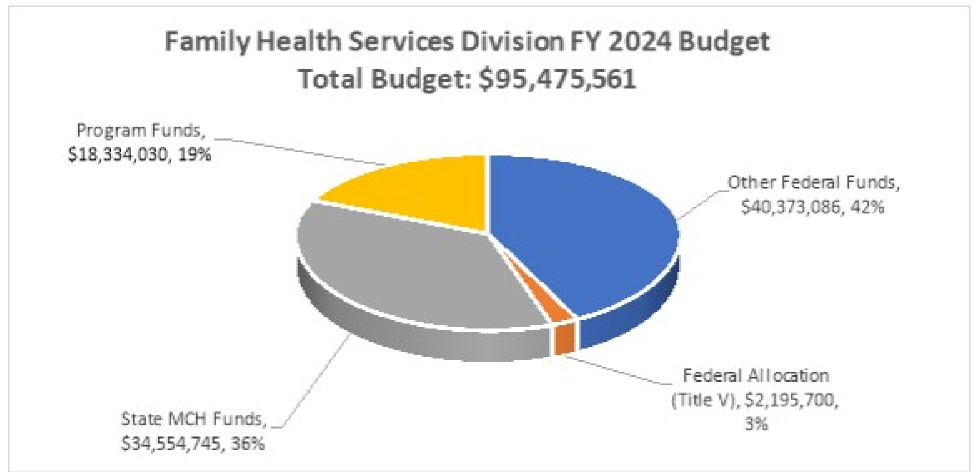
III.D.2. Budget

Budget (FY 2024 Narrative for the FY 2024 Application)

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 accomplished through its division, branch, and District Health Offices consisting of approximately 30 programs and nearly 150 annual service contracts. In federal fiscal year (FY) 2024, FHSD's total state MCH budget is approximately $95M from which Title V will fund 26 unique FHSD positions out of a total of 265 FTE. The FY 2024 budget plan builds on the assessment of state MCH population needs and Title V program needs while maintaining a commitment to complying with the legislative financial requirements and block grant program regulations (e.g., 30% - 30% - 10% requirements).

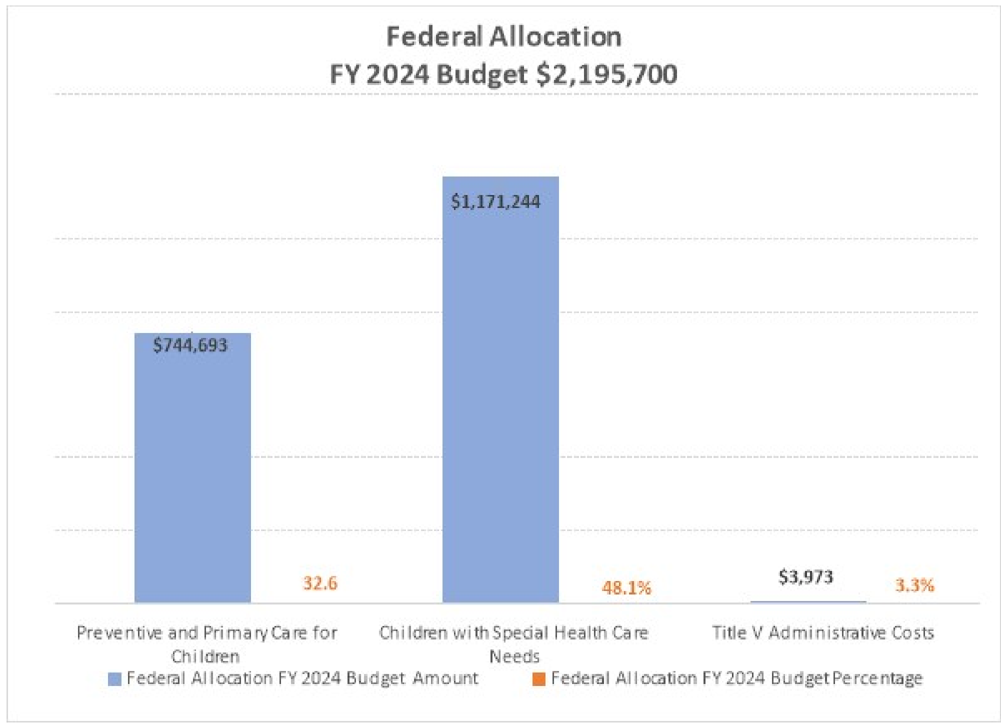
Budget Overview

The chart below provides a quick overview of FHSD's FY 2024 budget as reported on Form 2. The $95M FY 2024 budget is comprised of $2,195,700 from Title V; a State Match of $34.6M (which includes Program Income of $18.3M) and Other Federal Funds totaling $40.4M.



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

FHSD is committed to continued compliance with the legislative financial requirements that a minimum of 30% of Title V funds are used for preventive and primary care services for children; at least another 30% is used for services for children with special healthcare needs (CSHCN); and no more than 10% of the grant used for administrative purposes. For FY 2024, Hawaii is allocating $744,693 (34.8%) for Preventive and Primary Care for Children; $1,171,244 (54.8%) for CSHCN; and $3,972.63 (0.2%) will be budgeted for Title V Administrative Costs as reported on Form 2, Lines 1. A, B, and C.



Federal Funds. The FY 2024 Other Federal Funds budgeted includes 25 federal grants totaling $40.4M (excluding Title V). The Title V allocation is $2.2M, which is roughly 5.4% of all FHSD federal fund appropriations and 2.3% of the overall FHSD total budget.

In FY 2024, the overall FHSD federal fund budget decreased by $765,063 (-1.89%) from FY 2023 in part due to the Coronavirus Aid, Relief, and Economic Security Act (CARES) and American Rescue Plan Act (ARPA) fund appropriations/project periods coming to an end. Missing from the FY24 budget that was present in FY23 is the MIECHV ARPA grant, SHIP Coronavirus grant, and the AMCHP CARES Act: AMCHP Telehealth grant.

As in years past, FHSD relies heavily on federal funding (45% of total current budget). Most grants are used to fund positions that manage and administer federally funded programs. In FY 2022, consistent with recent trends, most of the federal grant funding levels did not increase, creating budget challenges as program costs increased. Operating and personnel costs for federal grants like Title V, Pregnancy Risk Assessment Monitoring System (PRAMS), and Infants and Toddlers with Disabilities IDEA Part C are stretched very thin from rising operating and personnel costs. For example, consistent increases in collective bargaining agreements for public employees contribute to steady increases in salaries and fringe benefits. The FY 2022 indirect cost rate (percentage charged of total salary and fringe) was 25.5% and the fringe benefit rate was set at 52.83%. For programs that rely on grant funding for positions, this can be a substantial expense. As a means of offsetting fixed costs, in some cases, FHSD requested and received a department waiver of indirect costs. Title V is one of a few grants that the department allows an annual indirect cost waiver that ensures maximum use of the grant dollars for personnel and operating expenses.

FHSD also leverages its funding from other federal grants to support programs and will continue to seek state funds through the legislative process. Because funding remains relatively level with operating and personnel expenses rapidly rising due to inflation and ongoing collective bargaining, programs have intentionally considered reorganizations for efficiency and often postpone filling positions when they are vacated through retirement or attrition. Programs also redescribe and recruit vacated positions from high salary medical professional positions (e.g., nurses) to public health program specialists. State and federal budget funding cuts coupled with rising

operating costs have led FHSD personnel numbers to shrink from 337.5 FTE in SFY 2018 to 265 budgeted full and part-time positions for SFY 2023. This represents a 21.5% 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 2024. While it's still too early to determine the extent of state and possibly federal fund restrictions and/or reductions that lie ahead, the COVID-19 pandemic crisis negatively impacted Hawaii's economy. Although the state's economic recovery is stronger than expected, the tone is cautiously optimistic. Not surprisingly, the economic fallout was enormous in Hawaii during the April 2020–March 2022 period as unemployment rates rose to 9.2% (not seasonally adjusted) as the state's tourism-based economy came to a complete standstill. Visitor arrivals to Hawaii have not returned to pre-pandemic levels and the economic outlook remains stagnant. Although the effects of the pandemic have subsided, the influx of federal spending to support COVID-19 related actions that supported the state for the past couple of years is beginning to wane. Early Intervention received a state fund appropriation increase in SFY 23 of an additional $3.6M to the recurring base budget for purchase of services (POS) contracts statewide. In 2023, FHSD received three new federal grants: Pediatric Mental Health Care Access Expansion grant and two new Home Visiting ARPA grants.

Additionally, 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 Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities grant awarded to the Hawaii Department of Health. The CDC granted Hawaii a no-cost extension to use these funds through May 31, 2024. These funds and other federal assistance received during the pandemic will continue to positively impact Hawaii's public health efforts into the FY 2024 budget year. Although critically important to the overall contribution of resources assisting the FHSD MCH effort, some of these funds reside outside of the FHSD budget; therefore, for Title V reporting purposes, these funds are not included in the budget.

State Funds. The FY 2024 state funds budget total is approximately $34M. Additional state funds generated from Program Income is budgeted at $18.3M in FY 2024, according to the SFY 2023 legislative budget worksheets. The FY 2023 legislature increased the general fund appropriation for the Early Intervention Program by approximately $3.6M annually. Note that the economic effects of the pandemic are anticipated to linger to some degree through FY 2024, especially in our ability to hire and retain new staff when positions vacate. Also note that Hawaii has a new Governor/administration from December 5, 2022, which will have an impact on the State's 2024 budget.

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 26 Title V-funded positions are critical to securing, leveraging, and managing a broad array of funding sources; addressing statewide surveillance needs; developing critical statewide partnerships; and improving quality to assure services are family centered, culturally competent, and community based.

Although WIC does not receive Title V or state funds, the program benefits from FHSD administrative and media support, epidemiology/data assistance, and technical assistance through collaboration with other FHSD programs. The WIC State Agency is the largest direct service program in FHSD and HDOH, serving a key MCH demographic. WIC benefits are critical to assuring the state's low-income families have food security and access to other health education and resources. Given WIC's broad reach, the program helps to broker services provided by other Title V programs including Home Visiting and Early Intervention and helps assure screenings and wellness visits for new mothers and their children. WIC's diverse service population is a key avenue to address health equity and disparities.

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

Because HDOH 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 critical support to use state funding to administer the Child Death Review and Maternal Mortality Review and continued efforts of the Lead Poisoning Screening and Prevention program, which is currently applying for a renewed funding project from the CDC.

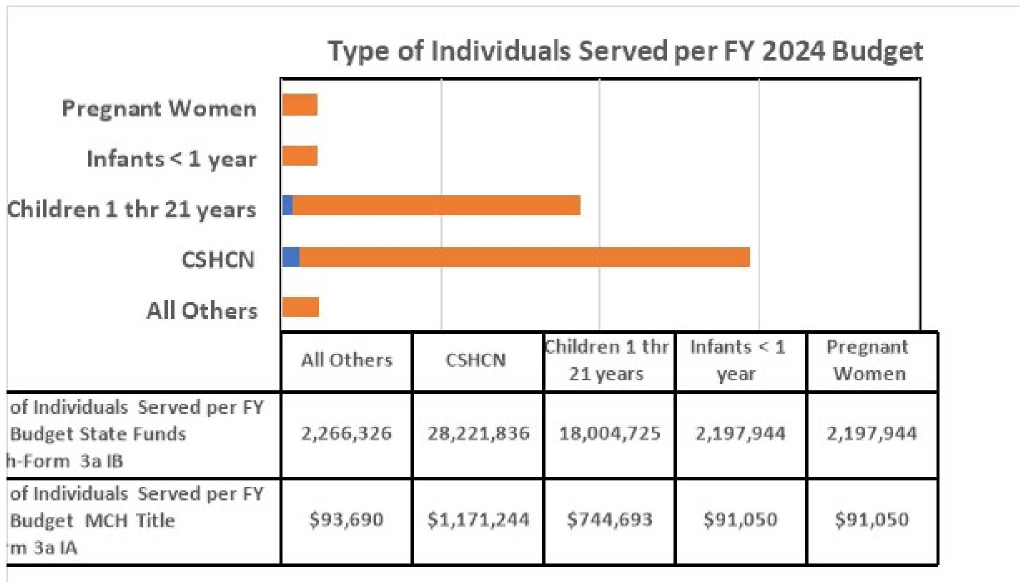
Another example of leveraging Title V funding is found in the distribution of the funding to support key positions within FHSD. The CSHN Branch Chief, also a pediatric M.D., is 75% funded by Title V and 25% funded by IDEA Part C. She also supervises Hawaii's Part C Early Intervention Services program as part of the CSHN Branch. A portion of both grants are used to support this critical management and medical professional position for FHSD. Note that the current CSHN Branch Chief (and Title V CSHN Director) will transition to a new part-time position in the summer of 2023 and her replacement will begin in August of 2023. The funding for this position is not anticipated to change. As the two Title V-funded Epidemiologist positions remain vacant entering FY 2024, FHSD has plans to use Title V funds for various epidemiological activities and public awareness media campaigns.

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

Title V Priority	Program Lead Funding	Key FHSD Partnerships
Women's Wellness Visits	Women's Health Section (Title V/State Family Planning Program)	Title V – Data/Epi Support Reproductive Health Services (State)
Food Insecurity	WIC Services (USDA/FNS)	Title V – Data/Epi Support Early Childhood Comp Systems Reproductive Health Services (State)
Safe Sleep	PRAMS (CDC)	Title V – Data/Epi Support Early Childhood Comp Systems Child Death Review (State)
Developmental Screening	Early Childhood Coordinator	Title V – Data/Epi Support EIS (Part C/State) MIECHV Hi'ilei Developmental Screening (State)
Child Wellness Visits	Early Childhood Coordinator	Title V – Data/Epi Support MIECHV CSHN Branch
Child Abuse & Neglect	Community based Child Abuse Prevention Program (ACF)	Title V – Data/Epi Support MIECHV Domestic Violence/Child Fatality Review (State) Rape Prevention & Education (CDC)
Adolescent Wellness Visits	Adolescent Health (Title V)	Title V – Data/Epi Support Personal Responsibility Education Program
Transition to Adult Care	CSHN Program (State)	Title V – Data/Epi Support
Telehealth	Genetics	Title V – Data/Epi Support Rural Health
Pediatric Mental Health Care Access	Pediatric Mental Health Care Access Grant	Office of Primary Care (HRSA) Early Childhood Coordinator

The performance measure 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 as vital resources to assure program progress.

Form 3a, Budget and Expenditure Details by Types of Individuals Served, FY 2024 application budgeted, demonstrates the federal and non-federal FY 2024 application budget. The chart below shows the state and federal breakout of planned resource allocation for each of the five population health domains. The 2024 Title V Federal Allocation budget of approximately $2.2M and a State Match of $52.8M create a Federal-State Title V Partnership budget of approximately $55.1M. The combined resources form the funding base for strategic collaborations with community providers and partners statewide. Annually, FHSD administers approximately 150 contracts with community organizations that serve Hawaii's MCH population. These vendors include Federally Qualified Health Centers (FQHC), local hospitals, and private and nonprofit providers in urban and rural communities throughout the state. The funds play a key role in building statewide capacity to assure the availability of services for all of Hawaii's families.



	All Others	CSHCN	Children 1 thr 21 years	Infants < 1 year	Pregnant Women
of Individuals Served per FY Budget State Funds h-Form 3a IB	2,266,326	28,221,836	18,004,725	2,197,944	2,197,944
of Individuals Served per FY Budget MCH Title m 3a IA	$93,690	$1,171,244	$744,693	$91,050	$91,050

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 2024 budget year.

Significant Variations – Form 2 and Form 3 (Fiscal Year 2024) – Budget

Note that due to TVIS character limits, additional comments regarding significant variations were addressed directly in the TVIS note section on each form's respective page.

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 the 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. Most service contracts for county/community providers are executed through FHSD central program offices located on Oahu in consultation/coordination with county staff. However, during the pandemic, FHSD county nurse managers have been able to partner with local community organizations to procure services to address emerging needs using both federal and state funds. The sharing of procurement duties with county offices, albeit limited, effectively addressed critical administrative vacancies in the central office and helped to distribute the increase in COVID-related relief funding to rural communities.

Together, 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 includes three branches—Maternal and Child Health (MCH); Children with Special Health Needs (CSHN); 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/State Systems Development Initiative
- Early Childhood Comprehensive Systems (ECCS)
- Oral Health Program
- Pediatric Mental Health Care 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 Small 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 to 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, Hiʻilei 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 and innovations that occurred as the state transitions into an endemic phase.

FHSD Vision/Mission: For several years, 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 as the department starts with new administrative leadership.

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 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 development 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 in Hawaii require a highly skilled, diverse workforce. This means that ongoing public health training and education are needed to address the increasingly complex and broad scope of health issues for women, infants, children, and their families.

With 265 employees, 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 training in public health. The FHSD staff have program management experience or subject matter knowledge in their respective program areas and would benefit from more public health-specific skill building.

Public health and MCH training resources in Hawaii are limited. Hawaii has three relatively small university-level public health programs offering both graduate and undergraduate public health courses at the University of Hawaii (UH) and two private-sector colleges, Chaminade University and Hawaii Pacific University (HPU). UH and HPU offer master's in public health and have an online MPH option. UH is the only university with a Ph.D. degree program. Chaminade University only offers an undergraduate public/community health program. None of the Hawaii academic institutions offer MCH-specific courses, and none have dedicated MCH faculty. All three programs are located on Oahu. Two FHSD staff are currently enrolled in the new UH online MPH program.

MCH LEND. The UH Medical School administers the MCH Leadership Education in Neurodevelopmental and Related Disabilities (LEND) grant, directed by pediatric faculty at the school. Several FHSD staff are LEND graduates and FHSD continues to encourage existing program staff to enroll in LEND, particularly the Children with Special Health Needs staff. LEND annually shares its curriculum calendar and invites Title V staff to participate in specific trainings to enhance skill building. In FY 2022, Title V also helped fund family incentives for LEND family focus groups conducted as part of the LEND research methods curriculum. Title V and LEND maintain 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 federal grants supporting staff participation in national conferences, access to national MCH subject matter experts, current research, technical assistance (TA), and state peer networking. State-funded staff generally has limited access to these invaluable resources.

MCH Academic Pathways: In the past, the MCH Bureau funded a public health leadership MCH certificate program at the University of Hawaii (UHM) public health program that:

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

Reinitiating this MCH leadership program in Hawaii is critical in light of growing MCH/Title V vacancies, difficulties in recruitment and retention, greater emphasis on workforce diversity, and emerging healthcare challenges. The UH Office of Public Health Studies is potentially interested in re-establishing an MCH program but has been impeded by position vacancies and difficulty recruiting MCH faculty.

Federal Workforce Support. In Spring 2023, FHSD met with the federal MCH Bureau Workforce Development Director, Lauren Ramos, to discuss issues relating to re-establishing an MCH program at UH. Hawaii shared information regarding workforce challenges, including the struggle to fill vacancies (particularly epidemiologists), the difficulty recruiting out-of-state due to high cost of living in Hawaii, and the struggle to find workable university

partnerships (including those with UH and MCH Centers of Excellence (COE) in other states). Ms. Ramos suggested Hawaii could apply for a Catalyst Grant, a small grant available to accredited university public health programs to build MCH curriculum/programs. If federal funding is available, a new grant announcement is scheduled for release in Fall 2024. This would provide Hawaii enough time to convene partners to explore a submission.

MCH Academic-Practice Partnerships. In 2021, FHSD participated in a study conducted by the MCH Bureau on MCH academic and practice partnerships. Hawaii shared its experience regarding the value of these partnerships, including the limited availability of MCH resources at local universities. Through this experience, Hawaii learned about the Association of Teachers of MCH (ATMCH) mentoring program to assist university public health programs build an MCH track/curriculum. FHSD was able to connect UH faculty with the Association to establish a possible mentoring partnership.

Public Health Workforce Interests & Needs Survey (PH WINS). 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 Fall 2021 (after a COVID delay). The 2021 survey included: new modules on COVID, well-being, and an MCH module sponsored by the MCH Workforce Development Center (WDC). The Association of State and Territorial Health Officials (ASTHO) and the de Beaumont Foundation (dBF) conduct the survey. Working with the dBF PH WINS epidemiologist, FHSD secured specific workforce survey findings for its staff, with comparisons to the DOH and the U.S. national public health workforce. A presentation of results was shared with FHSD program managers. Key findings for FHSD follow.

Compared with the state and national government public health workforce, FHSD staff are:

- Older (58% are 51 years of age or more) and are more racially/ethnically diverse
- Less likely to have formal academic public health education and training (8% of FHSD staff had a degree in public health, compared to 14% nationally)
- Served longer at their current agency (13% served 21 years or more) and are more likely to retire within the next 5 years (65%)
- Much more likely to report a training need in Justice, Equity, Diversity, and Inclusion (44%). Nationally and for DOH, budget and financial management was the number one identified training need.

While most FHSD staff are satisfied with their job and supervisors (81% vs. 79% nationally), their perceptions of their organization are lower than those of the national workforce (51% vs 68% nationally).

This survey confirms that stress (32%) and burnout (32%) are related to intent to leave among the FHSD staff. Generally, 47% of FHSD staff reported their mental health was very good or excellent, with 19% reporting their mental health as poor/fair, roughly equivalent to overall Departmental rates.

The MCH survey module measured leadership development opportunities, organizational supports for leadership development, and readiness to lead. Among FHSD staff, rates were relatively low, ranging from 26% to 40%, pointing to areas of need and opportunity for further staff training.

MCH Workforce Development Center (WDC). In FY 2022, Hawaii was accepted into the MCH WDC cohort. This was the third cohort Hawaii has joined. This year’s project focused on strengthening the Title V agency’s capability to address health equity by increasing staff knowledge and skills to integrate equity into public health practice. The project focus was informed by PH WINS survey data which confirmed that the primary training need for staff was health equity. Going forward, plans include coordination with the DOH Office of Health Equity for trainings; technical assistance to support staff learning/practice integration; workforce assessment; developing an FHSD land

acknowledgment (that honors Hawaii's indigenous population); and development of adoptable health equity practices for individuals and programs.

COVID Impacts on Program Staff: Conditions have normalized considerably in 2022-2023 for program staff. Infection-acquired immunity and vaccinations have minimized the severity of COVID spread, although risk remains potentially high for those providing direct in-person services. Title V programs continued to be flexible, adapting/revising plans and operations in collaboration with community partners to address continuing and emerging economic and healthcare needs for families and youth. Resilience remains a key operating principle for FHSD staff.

While the state budget was significantly bolstered by federal relief funding and the strong rebound of the local visitor industry, state operations continue to be burdened by increasing staff vacancies, requirements for new funding opportunities, challenging personnel/procurement processes, and under-funded core public health infrastructure.

During COVID, FHSD conducted a quick survey of 30 program managers to assess their perceived needs and concerns. Managers reported that the high level of change, uncertainty, and resulting stress for management and staff was a major issue. Personnel (and other state systems) have varying degrees of ability to respond effectively to change. Despite the challenges experienced during the pandemic, nearly half of FHSD program managers reported in 2021 that the changes in service delivery due to COVID conditions helped to focus and strengthen overall 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 had planned to conduct an employee survey to capture staff demographics and concerns coming out of COVID. The data would be used to assess staffing diversity, inform planning for succession needs, and create workforce training plans. Plans were delayed for the PH WINS survey results. The survey will be included in the Title V 2025 needs assessment scope of work, which will be contracted out to a qualified entity.

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 the 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, as well as ensure the alignment of strategies with Title V measures.

Since 2021, continued TA for staff has been provided by Nancy Partika, RN, MPH, in conjunction with the Title V coordinator. Ms. Partika served as director and lead faculty for the former MCH Leadership Certificate program at OPHS from 2007-2011. Her TA supports building staff public health knowledge and skills, assists with the review of evidence research, and assistance with reviewing and updating logic models.

One Shared Future: To support the FHSD staff, One Shared Future (OSF) was contracted to conduct resiliency training in Spring 2022 using a strengths-based approach to address workplace stress and help minimize burnout and staff turnover. OSF is a firm started by the former state Department of Human Services (DHS) director that supports public sector professionals in implementing positive organizational and community change. The resiliency series, comprised of seven 90-minute virtual sessions, were conducted in cohorts of 20-25 and held over six weeks to allow optimal 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 self-care. OSF also arranged for appearances by the Governor and DOH Director/Deputy to reinforce the messages of appreciation and

self-care. Two cohorts were completed and more may be scheduled in the future.

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 Workforce Development Center trainings
- The CityMatch/MCH Epidemiology Conference

These TA opportunities help develop staff and community capacity and also provide an opportunity to share Hawaii's MCH 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 and private health professionals, with 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: In FY 2022, several trainings on health disparities, structural racism, and systemic inequities were sponsored by FHSD to help 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, which 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, as well as 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/Domestic Prevention programs sponsor several trainings each year on healthy masculinity and interpersonal violence prevention in conjunction with Na Leo Kane (Hawaiian for the Voices of Males), a DOH-sponsored community collaborative to engage men and boys in violence prevention.

- A consortium of Title V programs supports the Parent Leadership Training Institute.

Conferences: Programs 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
- WIC Services Branch annual staff meeting

Most meetings have returned to in-person and may offer virtual options for easier access.

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

Hawaii remains committed to increasing 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. This report highlights efforts to build the Title V agency capacity for family partnership/engagement.

Several FHSD programs have a strong family engagement (FE) component to their work (i.e., CSHN programs) and grant-funded programs with a FE requirement (i.e., the Early Childhood Comprehensive Systems (ECCS) grant). 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 program staff (CSHN, Early Childhood programs, Rural Health, Family Violence Prevention, 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

The workgroup met for four years and was able to:

- conduct three surveys to assess FHSD program needs for FE (pre- and post-COVID)
- contract for a Title V family representative
- pilot a FE training
- develop recommendations for compensation when working with families
- establish a funding source for Division programs to conduct more engagement activities and
- provide continued funding for the Parent Leadership Training Institute and utilize PLTI alumni in FHSD program activities.

Unfortunately, the workgroup has been put on hold due to staff shortages and changing priorities. However, progress on FE continued through individual program efforts.

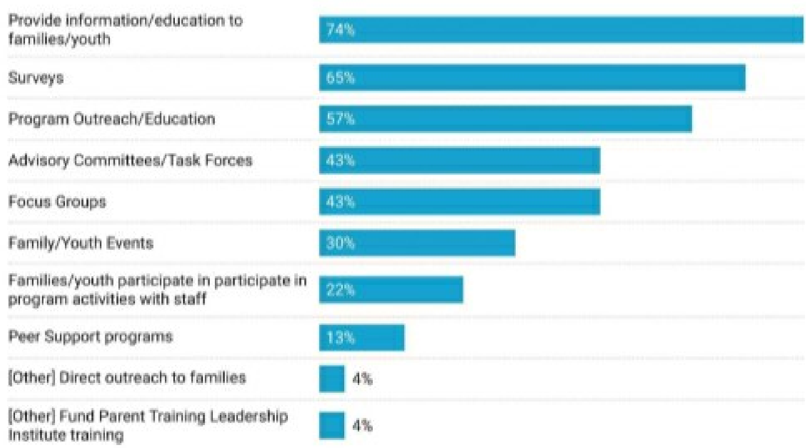
Family Engagement Surveys. To help inform the FE Workgroups activities, several surveys of FHSD programs were conducted to:

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

Initially, two short surveys were conducted in 2018-2019 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, a third FE survey was conducted among FHSD programs to assess activities as COVID activities waned. Programs were asked about changes and challenges with engaging families given the pandemic. The most common method for engagement had switched to outreach (remote), followed by surveys, direct outreach, advisory committees, and focus groups.

Q1. What are some of the key methods you use to engage families/youth?



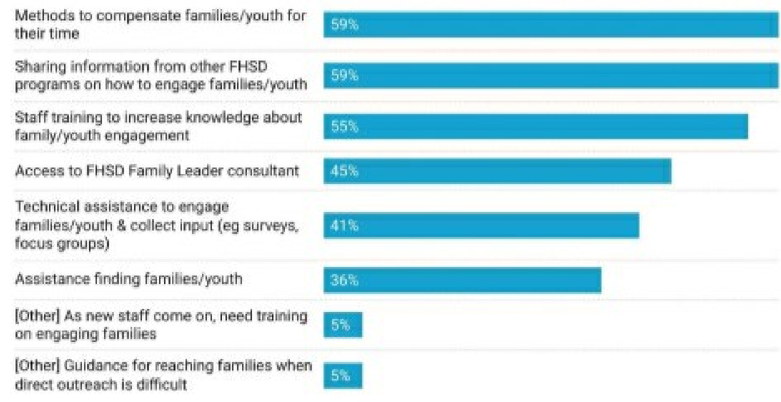
23 responses. Respondents could choose multiple options.

The survey asked how COVID impacted FE:

- As of June 2022, most programs reported that 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 are methods to compensate family participation, sharing information between programs, and staff training.

Q7. What assistance does your program need to increase your family engagement activities?



22 responses. Respondents could choose multiple options.

Other key findings from the survey included:

- Family/youth input was often collected to develop educational materials/health messaging, followed closely by needs assessments.
- There was an increase in the percentage of programs that engage families in program planning, priority, and goal setting since 2019.
- Programs expressed a greater need for more information sharing among FHSD programs, especially regarding sharing research/survey findings and promoting family/youth research (surveys), events, and trainings.

FHSD Advisory Committees. FHSD has six long-standing advisory committees/task forces identified as needing family volunteers: the Violence Prevention programs, Early Intervention Coordinating Council, Hawaii Children's Trust Fund Coalition, Newborn Hearing Program, Early Intervention program, Deaf and Blind Taskforce, and several service contracts that require community/client input for quality improvement.

Peer Support. WIC Services was the only program to employ mothers part-time for its breastfeeding peer counseling program. The Hearing Screening program offers volunteer family peer supports.

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 works for the Hawaii Family to Family Health Information Center staff. She is the 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 partnerships, primarily with the Children with Special Health Needs Branch (CSHNB).

Conference Presentations. Ms. Wood and CSHN Branch/Adolescent Health staff with the Department of Education partnered to develop a presentation on *Innovative Approach to Support Youth in their Education and Health Transition Journey to Adulthood*. The presentation was done at the October 2022 Family Leadership Conference and updated for presentation at the May 2023 AMCHP conference.

Ms. Wood also helped facilitate the MCH Branch November 2022 Youth Summit. Lastly, Ms. Wood and staff from CSHNB participated in a Family Voices Leadership in Family & Professional Partnership (LFPP) technical assistance cohort in 2022-2023. The focus was to develop a plan to enhance diverse family engagement and family professional partnerships at the individual, program, and/or policy level. Collaborative actions tools were introduced and state examples were shared. The team was able to draft a FHSD Family Engagement Policy for consideration.

ECCS grant: The ECCS HIPP grant was awarded to Hawaii in May 2021 and is used to develop 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 as the Family Engagement Specialist. 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.

In FY 2023, Ms. Baba and HCAN's Mele Andrade, Director of Community Engagement, lead the ECCS Infrastructure Development Workgroup. They researched current methods of family engagement used in programs around the state and proposed a FE model for use by the grant Advisory Committee. Ms. Baba also worked closely with the ECCS program director as a key consultant for the grant work, including developing a family survey and drafting a system assessment and strategic plan.

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

Fund to Support FHSD FE Activities

In FY 2022, FHSD contracted with HCAN to support program engagement activities with families. The funds were used to provide incentives to participate in three projects:

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

Family/Community Compensation In response to FHSD's request, HCAN developed a compensation policy for families and community members with lived experience. HCAN now compensates family leaders following this policy and is sharing it as model language for other organizations.

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 cohorts. In FY2022, there were two virtual cohorts and one Maui-Hybrid cohort. The program had 21 participants from across the state. Although a choice of in-person sessions was offered on Oahu, there was a much larger interest in virtual cohorts, with only two people applying for the in-person cohort on Oahu and 54 for virtual. Participants also enjoyed the hybrid option offered on Maui, which allowed for a mix of in-person and virtual sessions.

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 was attrition, as we started with 56 parent leaders who were accepted into the program. For virtual participants, it is challenging for parents to juggle being at home and managing daily family tasks while trying to participate, which may be one reason for the dropout rates.

HCAN plans to return to an in-person cohort for Oahu in 2023-2024, with dinner and childcare provided. The session provides some level of respite for parents and adult interaction. An additional remote cohort will be offered to expand PLTI to neighbor island participants, and a hybrid version will be offered specifically for Maui.

PLTI Diversity: The diversity of PLTI participants is a primary focus of HCAN's recruitment efforts to ensure inclusion of the state's varied ethnic groups, parents with special needs children, and income levels. PLTI participants to date have included 24% Native Hawaiian, 38% Pacific Islander/Asian, and 38% have a family income of less than $60,000. Over the past year, PLTI included discussions about race/structural racism in the curriculum as racial justice issues gained wider attention. FHSD is supporting HCAN to modify the evidence based PLTI curriculum to reflect Hawaii's unique cultural composition and history without losing fidelity to the original model and has begun making adaptations to better reflect Native Hawaiian culture and values.

PLTI Alumni: The more than 100 PLTI Hawaii alumni continue to remain active and serve as mentors for new cohorts, and over half of HCAN facilitation staff are also PLTI alumni. The alumni group convenes quarterly and communicates

via a quarterly newsletter and social media through Facebook pages/groups and Twitter. In 2022-2023, PLTI alumni used their acquired knowledge/skills to become active in the 2023 legislative session, providing testimony on bills impacting families, attending Lobby Days, and speaking at the Working Families Coalition rally for Paid Family Leave as seen here:
https://www.dropbox.com/s/libhn9i08h60it3/Video%20Mar%2016%202023%2C%2010%2023%2036%20AM.mov?dl=0

In 2022-2023, PLTI graduates were featured in several media messaging campaigns, including:

- On Hawaii Public Radio: Could a worker subsidy program entice early childhood educators? | Hawai'i Public Radio (hawaiipublicradio.org)

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

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

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

Over the past four 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, and 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 three prospective assignees over the past four 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 12 other epidemiology/data-related 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. The FHSD Division Chief continued to recruit at national conferences and listservs for the position.

Research Statisticians: FHSD has three FTE research statistician positions at the division and CSHN and MCH branches that provide data analysis support.

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). Her focus was 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. Dr. Fok provides statistical assistance and data analysis for the Title V and PRAMS programs. She also works with the DOH vital statistics office to draw the PRAMS monthly sampling and annual birth files. In 2022, Dr. Fok also assisted the Department's Disease Investigation Branch program with data reporting for COVID case 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 Title V ability to access these datasets electronically, routinely, and promptly. 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 SSDI datasets 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 regained 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 is no Hawaii PRAMS data for 2017 and 2018. Additionally, issues with the 2019 sample resulted in only six months of usable 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. WIC may also request a copy of specific elements of the program dataset for analysis.

Medicaid Data: In 2021, FHSD executed a new Memorandum of Agreement (MOA) 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 includes provisions for FHSD to request and receive Medicaid data. The agreement states that the Medicaid program will respond to data requests within 60 days of submission. Currently, Medicaid provides data needed to complete the Title V annual report, including:

- Information for Form 6 (Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX)
- SSDI Core Measures (child immunizations)
- Enrollment data (including numbers of children, pregnant women)
- Data for several federal Medicaid quality measures used for Title V performance measures on developmental screening and child wellness visits.

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 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: FHSD successfully linked data to vital statistics birth records with the amendment to the data sharing law that now permits access to vital records for public health research. Hawaii Title V has access to four linked electronic datasets to birth records:

- Birth and infant death records
- Birth and newborn metabolic screening records
- Birth and newborn hearing screening records
- PRAMS

Currently, the FHSD research statisticians can draw and link the records for newborn screening and PRAMS. Every month, the statisticians physically go to the Office of Health Status Monitoring (OHSM), the vital statistics program, to draw down birth certificate records using a program developed by OHSM. The software program can link with infant death records and delete those records, so FHSD programs are not contacting those families. Data linkage for newborn screening is conducted in the CSHN Branch office. For PRAMS, the sampling frame is applied to the dataset to develop the sample in the FHSD office. The final analytic file includes a partial linkage of some variables from the birth certificate.The linkage for the birth and infant death file is conducted annually by OHSM and provided to FHSD for Title V reporting.

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 continues to recruit for the position vacancies at national conferences, public health programs, and locally; but is unsuccessful to date. The SSDI Project Coordinator has been helpful with circulating the recruitment announcement.

Title V Data Support: Given staffing vacancies, University of Hawaii faculty and resources have helped strengthen and supplement FHSD data activities. From 2018-2021, Hawaii used SSDI funds to contract with the University of Hawaii Office of Public Health Studies (OPHS) faculty to complete the 2020 Title V needs assessment, review data, provide technical assistance for planning and evaluation, and help with ongoing assessment. OPHS also assisted with the development of several data publications. The FHSD epi vacancies hampered the latter effort.

An OPHS graduate assistant helped complete 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, her poster presentation was accepted by AMCHP on the importance of disaggregated race/ethnicity data to understand infant mortality disparities in Hawaii. After graduation, the student was hired to work on the FHSD Pediatric Mental Health Access grant. This experience highlights the importance of establishing an MCH academic pathway for FHSD and the larger MCH workforce in Hawaii.

Planning/Evaluation: In FY 2022-2023, 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 and leading community nonprofits like Healthy Mothers, Healthy Babies. Her TA supported building staff's public health knowledge and helped staff assess and respond to the challenges posed by the COVID pandemic. Ms. Partika also assisted staff with reviewing research by the MCH Evidence Center (EC) to support strategy selection, assist with planning and evaluating 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 given other program demands and research interests. With limited faculty prospects at OPHS, Hawaii searched out-of-state for MCH epi support to assist with the Title V report.

MCH Centers of Excellence: With assistance from the MCH Bureau staff (the Hawaii Title V Project Officer, Data Scientist, 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 to a lack of qualified or available faculty. Hawaii was able to contract with recent COE epidemiology graduates to assist with reviewing and interpreting data for the Title V report. Although the support was helpful, the post-graduate epidemiologists were challenged working with the population-based data and diverse scope of MCH data contained in the Title V report.

In 2023, FHSD contracted the University of Alabama Birmingham (UAB) Public Health Program for data services. UAB is nationally one of a few public health programs with a robust MCH program and faculty. A team of several faculty and researchers from the Applied Evaluation and Assessment Collaborative are providing technical assistance to review and interpret the Title V data to present a clear story about the MCH population in Hawaii. Their work is reflected in the Needs Assessment update section of this year's Title V report. Hawaii may also contract with UAB to plan/assist with the Title V 5-year needs assessment. Coming out of COVID, a comprehensive needs assessment will be critical to identify priorities for the next five years.

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. Other states have used the data effectively to reinstate Medicaid adult dental preventive benefits since EDs cannot 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 also provided 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 overutilizing 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 in the state Medicaid base budget to ensure sustained funding for the program. The Medicaid program is now working to contract for the services. The Coalition is working on a campaign encouraging more dentists to register as Medicaid providers.

Child and Family Mental Health data: In May 2023, national mental health month, FHSD partnered with the Hawaii Health Data Warehouse (HHDW) to launch an MCH mental health dashboard on the HHDW website. Mental health emerged as a growing concern coming out of the COVID pandemic. The dashboard provides a user-friendly summary of over 40 mental health measures from the major public health surveillance surveys, including the (Adult) Behavioral Risk Factor Survey, the Youth Behavioral Risk Survey, PRAMS, and the National Survey on Child Health. Healthy People 2030 targets are provided when available. Other measures include suicide fatality data and behavioral health workforce data. The advisory committee for the FHSD Pediatric Mental Health Access grant and other behavioral health partners provided input to the dashboard development.

Data Products/resources:
Without in-house epidemiology staff, FHSD data products are somewhat limited.

Publications

- Fok, C. C. T., Shim, M. J. Race and Depressive Symptoms are Associated with the Prevalence of Adolescent Suicide Attempts in Hawaiʻi, 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

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

Presentations

- Study of Adult Emergency Room Visits with a Dental-Related Diagnosis in Hawaii: 2016-2020. October 2021 Masako Matsunaga, PhD. & John Chen, Ph.D. 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 of 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.

Hawaii State Department of Health, The MCH Mental Health Data Tracker https://www.hawaiihealthmatters.org/indicators/index/dashboard?alias=MentalHealth This convenient online tool allows users to quickly review data across over 40 mental health indicators for pregnant women, children, adults, and families.

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

FHSD executed several contracts in FY 2022/FY2023 to secure services for data collection, analysis, and developing publications/dashboards to ensure data is available for public use.

CSHN Ongoing Needs Assessment**:** The CSHN Branch is collaborating 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 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. The assessment is designed to:

- collect better demographic & health data for this population in Hawaii by race/ethnic groups
- assess COVID impacts on physical and emotional health
- assess youth access to healthcare services, and
- collect information to help teens transition to adult healthcare (a CSHN priority area).

Questions for the survey were adapted from the National Survey on Children's Health (NSCH). The survey is being translated into Tagalog, Ilokano, and Hawaiian to collect better data from underrepresented groups. Since Pacific Islander communities are so diverse in language and culture, focus groups or other methods will be used to access this community.

The survey was disseminated widely through outreach from community programs for youth with special needs. CDS secured approval from the Department of Education Superintendent to distribute information about the survey to students receiving special education services. Approximately 440 people started the online survey, and 272 respondents completed the full survey. Participants who completed the survey received a $20 gift card in appreciation for their time.

Focus groups with YSHN and/or their caregivers are currently being conducted to gather related qualitative information. However, CDS is having a difficult time recruiting for focus groups. Partnerships with youth-serving organizations are being considered to develop more effective recruitment strategies.

Results of the needs assessment will be published and disseminated to stakeholders and the public. This project also supports the CDS 5-year needs assessment required for their grant funding.

Mental Health Data Tracker: In FY 2022, FHSD contracted with the University of Hawaii Office of Public Health Studies, which manages the DOH Hawaii Health Data Warehouse (HHDW), to create a Family and Child mental health data dashboard. The Warehouse's user-friendly website, *Hawaii Health Matters*, 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 ensure reliable analysis, reporting, and documentation for all data measures and sources. Data is also routinely updated from the HHDW dataset, including the major public health surveillance surveys and vital statistics. The mental health data dashboard is the third FHSD project completed with HHDW. Dashboards on oral health and primary care are also available at: https://www.hawaiihealthmatters.org/

HHDW and Title V partnered with the Pediatric Mental Health Access Advisory Group and other community partners

to select indicators and design the dashboard launched during Mental Health Awareness Month in May 2023. OPHS helped promote and present the tracker to community stakeholders, and the tracker is being promoted through DOH and community social media sites.

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 ensure family input to the program's strategic planning efforts, the University Center on the Family (COF) and the Hawaii Children's Action Network conducted a survey of families with pregnant people, 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 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. A report is expected later in Fall 2023.

WIC Family Research: The University COF was also contracted to analyze WIC program data to better understand the WIC service population characteristics, how clients utilize benefits, and enrollment patterns. WIC has limited internal resources for data analysis. COF worked with a WIC Community Advisory Committee to help develop the analysis plan. Findings and fact sheets will be available later in 2023. See the narrative for SPM 2 (food insecurity) for preliminary data results.

CDC PRAMS Interns: To address the epidemiology vacancies, the CDC PRAMS program offered Hawaii an opportunity to utilize its 2023 Spring and Summer epidemiology interns to assist with PRAMS data analysis. The interns are focusing on analysis of data for WIC-enrolled mothers.

TeenLink Hawaii Youth Assessment Survey. Data from this 2021 youth-directed survey are being utilized to develop health messaging and outreach. 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 electronic and paper format. Key findings are reported in the NPM 12 narrative. The 2021 survey built on results from a broader youth survey conducted by TeenLink in 2020 during the height of the pandemic.

Child Surveillance Data: FHSD met bi-annually with the DOH Chronic Disease program (and community partners) through FY 2021-2022 to explore options to generate better data for younger children and families. The National Survey on Children's Health (NSCH) 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, limiting 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 nutrition and physical activity data. 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 was released in FY 2022. 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, several issues with the NSCH data limit 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, the population of Hawaii 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, and socioeconomic 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 exacerbate existing inequities. Unfortunately, the NSCH data are 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 communities 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 COVID most adversely impacted these communities, 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. Since Hawaii is an island state, the geographic barriers across counties often result 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. Oversampling is costly and the process to develop the oversample is complex. Without an epidemiologist on staff, designing the oversample would be difficult. To reduce costs, the Bureau recommends generating aggregated datasets over multiple years which means substantial time lags before useable data is available. This approach does not allow for trend analysis since it produces only a point-in-time estimate. 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, accessing data from a Census Regional Data Center (RDC) created additional challenges. Hawaii does not have an in-state RDC. The MCH Bureau recently announced that in-person access to an RDC is no longer required. Without an oversample, the NSCH data will continue to have limited value for program planning and policy development. Hawaii encourages the MCH Bureau to consider expanding the survey sample sizes for states, especially those with ethnically diverse populations.

Public Health Workforce Interests & Needs Survey (PH WINS). In 2022, FHSD began working with Melissa Gambatese, the de Beaumont Foundation (DBF) PH WINS epidemiologist, to analyze Hawaii's Department of Health (DOH) and Title V agency 2021 survey data. The FHSD sample size was large enough to generate usable

results, including data from a new MCH module. Given FHSD’s work with PH WINS, the new DOH administration appointed the Hawaii Title V director as the Department’s lead for the PH WINS survey. The raw dataset was recently acquired, and an analysis plan was developed to address manager/employee questions to help with program planning and policy in the future. Findings of the survey results will be shared in a series of short briefs in future FHSD newsletters. Title V will work with the DOH Communications Office to help share data results and is working with the DOH Office of Health Equity (OHE) to analyze to inform OHE's future work plans. Highlights of Ms. Gambatese’s findings are reported in the Workforce Development narrative.

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 coordinates 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), an all-hazards plan that establishes the shared framework for the state's response to an 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 provides additional detail on the response to specific types of issues and incidents.

The last HI-EOP basic plan was completed in 2022. 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: Each county develops its own EOPs that are consistent with the HI-EOP and provide guidance on the utilization, direction, control, and coordination of local resources during emergency operations and address the 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), 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.

DOH 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.

COOP: OPHP is coordinating the update of the Department’s Continuity of Operations Plan (COOP), in which each division or office indicates its Mission Essential Functions and Essential Support Activities. The Family Health Services Division is updating its information and has already identified the Newborn Metabolic Screening Function and WIC Formula Distribution as Mission Essential Functions. September 2023 is the target timeframe for completion of the Department’s COOP.

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, including pregnant women and children. In the situational analysis, HI-EOP does acknowledge specific 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 by activating the State Emergency Operations Center (SEOC) and State Emergency Response Team. The Title V Director serves as the DOH ESF-8 (Public Health & Medical) liaison to the SEOC before 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 and section staff. Family Health Services Division (FHSD) members have been trained on and served in emergency management leadership roles before and during the pandemic as Section Chiefs in the DOC.

The Hawaii Title V Director has served as the DOC Planning Section Chief, while FHSD's Administrative Officer has served as DOC Logistics Section Chief during the COVID-19 response.

Hurricane Season Preparedness

In Hawaii, Hurricane season is from June 1 through November. The season begins with major forecasts by the national weather service and a major emergency preparation informational campaign from June through August. Forecasters warn of above-average hurricane season for 2023.

OPHP produced hurricane preparedness PSAs in 2022. One featured a mother with her young children discussing the importance of preparing for emergencies and building an emergency kit. In 2022, these PSAs were shown statewide on TV and digital media during hurricane season. For the 2023 hurricane, the audio from the PSAs is airing on numerous statewide radio stations and digital media.

Building Resilience in Children

OPHP partnered with a local children's theatre group to promote resilience to its audience through one of its plays and in one of its television segments. The message described simple actions children can take when faced with adversity. These actions can be used for everyday challenges or during times of emergency. The play, *The Pa'akai We Bring,* was performed statewide to public audiences (of families) and thousands of elementary and middle school students as a school-sponsored activity. The television segment was broadcast several times on local networks during prime viewing hours.

COVID-19 After Action Review

OPHP continues to assess the DOH response to the COVID-19 pandemic. Several draft documents have been produced that focus on different timeframes within the three-year response.

Staff from across the department who were actively involved in the response were invited to participate in surveys, interviews, and meetings to discuss timelines, actions taken, and areas of improvement (AOI). Partners and community stakeholders were also included in this assessment process.

Red Hill Water Crisis

Approximately 10,000 households on Oahu were impacted by the contamination of drinking water from the Navy's underground storage tanks, which was identified in November 2021. The DOH's public FAQ document included a response for pregnant women exposed to contaminated drinking water based on what was known then.

The Department of Health's WIC program supported its affected clients by allowing a change from powered or concentrated formulas to ready-to-drink formula, as well as providing advice on how to increase milk supply for lactating mothers.

The DOH and the Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry (CDC/ATSDR) conducted a follow-up survey in September 2022 to learn more about the experience of people affected by the petroleum contamination in the U.S. Navy's Joint Base Pearl Harbor-Hickam drinking water system.

DOH continues to oversee the Navy's long-term drinking water monitoring plan, which requires two years of monitoring of homes, schools, childcare facilities, and other buildings on the Navy water system.

Title V Preparedness Efforts

The Hawaii Title V Director participated in developing 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, a public-private governing board tasked with formulating statewide policy relating to early learning. FHSD programs and services helped share information with its constituents, providers, and families, as applicable, on both testing and vaccinations.

During the pandemic, Title V programs provided leadership for 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 ensure evaluations could be completed remotely and promptly. Most Title V programs have returned to offering in-person services in FY 2022 but maintain remote/telephonic options, given several COVID variant surges.

OPHS/Title V collaboration

The Hawaii Title V program has a history of collaboration with OPHS. OPHS provides updates for this Title V narrative every year. In 2019, Hawaii participated in an AMCHP Emergency Preparedness and Response Learning Collaborative (ALC) opportunity to address the maternal and infant health population. The Hawaii team included representatives from the Title V CSHN Branch, OPHP, DOH Planning Office, and Hawaii State Medicaid agency. Relationships from the ALC help support ongoing information sharing and project collaboration when opportunities arise.

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 the 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 mothers were relatively well aware and prepared for emergencies, with 79.3% reporting at least one preparedness behavior. The high rate was attributed to the state's experience enduring severe hurricanes and the annual state hurricane season educational campaigns.

Updated PRAMS for 2019-2020 with disaster preparedness question and shared with OPHP.

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

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

The Hawaii Title V program and staff use a collaborative approach to leverage federal and state resources to assure healthcare service delivery capacity. 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 ensures a statewide system of care by providing safety-net and gap-filling community-based services through purchase of service contracts or subsidies.

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

Early Intervention Services (EI). FHSD is responsible for the statewide EI services to help young children (birth to age 3) with developmental delays. Various coordinated services are offered to those meeting eligibility in all counties through contracted providers and state offices.

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 Services have operated at its main site in Waianae since 1975 and since 1986, the health center provides 24-hour emergency department services. 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. From 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 services include 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, thereby preventing the development and exacerbation of serious health conditions.

FHSD's Office of Primary Care and Rural Health ensures a statewide system of care and supports 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 emphasizing quality and financial and operational improvements for Hawaii's Critical Access Hospitals (CAH). This assists small rural hospitals in improving 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.

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 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, services, and system for children with special needs in partnership with families. The Hawaii Title V CYSHN Director serves as an ex officio member of the council.
- 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 recommends programs, services, contracts, policies, and laws relating to children and families. Title V Project Director, Matthew Shim, serves as an ex officio member/designee of the Director of Health.

Improving quality to ensure services are family-centered, culturally relevant, and community-based (contract monitoring, program evaluation).
- Hawaii’s Home Visiting Program promotes evidence-based home visiting programs through the Maternal Infant Early Childhood Home Visiting (MIECHV) model, manages contracts, and ensures programs maintain fidelity to its model and meet benchmarks set by MIECHV. Currently, six contractors 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 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.

Ensuring development/dissemination of public health messaging.

- The Hawaii Childhood Lead Poisoning Prevention Program developed various materials for parents, providers, and community members. Many of these materials are in 12 different languages.
- The Hawaii 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 the health needs of the MCH population.

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

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

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

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

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

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

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

Examples of Title V partnerships activities include:

Agreements

- CSHNB/Early Intervention Services (EIS) worked with MQD to 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 supported Medicaid efforts for eligibility redetermination by updating addresses for Medicaid enrollees in Title V direct service programs. In June 2022 and again in April 2023, the Medicaid Public Relations Director conducted several presentations on Hawaii Medicaid's plans for redetermination (including a prepared media messaging campaign) to roll out in May 2023, at the end of the public health emergency. The presentation also included training on Medicaid eligibility, the enrollment process (both online and in-person resources), a review of benefits, and the Medicaid process for transitioning youth to adult health care plans. 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 Quality/Member Relations RN provide input on issues that arise and are invited to participate in workgroups, including the group convened to develop the media campaign to promote child wellness visits (a Hawaii Title V state priority).
- Most Title V health service programs and contracts promote enrollment in 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. MQD now provides FHSD with data for these priorities for the Title V annual report.
- MQD also provides data for the Title V annual report for Form 6 and updates on Medicaid enrollment numbers. They will make monthly enrollment data available through the redetermination period.
- The Medicaid Quality/Member Relations RN serves on the Early Childhood Comprehensive Systems (ECCS) Advisory Board to help improve the system of maternal/infant 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 exceed the grant award.
- In January 2023, the state Medicaid program started convening regular bi-monthly meetings with Medicaid health insurance plan EPSDT coordinators and community partners. The CYSHNS Supervisor attends the meetings. An overview of FHSD programs and Title V priorities was presented at the first meeting. In subsequent meetings, CSHNB staff have presented on transition to adult healthcare, lead poisoning prevention, and developmental screening. Discussions also focused on areas to improve services to CSHN by Medicaid and improving adolescent wellness visits.

Other Activities

- The MQD QI/Member Relations RN co-chairs the Hawaii Maternal and Infant Health Collaborative (HMIHC)

Pre-Inter Conception monthly workgroup overseeing this work. The Title V MCH Branch is founder and active participant in the workgroup.

  - HMIHC was instrumental in supporting 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 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.
  - In 2021, MQD issued an updated policy relating to Pregnancy Intention screening and Contraceptive Coverage, which provided clarification on outpatient coverage of LARC devices, updated billing codes, and opened up the options of reliable, evidenced-based pregnancy intention screeners (beyond OKQ) healthcare providers may use to support reproductive life planning.

- FHSD continues to partner with DHS to support infant and early childhood mental health. The MQD Quality/Member Relations RN participates in the Hawaii ZERO TO THREE® Technical Assistance (TA) project on Infant and Early Childhood Mental Health Financing & Policy to help support the advancement of policies that contribute to the healthy development of young children.
- Project ECHO Hawaii is included in the MQD HOPE plan. 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 developing policy briefs and testimony.
- MQD provides FHSD data for inclusion in the Oral Health Data Dashboard located in the DOH Data Warehouse. Data requested includes the number of Medicaid dental providers, Medicaid provider data by the level of claims submitted, disaggregated data for EPSDT service utilization, and numbers of interisland flights funded by Medicaid to access specialty care for children and adults.

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

State Action Plan Introduction

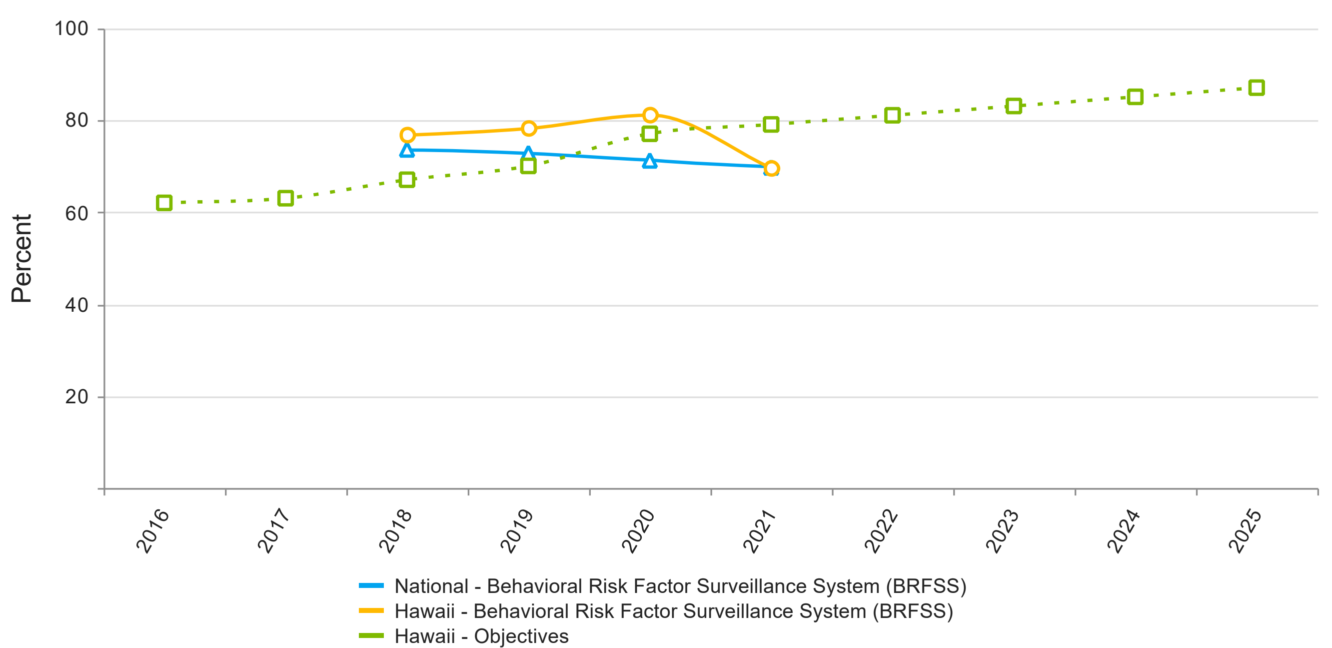
The following section provides report and plan narratives for Hawaii's priorities, National Performance Measures (NPM), and State Performance Measures (SPM) by population domain as reflected in the 5-year plan. Hawaii's priorities discussed in this next section are listed below with the associated NPM/SPM number and subject matter.

Domain	PM #	Subject
Women's/Maternal Health	NPM 1	Women's Wellness Visits
Perinatal/Infant Health	SPM 2 NPM 5	Food Security Safe Sleep
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

Although COVID restrictions have been eliminated, activities planned for FY 2022 continue to be impacted by the pandemic due to staffing shortages and economic hardships for many families, which is a result of inflation and uneven financial recovery across the population.

Women/Maternal Health

National Performance Measures



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			77	79	81
Annual Indicator		76.6	78.1	81.1	69.5
Numerator		184,106	185,323	191,337	167,306
Denominator		240,287	237,398	235,933	240,808
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

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

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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:	Inactive - Replaced				
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	31	31	31	31	31
Annual Indicator	31.9	30.9	32.4	33.3	33.1
Numerator	2,773	2,661	2,558	2,614	2,518
Denominator	8,693	8,599	7,903	7,851	7,609
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Provisional

ESM 1.2 - The number of women aged 18-44 years served through the state MCH reproductive health and wellness program.

Measure Status:	Active
State Provided Data	
	2022
Annual Objective	
Annual Indicator	3,681
Numerator	
Denominator	
Data Source	Family Planning and Reproductive Health program
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	4,000.0	4,200.0

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
Promote health equity

ESMs	Status
ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception	Inactive
ESM 1.2 - The number of women aged 18-44 years served through the state MCH reproductive health and wellness program.	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 Visits, based on the 2020 five-year Title V needs assessment results. The 2025 Title V state objective is to increase the percentage of women who have a preventive medical visit from 78% to 87%.

Data: The FY 2022 data (2021 data) indicates that 69.5% of women in Hawaii received a preventive medical visit, which did not meet the annual objective and was significantly lower than the previous year. This is likely due to COVID isolation, shutdowns, and healthcare service disruptions during 2020-22. Hawaii's rate was similar to the national estimate of 69.7%. The BRFSS preventive checkup survey measure was revised in 2018 and is not comparable to previous survey years. There were no significant differences in reported subgroups by race/ethnicity, maternal age, household income, health insurance, or marital status based on 2021 data.

Objectives: The state objectives reflect a projected annual increase of two 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 key leadership for this issue and is partially Title V funded. This supervisory position has remained vacant since November 2021. Recruitment efforts are ongoing for this position.
- MCHB no longer administers the federal Title X Family Planning grant for Hawaii. The program was temporarily sustained in 2020-21 using Title V funds but eventually ended.
- The state-funded Family Planning supervisor position was vacant from May to November 2021. This position was filled temporarily from November 2021 to September 2022 and has been permanently filled since September 2022.
- The programs in the WRHS section also include Adolescent Health. The Adolescent Health Supervisor vacancy was filled in August 2022. The Program Specialist IV position remains vacant in the unit.

Strategies/Evidence: The strategies for this priority, in large part, reflect the work of the Hawaii Maternal and Infant Health Collaborative (HMIHC), which has provided community-led leadership for women's health and perinatal issues in the state for the past 10 years. Title V helped establish HMIHC and continues to be 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 inter-conception healthcare visits
- Promote reproductive life planning
- Promote health equity

Research provided by AMCHP and the MCH Evidence Center indicates that most women's health evidence-based practices focus on clinical and direct service approaches rather than Hawaii's broad systems-level change strategies. Hawaii has been implementing two evidence-based approaches that promote pre- and inter-conception care and women's wellness visits for the past six years.

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

The MCH Bureau Infant Mortality Collaborative Innovation and the Improvement Network (CoIIN) promoted the two approaches as best practices.

COVID Impacts: COVID-related safety restrictions were largely eliminated in 2022, with healthcare providers reopening for in-person clinic visits and continuing some telehealth appointments. Telehealth remains part of the 'new normal' as the state transitions to COVID as endemic status. Throughout 2022, many of Hawaii's families continued to struggle economically to meet basic essential needs (rent, employment, education, and food security), given rapidly increasing inflation and housing costs. These factors have affected access to healthcare.

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

This strategy recognizes that public health issues are best addressed by developing and sustaining partnerships between and within community organizations, academic institutions, and government. These partnerships provide opportunities to improve women's health before, after, and between pregnancies. In Hawaii, women's wellness is currently 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 their infants, children, and families.

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

In-person ECAS and HMIHC meetings and activities resumed in 2022-23. The HMIHC continues to meet via teleconference with active involvement of many physicians in HMIHC. Virtual meetings have helped sustain more participation by doctors and other clinical providers.

Strategy 2: Promote pre/inter-conception 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, after, and between pregnancies. Its goal is to reduce unintended and untimed pregnancies statewide by promoting comprehensive clinical, educational, and programmatic supports for reproductive life planning. Particularly important is the use of culturally appropriate approaches to improve access to family planning services.

The State Medicaid program and a family practice physician currently co-chair the workgroup, which includes: representatives from the Hawaii American College of OB-GYNs (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 Coalition (HMHB); Planned Parenthood; and several federally qualified

health centers (FQHC), among others. The involvement of Medicaid and FQHCs helps to focus and deliver services to more lower-income, at-risk women of reproductive age. The workgroup continued to meet regularly and remotely throughout 2022.

One Key Question® (OKQ): In FY 2022, the Pre/Inter-Conception Workgroup reduced efforts around OKQ promotion and training. 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. Many organizations are opting to continue screening but no longer adhere strictly to the QKQ protocols. This change will provide clinicians and counselors with more options and flexibility in reproductive counseling questions/approaches and enable more diverse counseling-related training and education.

Title V WRHS contracted with Healthy Mothers, Healthy Babies to provide OKQ-certified training through the national *Power to Decide* (PTD) program in 2021. The curriculum and materials were offered as a self-paced, one-month online course with continuing education credits offered. This HMHB contract was implemented during the height of COVID, from May 2021 to January 2022, when many providers were closed and/or reduced clinical services. Participating in OKQ training was not deemed critical at that time given fewer patients seen and COVID safety concerns. A total of 146 participants signed up for the online workshop, and 28% (42) completed the Power to Decide (PTD) training.

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 non-directive counseling and respect clients' decisions about their acceptance of LARC.

If discussion of reproductive health intent/goals can occur prior to or immediately following delivery, the provider can counsel and facilitate insertion of LARC at the birthing hospital prior to discharge. This benefits women at risk for short-interval pregnancies and/or those less likely to return for recommended postpartum care.

The HMIHC Pre/Inter-Conception workgroup developed and distributed a LARC toolkit in 2021 that includes billing guidance related to inpatient stocking of LARC and a chart with reimbursement codes. It is also available at all birthing hospitals and with many women's health providers.

Despite the updated Medicaid LARC policy, changing birthing hospitals' operational/insurance practices is challenging. HMIHC continues working with several hospitals to establish inpatient pharmacy protocols to ensure that LARC is in-stock. HMIHC is also addressing issues with Medicaid reimbursement and private insurance coverage.

Many hospitals now stock LARC for same-day access; however, the goal is for all 13 Hawaii birthing hospitals to stock and receive unbundled Medicaid reimbursements for LARC inpatient insertion.

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 policies.

In December 2021, an updated policy from DHS relating to Pregnancy Intention Screening and Contraceptive Coverage (Qi-2137) was issued, which provided further clarification on outpatient coverage of LARC devices with an updated current billing code. It also encouraged all healthcare providers to adopt a reliable, evidenced-based pregnancy intention screening tool to assist members in accessing appropriate services to support individual reproductive life plans. The memo specified that OKQ is one of several evidence-based pregnancy intention screening tools available to providers.

Extension of Postpartum Care. In August 2022, Hawaii's request to extend Medicaid postpartum care from 2 to 12 months received federal approval as a result of 2022 State Legislature appropriation of $2.4 million to the State Medicaid program. This appropriation will be matched by $3.4 million in federal funds. Hawaii was one of several states that enacted this change due to the American Rescue Plan Act, which allows states to extend postpartum coverage. Well-women visits are particularly important postpartum given the risk of pregnancy-related deaths and severe maternal mortality, which data indicates is rising in Hawaii.

The extension of postpartum care is also essential since Medicaid enrollee redeterminations are being conducted at the end of the federal public health emergency declaration in May 2023.

Strategy 3: Promote reproductive life planning

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

Title X ended: Initially, Hawaii stopped accepting Title X funds in April 2020 in response to the Trump Administration's Title X conditions prohibiting grantees from providing any information regarding abortion services options. Hawaii submitted a new application under the current administration that had lifted the abortion restrictions, but the application was 'approved, but not funded' for an award. The Hawaii service-area grantee is Essential Access Health (EAH), which serves California's statewide Title X provider network. EAH partnered with seven local healthcare organizations in Hawaii, including FQHCs, the University of Hawaii health service programs, and Planned Parenthood. Limited existing state funds for FP service contracts continued through June 30, 2021.

New RFP: Given the adverse economic impact of COVID on most Hawaii families, the MCHB-WRHS immediately issued a new RFP to help community providers continue to offer reproductive and wellness health services for underinsured and uninsured persons, using a small amount of state general funds. These new contracts began on July 1, 2021. Although the numbers served were significantly reduced (when compared to those previously served with Title X funding), the eight selected community providers delivered reproductive health services to most of the counties through FQHCs, neighbor island college health centers, and the Healthy Mothers, Healthy Babies Coalition mobile units on Oahu and Hawaii Island.

The new RFP allowed providers to cover a comprehensive range of preventive wellness and reproductive health services, including health assessments and routine lab tests, family planning, STD/HIV testing, pregnancy diagnosis and counseling, and care for high-risk pregnancies. Additional services covered include health education, annual women's wellness examinations, maternal and infant supplies, transportation, childcare, respite care, and health outreach activities.

During COVID services closures, WRHS amended service contracts to allow for expanded telehealth services, extended clinic hours, and additional protective PPE safety supplies to help protect providers and clients. These added provisions remain in the current service contracts.

ESM 1.2 - The number of women aged 18-44 years served through the state MCH reproductive health and wellness program.

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective								3800	4000	4200
Annual Indicator							3681			

Based on the RFP, a new Evidence-based/Informed Strategy Measure (ESM) was selected for women's preventive medical visits: the number of women aged 18-44 years served by the state's reproductive health and wellness program. This replaces the former population-based measure on birth spacing, which did not directly relate to the Title V strategies. The ESM relates to the evidence-based strategy Engagement of Other MCH Programs to Disseminate Information and Make Referrals for Well-Women Visits. Providers across the state were sought to offer critical wellness and reproductive health services to those most in need. The FFY 2022 data collected indicates that 3,681 women were served. Contractors are expected to work on increasing the program's reach; thus, objectives now reflect an incremental yearly increase.

The new ESM meets many of the MCH Evidence Center selection criteria and focuses on the quantity of effort. Because the RFP was expedited to address funding needs and service gaps for community providers, it is a formative quantity measure that will be strengthened in the future to assess quality of effort and outcome.

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 ensures that program activities benefit identified lower-income and underserved population groups.

In 2022, MCHB responded to community requests for implicit bias training for perinatal healthcare providers by partnering with the JABSOM faculty within the Native Hawaiian Health Department. The presentation was offered online in June 2022, entitled '*Contextualizing Maternal Health in Hawaii,*' and addressed the significant historical, cultural, and social determinants of health. It included important findings from original Hawaii-based research on implicit racial bias among perinatal providers toward Native Hawaiians and Pacific Islander patients. A total of 71 providers attended this online presentation, which is available at https://www.youtube.com/watch?v=72cOtSPJjVU.

Current Year Highlights for FY 2023 (10/1/2022 – 6/30/2023)

Service updates:

- MCHB WHRS continued to provide ongoing reproductive health care and support services through eight community-based providers across all counties except in Kauai County and on the island of Molokai.
- Systems-building work, through the HMIHC Pre/Inter-Conception Workgroup, continued to promote OKQ and other evidence-based forms of reproductive counseling and address LARC administrative issues. The workgroup is now contacting all birthing hospitals, FQHCs, and Rural Health Clinics to assess whether LARC remains stocked in their pharmacies and identify any logistical barriers/challenges.
- A new MCH Branch contract is being executed for a Birth Control Resource Methods Access Coordinator to help expedite the work on LARC stocking in birthing hospitals and pharmacies.

New RFP for reproductive health services: In 2023, MCHB conducted focus groups with reproductive health providers to help identify women's health service needs for their communities. Based on the input, a new RFP was developed that includes the following:

- Services to uninsured and underinsured participants seeking reproductive health care and related preventive health services statewide and assist the uninsured in applying for healthcare insurance upon initial visit
- Supplies that are not covered by health insurance plans or occasionally difficult to obtain to maintain good health and promote healthy birth outcomes
- Subsidized transportation and child/respite care costs for participants who may have challenges (e.g., reside

in rural areas and/or experiencing poverty) with attending medical appointments that are not covered by health insurance plans or occasionally difficult to obtain

- Collaboration with community programs to reach underserved populations to provide educational activities and presentations that are age and culturally respectful of the history, traditions, and values of different ethnic groups to help increase positive parenting and family support
- Provide medically accurate and cultural perspective information, education, awareness, reproductive health screening (using OKQ), family support, violence prevention, and ensuring the promotion of voluntary family planning clinical services throughout Hawaii
- Enhance and increase outreach activities/strategies by utilizing media sources

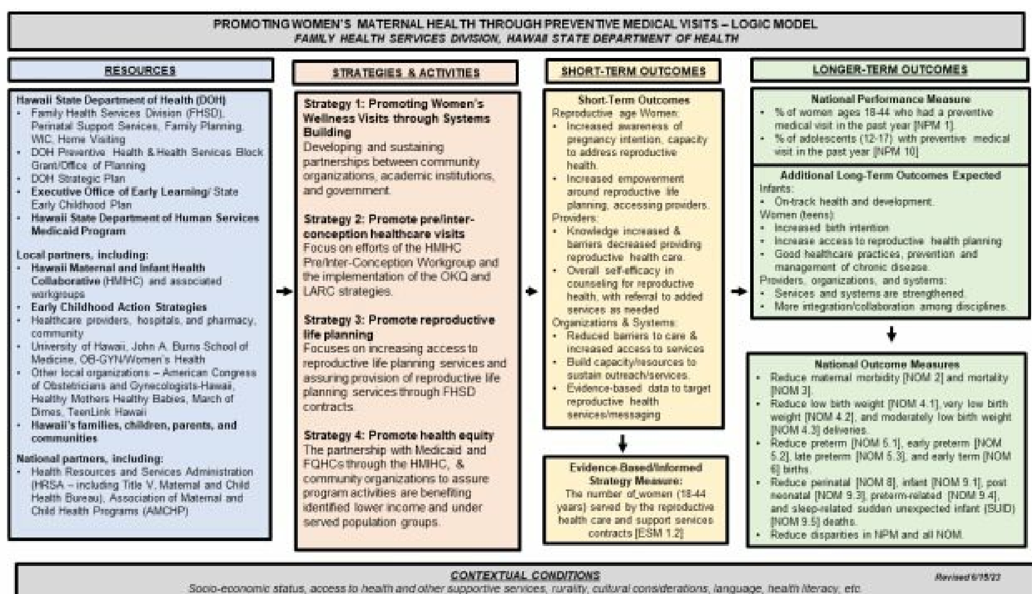
Health Equity: The new WHRS RFP for reproductive health services specifically targets at-risk populations that need more culturally sensitive services and support. These services are designed to reach rural populations and communities with lower income and access issues.

Abortion Protections: In response to the overturning of Roe v Wade by the Supreme Court, Hawaii's out-going governor, David Ige, signed an executive order in October 2022 to protect out-of-state visitors who obtain abortions in Hawaii, as well as anyone who assists them, from civil and criminal penalties that their home states may impose. The order also protected Hawaii healthcare providers who perform surgical abortions or provide abortion medications to non-Hawaii residents.

The 2023 Legislature codified these protections with Act 2, which Governor Josh Green signed into law. The bill further expanded abortion access by allowing physician assistants to perform abortions. It repealed requirements that abortions be performed at a hospital or clinic to allow for non-surgical abortions.

Review of the Action Plan

A logic model developed for NPM 1 aligns strategies and activities with performance measures and desired outcomes. This logic model was updated to reflect changes in women's health and wellness activities since last year, including the addition of a new ESM. The fourth health equity strategy was added in 2022 to the logic model to help address the need to reduce health disparities in Hawaii's women.



The vital work of the HMIHC is continuing, despite the ongoing demands and challenges resulting from COVID, including workforce turnover. Health messaging for both providers and consumers continues to be developed by the HMIHC Workgroup on OKQ and other reproductive health counseling options, as well as access to LARC and other reproductive health services.

Priority Populations: Priority populations to be reached include lower-income women, particularly in light of the health, social, and economic consequences of COVID in Hawaii. Partnering with DHS Medicaid facilitates Title V efforts to address/track this growing population's needs. Although the NPM Title V federally available data does not indicate any significant disparities by subgroup, further analysis of women's health data using local datasets will help us identify key findings to help guide future women's health program planning efforts.

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

Challenges Encountered

Women's Health Services. With the FY 2020 loss of Title X family planning funding, MCHB is reevaluating its future programmatic focus on women's/maternal health, as Title X funding was a cornerstone in supporting reproductive life planning, women's health services, and workforce training.

Workforce Vacancies. Transitions in the women's health workforce during COVID significantly and adversely affected the Title V Women's Reproductive Health section. Although some positions were filled, the section supervisor position and other key positions remain vacant. These program vacancies are compounded by a need for more skilled MCH epidemiological support to help track and analyze Hawaii health data, such as COVID health impacts and key women's health disparities.

Hawaii also acknowledges the need to continue to improve its performance and evaluation measures when contracting for services. Gaining epidemiology support and regaining key staff support for the program is expected to assist in these efforts.

Some of the challenges faced in advancing widespread exclusive use of OKQ and LARC as the sole recommended reproductive health counseling option include:

- Lack of a centralized data management system to establish OKQ and LARC benchmarks, performance measures, and creating systematic data collection processes
- Continuing 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
- Lack of clinician interest in completing the required course content and certification process

Overall Impact

Despite the challenges over the past two years, Title V achieved significant milestones in promoting reproductive life planning and women's wellness visits:

- Integration and continued efforts to improve maternal health as part of three key state plans
- Collaborative health work facilitated sharing of women's health leadership, expertise, and funding
- Successful partnership building in the formation of HMIHC with Title V's regular leadership and participation with Medicaid, physicians, and safety net providers in Pre/Inter-Conception Workgroup. The diverse HMIHC membership helped to provide support to maintain and sustain 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's supply of oral contraceptives, unbundled LARC reimbursement from delivery fees, stocking of LARC in hospital pharmacies)

- The 2021 Medicaid provider updated the title and references, clarified outpatient coverage of LARC devices, and updated the current CPT code. It also encouraged all healthcare providers to adopt a reliable, evidenced-based pregnancy intention screening tool of their choice to assist members in accessing appropriate services to support the individual reproductive life plans. The memo specified that OKQ is one of several evidence-based pregnancy intention screening tools for providers.
- Over 1,000 OKQ-trained health care providers statewide
- LARC now stocked in most of the state’s birthing hospital pharmacies.

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 2020 Title V five-year needs assessment results. By July 2025, the state seeks to increase to 87% the number of women who have a preventive medical visit, including pre- and inter-conception care. Plans to address this objective and NPM are discussed below.

Due to significant operational and personnel changes within the MCHB over the past two years, many planned activities were either delayed or revised. Given maternal/women's health recognition in the state's key MCH plans and collaboratives, Strategy 1 (promoting women's wellness visits through systems-building) will be retired in FY 2023. Collaboration and systems-building is integrated into each of the specific strategy activities. Plans for the remaining three strategies are below.

Strategy 1: Promote Pre/Inter-Conception Healthcare Visits

The HMIHC Pre/Inter-Conception Workgroup plans will continue to focus on expanding use of OKQ and other evidence-based reproductive health counseling options and improving access to LARC via birthing facility pharmacies.

LARC activities include:

- Implement MCH Branch contract to hire a Birth Control Resource Methods Access Coordinator to help support the HMIHC work on LARC stocking in birthing hospitals and other healthcare facility pharmacies
- Continue to assess and address barriers to implementing the Medicaid LARC and other reproductive health counseling policies at Hawaii's birthing hospitals, Federally Qualified Health Centers (FQHC), and Rural Health Clinics. In partnership with Medicaid, the University of Hawaii John A. Burns School of Medicine, Department of Obstetrics, Gynecology and Women's Health 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 women's reproductive health counseling.

Strategy 2: Promote Reproductive Life Planning

Title V MCHB will continue to work towards increasing access to reproductive life planning services through RFP-based service contracts to community-based providers. Activities include:

- Service contracts for the new RFP will be issued and services provided across the state to reach identified uninsured and underinsured Populations
- Contracts will be monitored and key data collected and analyzed for Title V reporting and evaluation purposes
- The contracts will be reviewed to identify potential performance measures for possible ESM revision

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 other health equity topics.

FHSD continues to address the vacant epidemiology positions by contracting MCH data analysis services, focusing on identifying key disparities and monitoring maternal health status in this post-COVID period.

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 five 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 postpartum.

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 receives the Personal Responsibility Education Program grant. It administers the Evidence-Based Prevention Teen Outreach Program, a program directed toward reducing teenage pregnancy, school failure, and school suspension rates.

Hawaii Home Visiting: Provides comprehensive early identification of high-risk families, including expectant families and families of newborns who may benefit from 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.

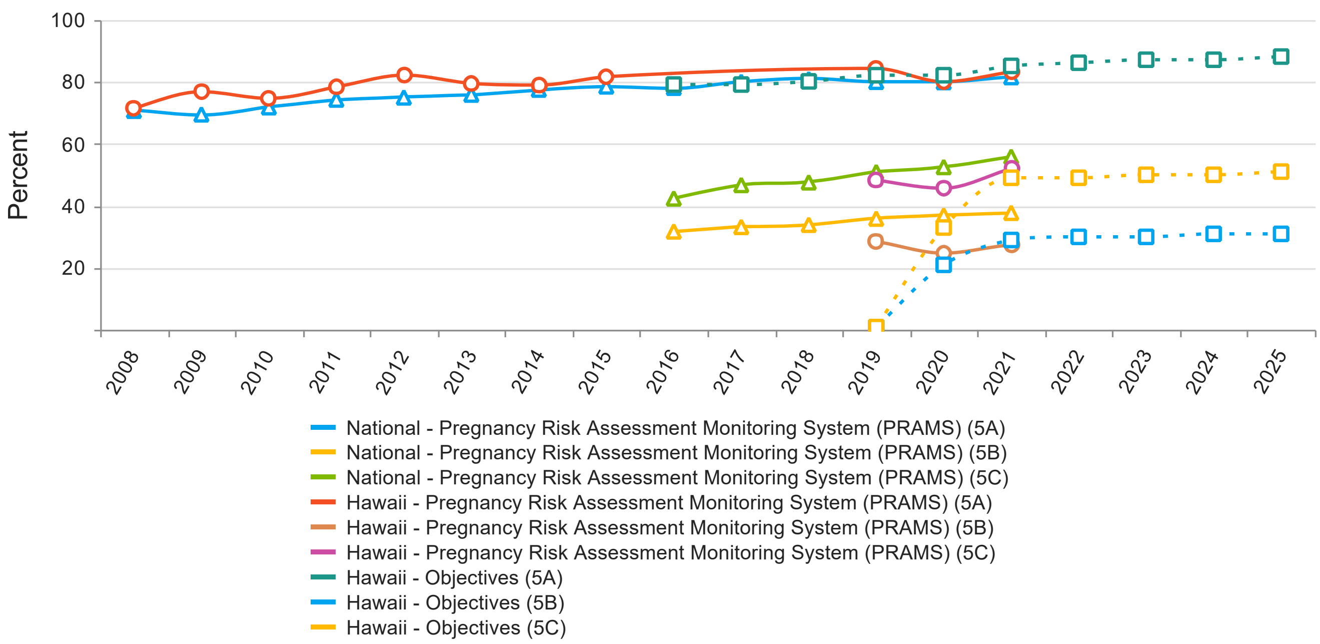
Maternal Mortality Review: Reviews causes of maternal deaths occurring during pregnancy up through one year of giving birth to identify public health and clinical interventions, improve systems of care, and reduce preventable deaths. The team is compromised of representatives from multiple disciplines and agencies.

Domestic Violence Fatality Review: Conducts multidisciplinary and multiagency 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



- National - Pregnancy Risk Assessment Monitoring System (PRAMS) (5A)
- National - Pregnancy Risk Assessment Monitoring System (PRAMS) (5B)
- National - Pregnancy Risk Assessment Monitoring System (PRAMS) (5C)
- Hawaii - Pregnancy Risk Assessment Monitoring System (PRAMS) (5A)
- Hawaii - Pregnancy Risk Assessment Monitoring System (PRAMS) (5B)
- Hawaii - Pregnancy Risk Assessment Monitoring System (PRAMS) (5C)
- Hawaii - Objectives (5A)
- Hawaii - Objectives (5B)
- Hawaii - Objectives (5C)

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80	82	82	85	86
Annual Indicator	81.5	81.5	84.0	80.1	83.0
Numerator	14,376	14,376	6,895	12,016	12,363
Denominator	17,634	17,634	8,212	15,003	14,891
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2015	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective	21	29	30
Annual Indicator	28.7	24.7	27.7
Numerator	2,245	3,565	4,047
Denominator	7,829	14,455	14,591
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		1	21	29	30
Annual Indicator	100	20.3	28.7		
Numerator	1	3,306	2,245		
Denominator	1	16,296	7,829		
Data Source	1	PRAMS	PRAMS		
Data Source Year	1	2016	2019		
Provisional or Final ?	Provisional	Final	Final		

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective	33	49	49
Annual Indicator	48.1	45.9	52.0
Numerator	3,755	6,633	7,507
Denominator	7,801	14,447	14,442
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		1	33	49	49
Annual Indicator	100	46.2	48.1		
Numerator	1	5,186	3,755		
Denominator	1	11,228	7,801		
Data Source	1	PRAMS	PRAMS		
Data Source Year	1	2016	2019		
Provisional or Final ?	Provisional	Final	Final		

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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:	**Inactive - Completed**				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			11	11	11
Annual Indicator			0	11	11
Numerator					
Denominator					
Data Source			Hawaii Safe Sleep Program	Hawaii Safe Sleep Program	Hawaii Safe Sleep Program
Data Source Year			2020	2021	2022
Provisional or Final ?			Final	Final	Final

ESM 5.2 - The number of translated Safe Sleep Guides for Parents that were provided to the agencies, organizations and individuals, on request

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	7,839
Numerator	
Denominator	
Data Source	Hawaii Title V Safe Sleep program
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	9,000.0	10,000.0

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**	**2022**
Annual Objective			27,000
Annual Indicator	25,584	25,907	25,855
Numerator			
Denominator			
Data Source	Hawaii WIC Services	Hawaii WIC Services	Hawaii WIC Services
Data Source Year	2020	2021	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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.	Inactive
ESM 5.2 - The number of translated Safe Sleep Guides for Parents that were provided to the agencies, organizations and individuals, on request	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

Perinatal/Infant Health – Annual report

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

Introduction: Safe Sleep

For the Perinatal/Infant Health domain, Hawaii selected NPM 5 based on the 2020 Title V needs assessment results. The 2025 Title V state objective for NPM 5A is to increase the percentage of infants placed to sleep on their backs from the current rate of 83% to 86.0%.

Data: NPM 5A: The latest data from the 2021 PRAMS survey (83.0%) indicates that Hawaii did not meet the 2022 state or Healthy People 2030 objectives of 88.9%. No national estimate was available for 2021, but the 2020 Hawaii estimate (80.1%) was slightly above the 2020 national estimate (79.8%). The increase from the 2016 estimate was not statistically significant. The state objectives through 2025 reflect an approximate 5% projected improvement over three years.

Analysis of Hawaii PRAMS 2019-2021 aggregated data indicates that Native Hawaiian (77.5%), Black (72.2%), Samoan (62.7%), and other Pacific Islander (66.2%) mothers were significantly less likely to place their infants to sleep on their backs when compared to White (89.9%) or Japanese (90.3%) mothers. Mothers who were under 20 years of age (60.8%) were less likely to place their infants on their backs to sleep when compared to mothers who were 20-34 years of age (82.0%) or 35 or more years of age (84.9%). Mothers at the FPL below 100% (73.6%) and those between 101-185% FPL (75.8%) were less likely to place their infants on their backs to sleep when compared to those mothers who were between 186-300% FPL (85.6%) or those who were at 301% and greater FPL (90.1%).

NPM 5B: The latest data from the 2021 PRAMS survey (27.7%) indicated that Hawaii did not meet the 2022 state objective (30.0%) and was significantly lower than the 2021 national estimate (37.8%). The increase in estimate from 2016 (20.3%) was statistically significant. The state objectives from 2021 through 2025 reflect a projected 5% improvement over three years.

Based on the 2019-2021 PRAMS data, Native Hawaiian (24.6%), Filipino (15.7%), Black (20.3%), and other Pacific Islander (23.9%) mothers were less likely to place their infants to sleep on an approved surface when compared to White (38.8%) mothers. Mothers at FPL below 100% (21.4%), those mothers at FPL between 101-185% (24.1%), or mothers between 186-300% (23.8%) were less likely to place their infants on an approved surface to sleep when compared to those at 301% and greater FPL (33.3%). No age differences were found in subgroup analyses based on 2019-2021 data.

NPM 5C: The latest data from the 2021 PRAMS survey (52.0%) indicates that the 2022 state objective of 49.0% was exceeded and was similar to the 2021 national estimate (55.9%). The increase in the estimate from 2020 (45.9%) was not statistically significant, but the increase was significant when compared to the 2016 estimate (31.6%). The state objectives from 2021 through 2025 reflect approximately 5% projected improvement over three years.

Based on the 2019-2021 data, Native Hawaiian (32.9%), Filipino (48.1%), Black (44.4%), and other Pacific Islander (23.9%) mothers were less likely to place their infant to sleep without soft objects or loose bedding, when compared to White (66.4%) mothers. Mothers under 20 years of age (32.5%) or those between 20 and 34 years old (46.9%)

were less likely to place their infants to sleep without soft bedding when compared to mothers who were 35 or older (55.7%). Mothers at FPL 100% or below (38.4%), those mothers between 101-185% FPL (43.4%), or those mothers who were between 186-300% (46.4%) were less likely to place their infants to sleep without soft objects or loose bedding when compared those at 301% and greater FPL (62.9%).

PRAMS data: There was no PRAMS data collection in Hawaii from 2017 to 2018 while there were legal issues regarding clarification on the use of vital records for public health research. The Title V 2019 NPM 5 indicators are derived from the 2016 PRAMS survey, and the 2020 indicators are from the 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: The total number of child deaths during the pandemic remained relatively low (113 in 2020, 97 in 2021) compared to the Hawaii average of 140-160 child deaths yearly from 2016-2019. This is possibly due to COVID-related changes in home routines. During the COVID period, infant sleeping conditions were considered possible factors in several Child Death Review (CDR) cases.

Title V lead/funding: The supervisor for the Family Strengthening and Violence Prevention Unit (FSVPU) under the MCH Branch (MCHB) serves as the Title V program lead for safe sleep. The FSVPU supervisor also oversees family violence prevention and parenting support programs. The FSVPU position has been vacant since January 2023. There is no dedicated funding source for Safe Sleep staffing or program activities; however, state and some federal grant funds are leveraged to support efforts. Title V-funded staff provide branch-level leadership and overall support for safe sleep.

Strategies: In 2022, the strategies for safe sleep were:

- Increase 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 by translating 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 moderate evidence of effective supports targeting caregivers with safe sleep education. National campaigns have 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 by targeting key ethnic groups and developing multilingual educational outreach for limited English-speaking families. The strategy was also supported by input from local service providers who work with underserved, multicultural families. The new ESM 5.2 intends to measure progress on the strategy pertaining to translation.

A report on safe sleep strategies and activities is discussed below.

COVID-19 Impacts: In 2023-23, the intensity of COVID impacts lessened and Hawaii largely returned to pre-COVID conditions with most COVID restrictions rescinded. However, the economic effects of COVID remain, with soaring housing costs, limited housing options, and homeless issues. Record inflation has also increased Hawaii's cost of living, including the home rental market. These conditions are contributing to increasingly overcrowded households and housing insecurity in Hawaii, creating less safe sleep conditions, especially for vulnerable younger families.

Strategy 1: Increase 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 by bringing more public awareness to the issue. Strategies include providing public health information on safe sleep and referring families to resources for more information and support.

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 ensure information on safe sleep practices, following the current version of the *American Academy of Pediatrics (AAP) Evidence-Based Recommendations for a Safe Infant Sleeping Environment at Birthing Hospitals, Child Care Centers, and Child Care Providers.*

SSH has a diverse membership, representing government, nonprofits, for-profits, grassroots organizations, individuals, and families committed to preventing infant mortality through safe sleep practices. SSH held quarterly virtual meetings during COVID and continues to meet remotely with steady participation. SSH reviews trainings and public messaging campaigns on an ongoing basis to ensure that information remains consistent with current AAP guidelines.

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

The theme for the Summit was *Pūpūkahi i holomua* ("Unite in order to progress”). This meeting highlighted various medical professionals, case workers, social workers, family service workers, and others working with families on safe sleep practices. Along with the speakers providing training and information, the attendees engaged in an interactive learning experience and were provided time for valuable networking.

Media Campaign: Given the greater social isolation experienced by families and the limited availability of direct services during COVID, Title V opted to use mass media efforts to promote public safe sleep messaging. In 2021, a Safe Sleep media campaign was initiated 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), the evidence-based recommendations from AAP. The spots mirrored the content of a widely used *Hawaii Safe Sleep Guide for Parents* developed by SSH in 2018. The guide was jointly developed in collaboration with several state agencies, with SSH reviewing the content before its release. The call-to-action for the campaign steered the public to Safe Sleep information available via The Parent Line (www.theparentline.org), the primary Title V warmline for family support.

This multimedia campaign was estimated to have reached 244,290 adults, ages 25-54 (99.6% of that age group). Additionally, there were 412K digital media impressions.

The Parent Line: The Parent Line, 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. In preparation for the campaign launch, MCHB worked with The Parent Line to create a dedicated webpage for safe sleep guidelines, with electronic copies of the Safe Sleep Guide available, as well as a schedule of accessible online safe sleep workshops.

The Parent Line also distributed 21,815 hard copies of the Safe Sleep Guide for Parents, with 13,976 in English and 7,839 in non-English.

Strategy 2: Expand outreach to non-English-speaking families and caregivers by translating 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 non-English languages spoken in Hawaii 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 data sources, 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 cross-checked by focus groups of native speakers to ensure that all translations were accurate and that all information and graphics were appropriately displayed in a readable and understandable manner.

The Safe Sleep Guide distribution was contracted to The Parent Line to ensure broad public access statewide. Printed versions of the guide were mailed out upon request and electronic copies were located 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).

The ESM for this activity changed in 2022 since the work to reach more diverse communities shifted from developing materials in key languages to ensuring distribution of the information to families and communities. ESM 5.2 (The number of languages in which safe sleep educational materials are available for Hawaii’s communities) was achieved and retired as a completed activity in 2022.

A new ESM 5.3 was developed to track progress on dissemination efforts to reach diverse populations with the translated Safe Sleep information in conjunction with the SSH media campaign in FY 2022. ESM 5.3 measures the extent to which translated informational materials were distributed to non-English speaking populations.

ESM 5.3 (new) The number of translated Safe Sleep Guides for Parents that were provided to the agencies, organizations, and individuals on request

	2022	2023	2024	2025
Annual Objective	7000	8000	9000	10,000
Annual Indicator	7839			

These are the number of guides distributed by Parent Line by language for the reporting period:
Chinese Simplified: 705
Chinese Traditional: 670
Chuukese: 1,110
Ilocano: 930
Japanese: 462
Korean: 465
Marshallese: 1097
Samoan: 530
Spanish: 800
Tagalog: 615
Vietnamese: 455

The *Hawaii Cribs For Kids Program* under HMHB, which provides safe sleep education and cribs statewide to promote safe sleep practices and provides a safe sleeping environment, also prioritized language access. This contract, managed by FSVPU, mandated that the materials be translated into at least one of the non-English languages specified by the DOH, DHS, and OLA workgroup that identified languages for safe sleep guide translation.

Other Activities

Safe Sleep Assessment: The Family Strengthening and Violence Prevention Unit (FSVPU) in 2022 contracted for a needs assessment to identify all current efforts and partnerships, the impact of these efforts, gaps where there is a need, and an action plan for promoting Safe Sleep in Hawaii. This allowed FSVPU and community partners to develop more effective planning through a more systemic public health approach.

The information was collected through research, surveys, individual interviews, and listening sessions with key stakeholders. In addition to independent research, including reviews of numerous state reports and other official documents, input was collected from 65 people working in the field (16 caregivers and DOH staff).

Cribs for Kids: The Family Strengthening and Violence Prevention Unit contracted with the Healthy Mothers, Healthy Babies Coalition (HMHB) of Hawaii in 2022 to provide Safe Sleep education and distribute infant cribs. HMHB's Hawaii Cribs For Kids (CFK) Program has been virtually available on all islands. This program focused on providing educational and support services to families to help reduce the incidence of sleep-related deaths. Parent participants were provided safe sleep information and a *Graco Pack N Play* crib, so each infant had a safe place to sleep. The program works closely with Hawaii's birthing hospitals to ensure that parents, upon discharge, can provide infants with safe sleeping conditions at home.

Current Year Highlights FY 2023 (10/1/2022 – 6/30/2023)

SSH Staffing/Coalition. To ensure ongoing SSH Coalition meetings and outreach efforts, a contract was issued to Healthy Mothers, Healthy Babies to coordinate the coalition activities, including partnering with agencies and organizations; engaging in outreach and recruitment; addressing policy; working with advocates and families; and participating in planning of trainings, presentations, websites, and other activities to promote and educate about safe

sleep.

Media Campaign Repeated: Another Safe Sleep television and digital media campaign was launched in October 2022. The campaign was strategically aligned with October Safe Sleep and SIDS Awareness Month. The campaign ran through December, with activities that included a governor's proclamation signing and press release. The *Safe Sleep Guide for Parents* and The Parent Line were the central means to share information on the AAP guidelines. The campaign also coordinated with community-based programs supporting safe sleep efforts, such as *Cribs for Kids*.

Cribs for Kids (CFK): HMHB provided safe sleep education and services to over 450 parents and caregivers statewide as of May 2023. Outreach efforts included coordination with the Department of Human Services caregiver programs, such as Temporary Assistance to Needy Families (TANF), and with service providers that target families who are homeless or at risk for homelessness. Education is now provided in-person or remotely via email, video, or phone. HMHB is working to translate the CFK program materials to reach those with limited English proficiency and is also working with DOH to develop an evaluation tool.

Statewide Assessment: Work on the Safe Sleep assessment continues. Hawaii's birthing hospitals are being contacted to document current SS promotion/training activities and needs. Efforts are also being made to establish an ongoing working relationship between Hawaii's birthing hospitals and the SSH Coalition. A report will be finalized later in 2023, along with an Action Plan for the SSH Coalition going forward.

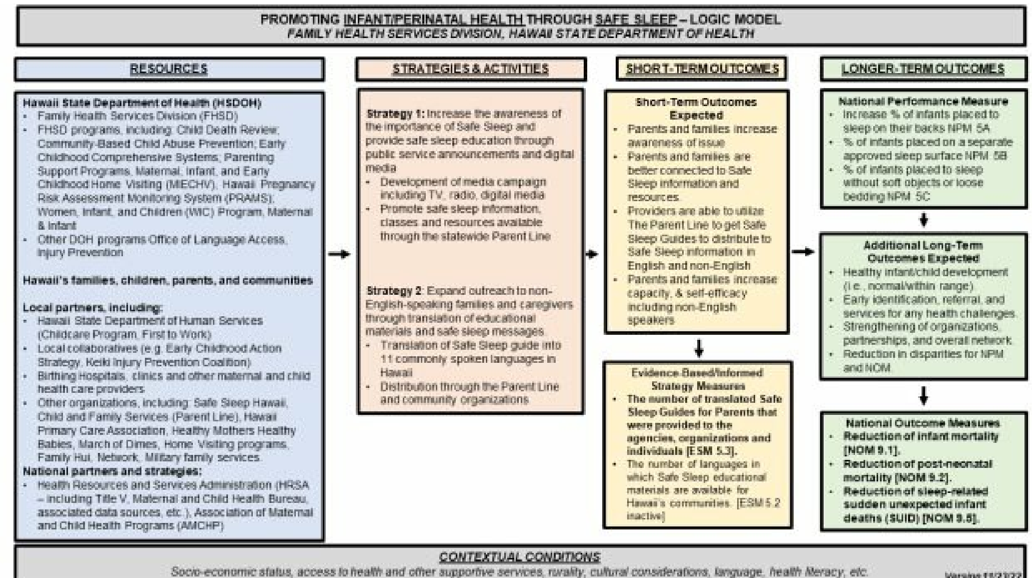
Safe Sleep Trainings. The Hawaii Children's Action Network was contracted to organize one or two August 2023 trainings on Safe Sleep for perinatal/postpartum service providers, including doulas, midwives, and lactation consultants.

Review of the Action Plan

A logic model was developed for NPM 5 to review alignment among the SS strategies, activities, measures, and desired outcomes. The program continues to focus on two strategic areas: messaging and translating educational materials for limited-English speaking populations and efforts to increase the percentage of infants placed safely to sleep and in safe environments.

The new ESM 5.3 was added to the logic model, focusing on dissemination of the translated safe sleep materials to the community. Reductions in disparities are anticipated for all measures, with improved outcomes reflected in PRAMS data. 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 ethnocultural 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

Key staff changes: The supervisor for the Family Strengthening and Violence Prevention Unit (FSVPU) under the MCH Branch (MCHB), who served as the Title V program lead for safe sleep, left this position in October 2022. The FSVPU position has been vacant since then, and the MCHB is actively recruiting for this key position.

COVID: Due to COVID, safe sleep activities were revised for 2022 in response to operational changes and dramatically-changing community needs. SSH continued to conduct remote partner meetings, but partnerships and services were disrupted somewhat by urgent public health priorities during this time.

Cribs for Kids (CFK) The CFK program 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 during 2020-22 to meet heightened safety guidelines. The program resumed in-person outreach but retained remote options to accommodate busy parents. A program evaluation is pending to determine whether/how these changes have impacted the effectiveness of the CFK program.

Addressing Co-Sleeping: As Hawaii PRAMS data confirms, co-sleeping is a common family/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, household overcrowding, housing insecurity, and multi-family living arrangements due to the high cost and unavailability of affordable housing. Data indicates that certain ethnic groups, young mothers, and low-income families are particularly at risk for co-sleeping practices. Working with cultural leaders and other community organizations is key to the success of targeted outreach to these at-risk populations. SSH will continue to 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. It is currently unknown to what extent the SS messaging has changed family attitudes and behavior around safe sleep practices. It is also unclear to what extent service providers have utilized the translated SS information with their client populations. The safe sleep environmental scan currently underway will collect and document additional data to

better determine effectiveness of these efforts.

Overall Impact

COVID challenges changed outreach efforts on safe sleep practices, with the program relying more on electronic/digital methods that have increased virtual access to key information statewide. The *Safe Sleep Guide for Parents and Caregivers* was previously primarily distributed through printed posters and is now widely 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 on safe sleep guidelines and resources can 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 provider interviews. This brought more awareness of the issue to the general public and highlighted the available SS resources.

The statewide crib distribution programs offered by community-based organizations were paired effectively with safe sleep education to help families needing support. This is mainly geared toward lower SES families most affected by COVID restrictions, economic challenges, 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 in FY 2021 to address food insecurity based on the results of ongoing needs assessment. 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 and escalating economic costs. This priority will focus on promoting and increasing utilization of the Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Data: The data for this measure comes from US Department of Agriculture WIC participation reports and reflects 12-month averages. The participation for WIC declined slightly through 2022 as the state transitioned to a new phase of COVID, with 25,855 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: 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. HCAN is a nonprofit whose mission is to ensure that all children are healthy, safe, and ready to learn. 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. In addition to HCAN, other organizational partners include the Appleseed Foundation and the University of Hawaii Center on the Family, which is assisting with data analysis. New opportunities for collaboration with the Supplemental Nutrition Assistance Program (SNAP) and DOH Chronic Disease Nutrition programs also arose during COVID.

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: The three food insecurity strategies for Hawaii come from 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.

COVID impact updates: FY 2022 saw the normalization of general life with rescinding of the last COVID-related emergency orders. Substantial federal relief funding and tourism's quick rebound helped to offset some of the community and financial hardships created by COVID. However, economic recovery remains challenging for many under-resourced WIC families and their communities with an unexpected rise in inflation and an exorbitant increase in housing/rental costs. Hawaii surveys and local service providers confirmed that many Hawaii families continue to suffer from housing and food insecurity.

In FY 2022, WIC total enrollments were 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 steady decline may have been due to the state's growing economy prior to COVID, the continued decline in births, and outmigration of Hawaii families due to the state's high cost of living.

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

The first grant strategy focused on establishing a community working group to partner with the WIC program to improve number of enrollments and expand services. A cross-sector working group was recruited for the WIC project. Members included WIC staff from the state WIC office, WIC community clinics (including those located in Federally Qualified Health Centers), university researchers, the Native Hawaiian Health System, advocates, and current WIC recipient mothers.

WIC Parent Voices: WIC families were deemed important partners in the working group. HCAN sent notices to recruit WIC parents through community networks and the Parent Leadership Training Institute alumni group to join the working 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 from October 2021 through June 2022. 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/work plan for WIC implementation.

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. 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

Some of the barriers identified by the Work Group:

- 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 lack WIC clinics, including parts of rural Oahu.
- Operationally, WIC is impacted by the competitive labor market and, like other agencies, is struggling to fill its vacant positions.

Assessment: HCAN assessed the Hawaii WIC program, including examining census data and other national 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.

Using 2019 federal US Department of Agriculture data, some of the findings on the WIC participation rate were:

- In Hawaii, 83.8% of WIC-eligible pregnant and postpartum women and 100% of eligible infants participated in the program.
- Only 42.5% of children (aged 1 to 4) eligible for WIC participated in the program.
- A major limitation of the national dataset is no disaggregated racial/ethnicity data based on Hawaii-relevant populations.

Additional Data Analysis: FHSD contracted with the University Center on the Family (COF) to analyze the Hawaii WIC dataset to better understand the current WIC service population characteristics, enrollment patterns, and utilization patterns. WIC has limited internal resources for data analysis; thus, COF is reviewing the status of the dataset and conducting analysis that is relevant for Hawaii program planning. COF partnered with the WIC Working Group to help develop a data analysis plan. In addition to county-level data, sub-regional areas were identified to provide more detailed geographic data analysis to help with program planning.

WIC Store Map: The working group also developed an updated list of WIC-participating Hawaii stores and WIC program locations and mapped the information for uploading to the website.

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

The last strategy focused on developing recommendations to improve WIC services based on the research and findings of the Working Group. Although the WIC Working Group is still awaiting data and assessment results, a strategic recommendation list was identified after reviewing the national FRAC WIC report. Since the report was published prior to the pandemic, the group found that several of the recommendations to increase access via technology, such as allowing for virtual appointments, had already been accomplished in Hawaii.

Some of the recommendations that the WIC working group agreed would be worth pursuing include:

- Harnessing the power of technology through social media, web-based advertisements, and a well-designed and strategic online website that leads to content specific to each of the Hawaiian Islands
- Creating a special outreach program to the Micronesian and other underserved communities to increase engagement
- Creating a WIC Advisory Council with representatives and stakeholders from each island
- Partnering with SNAP and Medicaid to share client data, extend program reach, and increase participation

Data Sharing w/SNAP: One of the recommendations was initiated in May 2022, when WIC executed a data-sharing agreement with SNAP to improve the enrollment process for clients who are eligible for both programs. Efforts are in the testing stage with migrating referral data from SNAP to WIC. Although WIC does not currently share its program data with Medicaid, staff from both agencies share program information with their clients.

The Department of Human Services (DHS), which administers SNAP and Medicaid, is leading the data-sharing effort as part of a broader WIC/SNAP collaboration. In 2021 during COVID, DHS was awarded a private grant designed to improve state systems that leverage SNAP and related programs to increase access to nutrition supports to reduce child hunger. WIC and SNAP met regularly to implement the grant activities.

Current Year Highlights for FY 2023 (10/1/2022 – 6/30/2023)

This section highlights the start-up work for the PAC grant in FY 2023.

WIC Data Analysis: WIC finalized a data-sharing agreement with the University Center on the Family (COF) in November 2022 and the dataset was provided to COF for analysis. COF found that while the required data fields were complete for most clients, many of the optional fields had very high proportions of missing data, rendering them of little use in an analysis. In May 2022, COF presented preliminary analysis of the WIC dataset and initial drafts of the demographic profiles for each county and regional areas. The analysis revealed that the WIC population is predominantly Native Hawaiian (34%), White (15%), Mixed (13%), Pacific Islander (11%), Filipino (10%), Other Asian (10%). There were some variations by county. Other characteristics:

Variable	State Average
Maternal Age	28.6 years
Household size	4.2
WIC clients per family	1.8
Per capita income	$7,200 annual
Medicaid enrollee	64%
SNAP enrollee	36%
TANF enrollee	7%

The data confirmed that the largest drop-off in WIC participants occurred after age one, a similar pattern among most WIC programs. Factors associated with longer participation with the program included: Native Hawaiian, mothers also enrolled in WIC, the child or family members were enrolled in other entitlement programs, smaller household size, and older mothers. A final report and completion of the county profiles are due in July 2023.

Another contract is being executed with COF to continue the WIC data analysis with an additional year of data.

WIC/SNAP Collaboration The data exchange is on hold due to limitations with the WIC data contractor. Given the delay, promotional efforts were prioritized and a social media campaign to inform the public about SNAP and WIC was developed for release in late July. The FHSD and DHS communications staff collaborated on images for social media and agency websites and a news release.

WIC Farmer's Market & Food Hubs As part of the implementation of the DOH Chronic Disease nutrition plan, WIC is working with community partners to increase access to locally grown produce by authorizing WIC benefits for fruits and vegetables to be redeemed at farmer's markets and food hubs. The pilot cohort for this project has two farmer's markets and two food hubs located in rural, predominantly Native Hawaiian communities. These projects will increase access to fresh produce, support local farmers, and promote WIC with greater community visibility.

WIC Innovation Grant. Another Work Group recommendation was completed when HCAN submitted a successful WIC Community Innovation and Outreach Project (WIC CIAO) grant application. In May 2023, HCAN received an award of $530,312, one of 36 awards nationally. The grant will be used to implement more Work Group recommendations to develop and implement innovative outreach strategies to increase WIC participation and benefit redemption and reduce disparities in program delivery. WIC and other partners will meet in July to finalize work plans for the grant.

Annual Conference Plans for the annual WIC conference in September 2023 include keynote speaker Dr. Jamila Taylor, the President of the National WIC Association. Other speakers will address topics on the intersection of counseling & social determinants of health, a baby-led approach to feeding, the impact of labor/delivery on lactation, and using a trauma-informed care client approach. The UH COF will also present WIC data findings. This will be the first in-person meeting since COVID.

End of Public Health Emergency (PHE) WIC is preparing for the end of the PHE and increased in-person visits. Remote services will continue through August, but in-person visits will resume with some flexibility for ongoing remote services. However, during COVID, WIC suspended collecting important health data on WIC mothers, infants, and children. In-person visits will help resume health checks and monitor the well-being of WIC families.

Challenges Encountered

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

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 to 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 assessments and evaluations 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, staffing, and supports to one of the state's largest and most significant maternal and child health

programs. Despite WIC's large budget, most of the staffing/resources go toward WIC operations with few resources for program enhancements.

The WIC Working Group provided valuable feedback from parties with different perspectives of the WIC program. 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.

The importance of 'independent' family voices proved invaluable to the workgroup. WIC clients provided candid input about their WIC services experience and the challenges facing young families given current economic conditions. There will be a greater focus on collecting input in future research and planning.

COVID helped focus greater attention on food insecurity and the importance of food/nutrition programs like WIC and SNAP. With the assistance of both private and public funding, there is greater collaboration between the two federal food assistance programs to improve awareness and access to services.

Additional partnerships with the DOH Chronic Disease Nutrition program and working with community partners have assisted WIC in piloting farmer's markets and food hubs as options to expand access to local fresh produce for WIC enrollees.

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 work plan highlights the three safe sleep strategies that are listed below.

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

Media Campaign: Another Safe Sleep television and digital media campaign may be repeated in FY 2024. The campaign will likely be relaunched during October Safe Sleep and SIDS Awareness Month. Activities may also include a governor's proclamation signing and press release. The *Safe Sleep Guide for Parents* and The Parent Line will again be the central means to share information on AAP guidelines. The campaign will also coordinate with community-based programs that continue to support safe sleep efforts for Hawaii's families.

Translation of Media Messaging: The television and digital media spots used in the media campaign will be translated into several languages to reach non-English speaking populations. 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 new strategy recently emerged from Safe Sleep Hawaii (SSH). The implementation activities for this strategy include the following:

- 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.

A contract executed with Healthy Mothers, Healthy Babies will ensure the coalition's ongoing work.

Implementation of Recommendations from the Statewide Assessment: The environmental scan and assessment of safe sleep activities in Hawaii will be completed in later FY 2023. The project includes conducting a focus group 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. It will help to inform future planning, including clarifying the role of SSH, identifying further evidence-based strategies to address disparities, and promoting health equity in safe sleep going forward.

Cribs for Kids. HMHB will meet with DOH to review program evaluation results and discuss plans, progress, tasks, and responsibilities.

Staff Vacancy. Once the SS coordinator position is filled, planning will resume for more SS activities, including the next Safe Sleep Summit.

SPM 2 – Number of participants in the WIC program in Hawaii

For the Perinatal/Infant domain, Hawaii added this state priority and performance measure during the COVID pandemic to address food insecurity issues, focusing on promoting WIC services/enrollment. Food insecurity emerged as a critical issue given the economic turmoil during COVID and subsequent inflationary trends.

The goal is that by July 2025, WIC participant numbers will increase in Hawaii to 30,000 pregnant women, infants, and children to provide greater supports and resources to Hawaii's families most in need. The measure for this priority may change given improved WIC data analysis and capacity. The current strategies to address this SPM emerged from increased community and family collaboration during COVID.

The three strategies and plans presented below emerged from a Partnership for Children (PFC) grant, which was awarded in May 2021 and ended in 2022. A new grant award to improve WIC services may result in a change of strategies.

The proposed 2024 Title V grant guidance includes a national performance measure on child food insecurity. Hawaii may consider changing this state performance measure to the new NPM.

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

The WIC Working Group convened for the PFC grant but has since stopped regular meetings. One of the Work Group recommendations included forming a more permanent WIC Advisory Group comprised of diverse stakeholders, including current and former WIC families. Resources to staff and implement the recommendation will need to be identified.

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

This strategy focuses on the primary data and research work to identify barriers and challenges experienced by the WIC program and its clients.

- The University of Hawaii Center on the Family will continue and expand its data analysis of the WIC dataset. The 2020 calendar year data will be added to the 4-year dataset that was analyzed.
- Additional qualitative data collection with WIC families, including focus groups and key informant interviews, is also being planned to address retention issues, targeting key population groups: Native Hawaiians, Pacific Islanders (Micronesians), and Filipinos.

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

As more data becomes available, the recommendations to improve WIC program planning will evolve.

The WIC Farmer's Market and Food Hub distribution pilot projects will be implemented in FY 2024. The pilot will be evaluated and modifications made if needed. Additional project sites will be identified.

Work on the WIC/SNAP data sharing MOA will continue through monthly meetings.

Title V Perinatal/Infant Health Programs

The Application narrative for that population domain provides a list of Women's/Maternal Health programs administered by the Hawaii Title V agency. The list of programs below focuses on infant/early childhood health programs administered by Hawaii Title V.

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.

Early Intervention Services (EIS): provides early intervention services for eligible children from birth to three years old with developmental delay or at biological risk, as mandated by Part C of the Individuals with Disabilities Education Act (IDEA). Services include care coordination; family training, counseling, 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.

Early Childhood: focuses on systems-building to promote a comprehensive network of services and programs that helps promote children with special health needs and children who are at risk for chronic physical, developmental, behavioral, or emotional conditions to reach their optimal developmental health.

Birth Defects Surveillance: 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.

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 Special Supplemental Nutrition Program for Women, Infants, and Children. The participants of WIC are either pregnant, breastfeeding, or postpartum women and infants and children under 5 years old who meet income guidelines and have a medical or nutritional risk.

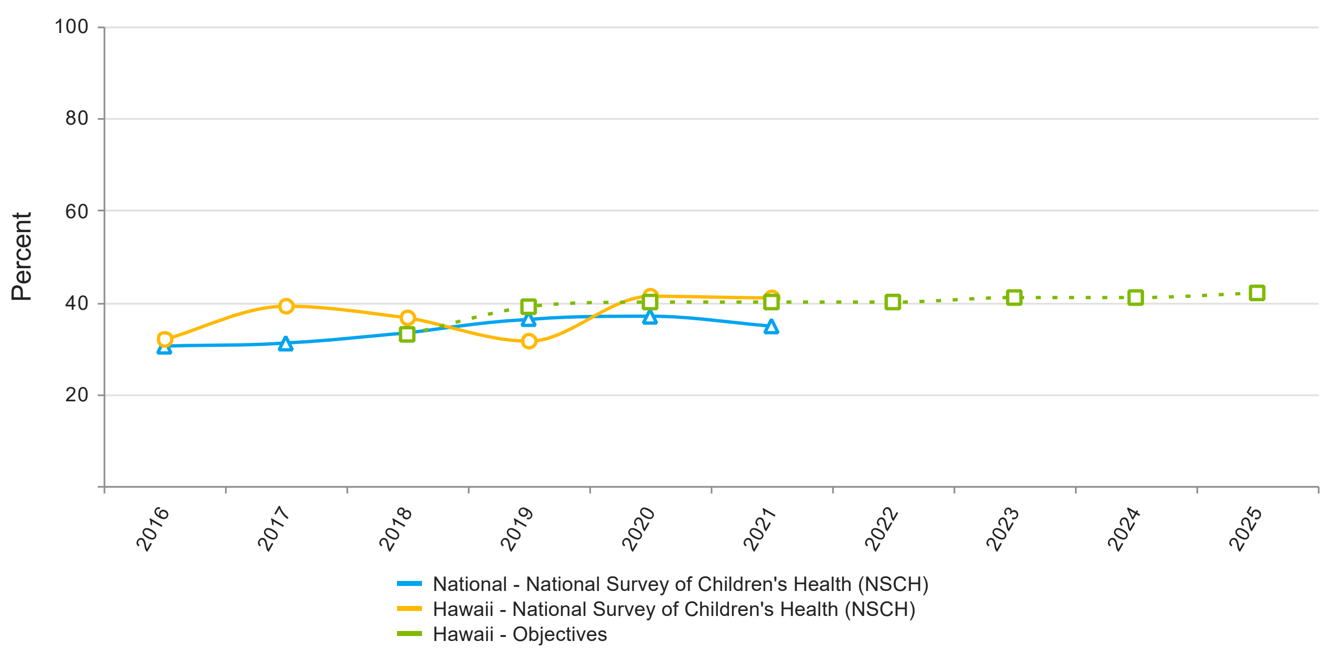
Hawaii Home Visiting: Through the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant, the Home Visiting Unit provides comprehensive early identification of high-risk families, including expectant families and families of newborns who may benefit from home visitation services to 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.

Early Childhood Comprehensive Systems: This program uses the collective impact model to strengthen, align, and sustain family-centered systems at the state and community levels that are equitable, sustainable, and comprehensive, using the health system as a key partner. These programs focus on the prenatal-to-age-3 (P-3) period, a critical window of opportunity for prevention and intervention. Early childhood experiences that nurture positive health and development—starting prenatally—have lifelong impacts on overall health and well-being.

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)					
	2018	2019	2020	2021	2022
Annual Objective	33	39	40	40	40
Annual Indicator	39.1	36.5	31.6	41.2	41.0
Numerator	14,121	13,201	12,899	16,334	15,213
Denominator	36,113	36,145	40,832	39,621	37,098
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective		12	18	24	27
Annual Indicator					
Numerator	19	23	26	26	28
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	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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

	2018	2019	2020	2021	2022
Annual Objective		5.9	5.5	5.4	5
Annual Indicator	5.9	5.5	5.7	5	5.8
Numerator	635	584	591	508	587
Denominator	108,119	105,815	104,141	101,271	100,421
Data Source	DHS CAN annual report	DHS CAN annual report	DHS CAN annual report	DHS CAN annual report	DHS CAN annual report
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			75
Annual Indicator	73.2	63.8	63.8
Numerator			
Denominator			
Data Source	Hawaii Med-QUEST	Hawaii Med-QUEST	Hawaii Med-QUEST
Data Source Year	2020	2021	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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

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

Promote health equity by addressing disparities in confirmed CAN cases

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 2020-2021 showed that the estimate for Hawaii (41.0%) did not meet the 2022 state objective (42.0%) but was not significantly different from the 2021 indicator (41.2%) and the national estimate of 34.8%. 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 or household income, which 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. The lead for this priority is the Children with Special Health Needs Branch (CSHNB) Early Childhood Coordinator (state-funded). 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 a broad collaboration among state 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 and the Strategic Implementation Plan focusing on “Early Childhood Health and Family Wellness.”
- Early Childhood Action Strategy (ECAS), 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: The five developmental screening strategies of Hawaii focus on systems-level approaches following the 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 MCH Evidence Center identifies this ESM as an 'innovative tool' to track and improve developmental screening efforts and "is a strong measure of an evidence-based strategy."

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 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 healthcare providers on developmental screening and screening through home visiting programs, although further evidence is needed. Following these promising practices, Hawaii provided and continues to provide community-based trainings on the Ages and Stages Questionnaires (ASQ) and CDC milestones to healthcare providers, early childhood education, and interested childcare providers. Although quality improvements in both healthcare settings and systems-level approaches were effective, Hawaii chose a general systems approach to continue quality improvement practices.

Updates for 2022 on the five strategies follow.

COVID Impacts: As safety restrictions were rescinded in 2022, COVID cases remained manageable and vaccination numbers increased. Childcare spaces, early learning programs, and public schools returned to in-person learning in the past year. Doctors' offices continued to implement safety protocols and began in-person and telehealth visits. Health concerns lessened with safety measure protocols and vaccination availability, but workforce capacity remained strained. Delays in healthcare visits and limited childcare/ early education service availability could have led to fewer children receiving screenings to track development or identify delays.

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. The healthcare and early childhood sectors of Hawaii are crucial partners in ensuring that the four stages of developmental screening: screenings, referrals, services, and supports occur.

Guidelines on Screening and Referral: The "Hawaii Developmental Screening and Referral Guidelines for Early Childhood and Community Based Providers" has been available online at health.hawaii.gov/cshcn/hiileihawaii/ since 2021, providing ongoing standard information for those conducting developmental screening of children ages birth through 5 years of age. These guidelines include community-informed best practices learned from early childhood direct service, medical providers, and other key stakeholders during the ECCS Impact grant awarded to Hawaii from 2016-2021. As a hybrid of in-person and telehealth services was offered, the guidelines were revisited with stakeholders to ensure the information was relevant for in-person or virtual screenings.

Workforce Training: Hawaii received a second Learn the Signs, Act Early (LTSAE) technical assistance grant from the Centers for Disease Control (CDC) in 2021-2022. The Hawaii LTSAE Lead Team included the LTSAE

Ambassador, a Project Assistant, and the CSHNB Early Childhood Coordinator. Under their direction, a convening was held once a month to propose ideas, support initiatives, and consider solutions to interested cross-sector partners. Additionally, participants were educated on CDC milestone updated materials and methods organizations could adopt to share materials more effectively. The LTSAE Lead Team trained WIC nutritionists statewide to conduct the CDC Developmental Milestone Checklist for 2- and 3-year-olds. WIC staff agreed to distribute the checklist to parents of toddlers via email until in-person visits resume. The LTSAE Ambassador, Dr. Jeffrey Okamoto, and Keiko Nitta, DOH CSHNB Early Childhood Coordinator, presented on developmental screening and monitoring at the Pediatrics Grand Rounds. Approximately thirty pediatricians received this training in September 2022.

Kākou for Keiki, a Maui community organization formed as part of the ECCS grant, continued to offer ASQ virtual trainings for direct service early childhood and P-3 health programs statewide. Programs receiving training included the DOH Public Health Nursing program, preschool programs, childcare centers, and direct service organizations providing early learning and home visiting supports. Approximately 150 participants were trained through Kākou for Keiki's efforts.

Strategy 2: Family Engagement & Public Awareness

This strategy focused on engaging families to promote the importance of developmental screening and child development and to develop a website on both the Department of Health's Children with Special Health Needs Branch page www.health.hawaii.gov/cshcn/hiileihawaii/, a stand-alone site at www.keikicheckup.com, and the Early Childhood Action Strategy at www.hawaiiactionstrategy.org. By having three options for families with consistent information since the DOH CSHNB Early Childhood Coordinator oversees them, it is anticipated that families and providers will find information on Hawaii's resources through whatever search engine they use.

Media Campaign: DOH conducted a media campaign in September 2022, "Time for Checkup," to promote the importance of preventive screenings: developmental, hearing, vision, and dental. Information and links to the campaign are found at www.keikicheckup.com. In addition, campaign follow-up occurred during morning news shows with pediatricians, DOH staff, and the Family Hui Hawaii as guests to promote developmental health and inform parents of the importance of screenings for young children.

Outreach to Families: Through various online parent cafes and parent support groups conducted across the state, screenings to encourage healthy development continued to be promoted. Hawaii families with Internet access often opt for online platforms which are more easily accessible and convenient. DOH continues to work with community partners to support outreach to families. The Family Hui Hawaii organization provides family support groups and conducts developmental screenings at community events and through their support groups. The Leadership in Disabilities and Achievement of Hawaii School Readiness Program conducts comprehensive developmental, behavioral, hearing, and vision screening for children up to age 5. Both these community partners have strong relationships with families and provide information and feedback to the DOH on emerging issues or concerns.

Kākou for Keiki (K4K): Maui County's early childhood collective impact team that originated from the ECCS Impact grant continued developmental screening work with DOH funding. Activities included community outreach, social media efforts, and caregiver support groups to promote skill building/opportunities and supports for families. The caregiver support groups allow families to 'talk-story' and encourage self-care and resiliency practices. Postcards and flyers were distributed at community events that promote the CDC Milestone App, the VROOM App, and the Talking is Teaching Spotify playlist to encourage on-track development for young children. Last, the K4K Facebook and Instagram pages promote healthy development and caregiver resiliency to reach and be more inclusive of any parent seeking support.

Screening Information Websites: Hawaii continues to work with the Early Childhood Action Strategy (ECAS), a

public-private collaborative focusing on children's issues from prenatal through age 8. 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 (hawaiiactionstrategy.org/). The DOH CSHNB website houses developmental screening information on its website: health.hawaii.gov/cshcn/aboutus/.

Throughout 2022, FHSD and other direct service programs for children and families saw levels of service utilization slowly return; however, anecdotally, services did not return to 2019 levels. Lags in population-based data sources make assessing the situation statewide for specific communities/populations difficult. Monitoring developmental screenings of young children helps to serve as a proxy measure to anticipate the effects of COVID-19 on children's development and DOH partners with the Department of Human Services Med-QUEST Division (Hawaii's Medicaid agency) to address emerging concerns.

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 was 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 2020-2021, which should have begun to capture the full impact of COVID. Yet, the indicator remained largely the same as 2019-2020. This may be due in part to the small sample size, with high variability and unstable estimates. The small subset of data for NPM 6 (ages 9 through 35 months) increases the data problem. In addition, several issues with the NSCH data limit its utility to inform planning and address health equity. The race/ethnicity data collected by the NSCH cannot provide detail to reflect Hawaii's Asian, Native Hawaiian, and Pacific Islander populations; county-level data is unavailable.

For several years, FHSD explored NSCH survey oversampling with the MCH Bureau, but there are too many cost/administrative barriers. Although the MCH Bureau has remedied some barriers, over-sampling remains costly and complex without an epidemiologist to help guide the project.

Additionally, the NSCH survey question asks parents about screenings that occur only in a healthcare provider's office; however, the developmental screening efforts in Hawaii include work with early childhood providers and other community-based service organizations, so the data may not reflect the local state efforts.

Medicaid: In 2021, a new Medicaid RFP was issued that included development screening as a health priority for the five state Medicaid insurance plans in Hawaii. The following data was provided for FY 2021. The percentages represent only children enrolled in Medicaid and 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%

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 successfully migrated these data to an electronic collection and management system. They are working to share the data in the future.

Title V Program Data: Developmental screening data is collected and reviewed for quality assurance and monitoring from FHSD's early childhood programs: MIECHV, Hi'ilei, ECCS HIPP, and Early Intervention.

Maternal, Infant, and Early Childhood Home Visiting (MIECHV): Data from the MIECHV Home Visiting program for FFY 2022 indicated that of the total of 598 children enrolled in the program, 235 children were eligible for screening. Per AAP screening recommendations and MIECHV reporting requirements, 77% of the eligible 235 children were screened for developmental delay. Of those children with positive screens for developmental delays, 84% of children received services in a timely manner.

Hiʻilei Developmental Screening Program: The Hiʻilei program allows parents and caregivers to complete an online screening or a paper copy of the developmental screener through the mail. FFY 2022 Hiʻilei data shows that 17 children birth through 5 years were screened. Four of the children were found to be in the "monitoring" range. Information on activities to encourage their children's optimal development was provided to offer support. Six of the children screened were found to be in the referral range. Referral supports and suggested guidelines for follow-up assessment needs were given through mail or email.

Early Intervention Service (EIS): In 2022, of the 2,484 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 (Battelle Developmental Inventory for Young Children) 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), a standardized tool that can be done remotely via interview. All children with partial evaluations were reevaluated and eligibility established unless the child exited before the DAYC was initiated.

EIS referrals come from various sources. In 2022, 63.7% of referrals came from primary care providers, 24.1% from families, 10.7% from community providers, 0.003% from resource caregivers, and 0.01% 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 ages at which children are screened often based on funding guidance. Though challenging, continued efforts to create an effective data collection system will be considered.

Strategy 4: Social Determinants of Health

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

In late 2019, developmental screens were being conducted in Maui WIC clinic waiting rooms before COVID closures. The ECCS Impact Program Coordinator piloted Ages and Stages (ASQ) screens at the central Wailuku clinic. A sustainability plan was needed as a partnership became more clearly formed between ECCS and WIC. An additional partnership was formed with Public Health Nursing (PHN) to assist with screenings. PHN can follow through with home visiting services and language translation if needed. The partnership allowed for sustainability of the practice. A similar screening effort was also piloted in Kauai WIC waiting rooms.

In May 2022, PHNs across Hawaii were trained in ASQ so the practice could extend beyond Maui and Kauai County. WIC Nutritionists were trained on the simplified CDC Checklist for 2- and 3-year-olds and referral practices as another strategy to include developmental milestones in WIC appointment practices. The use of the CDC Checklist was delayed due to the closures of the WIC offices, and Hawaii will resume efforts to measure the effectiveness of this piloted practice when WIC clinics open to in-person visits.

SWYC: In FY 2020, Title V began discussions with the AAP–Hawaii Chapter and MEDQUEST, the State of Hawaii

Medicaid agency, to promote use of the SWYC since it was added to the national AAP list of validated screening tools. SWYC is a free tool covering behavioral and family well-being (including social determinants of health). Referrals may be more extensive than IDEA Part C (EI services) and Department of Education developmental services. By 2021, SWYC became an option on medical practice Electronic Health Records (EHR). Medical practitioners could adopt the SWYC one segment at a time until the comfort level of the entire tool's usage increased. Hawaii continues to work with partners on adoption and full utilization of this tool, which can improve identification of socioeconomic needs of young children and their families and available cross-sector supports that effectively and efficiently meet their needs.

Four statewide efforts are underway to address physician concerns about an accessible referral site to provide information for families.

1. Hawaii State Department of Health CSHNB created a centralized resource directory of state services that includes county-specific and more accessible resources linked to the questions asked on the SWYC. This is found at health.hawaii.gov/cshcn/resourcelists.

2. In 2022, FHSD continues to partner with the Executive Office on Aging and the *No Wrong Door* initiative. This project promotes an improved coordinated intake and referral process for state agencies to receive and track referrals from other state agencies and local nonprofits. Hawaii's DOH CSHNB and Hiʻilei Developmental Screening Program are listed as a "Door" to help create and receive referrals from other state agencies. In September 2022, the Department of Education's Homeless Liaisons Program was added as another "Door" to help connect houseless families to other state services. In time, more state programs will continue to be added to the system to improve the process of connecting families to appropriate services.
3. The last effort being explored is the Central Intake and Referral System (CIRS) of Hawaii Unite Us. This platform was introduced to statewide community partners in 2020. With more state and medical provider investment, this platform could be another possible solution for referral/intake needs and its proper data collection. An ECCS HIPP performance measure is to guide and uplift a CIRS platform to better integrate P-3 system process and improve data collection. At this time, an ECCS HIPP workgroup is examining which CIRS, including Unite Us, may be the best fit to address Hawaii's needs and data collection desires.

4. The CDC Learn the Signs Act Early materials were translated into Chuukese, Marshallese, and Samoan to help better understand child development. The CDC children's book "Amazing Me: It's Busy Being 3!" translations were completed in 2022. The newly translated book versions will be distributed through community health centers, the Home Visiting program, and other early childhood partners statewide in 2023.

Strategy 5: Policy and Public Health Coordination

This strategy aims to track FHSD's infrastructure development efforts to help improve children's developmental screening rates.

ESM 6.2 – Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around systems development, family engagement, data collection/integration, and addressing vulnerable populations.

	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	28.0			

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 work plan, 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. The EC Coordinator, who oversees all the activities, self-reported the scale's completion.

The total possible points for the scale are 30. The FY 2022 indicator was 28.0 and met the annual objective set at 27.0. Despite statewide recovery from the pandemic, progress was made in systems development, family engagement, and addressing vulnerable populations. The EC Coordinator uses the rating scale to track progress on the NPM 6 strategies. Scores show room for improvement in systems development and social determinants of health identification.

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 ongoing 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	**28 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 new staffing, partnerships, and changes in healthcare delivery due to COVID.

Hiʻilei Program: By hiring new staff, the Hiʻilei program can expand its reach and scope to promote development screening services to families and service providers. The program may also address infrastructure issues to ensure

assessment of statewide needs, ongoing training, and policy development.

Early Intervention Services (EIS): EIS is the lead state program for development screening, evaluation, and follow-up services for young children. The recent staff hiring of a Child Find coordinator (a position that has remained vacant for several years) will expand EI's efforts to reach more diverse, under-served children and their families.

With new staff resources, Hiʻilei and EIS are poised to increase the DOH Title V developmental screening program efforts. The programs will collaborate with the CSHN Branch Early Childhood Coordinator to continue the systems-building work started by the federal ECCS grant. The team will meet over the next year to review and identify strategies and work plans.

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 support child development through developmental screening. ASQ training continues to be conducted to encourage this outcome.

Medicaid Data: In 2023, Medicaid provided developmental screening data for FY 2022. The percentages representing only children under Medicaid and are somewhat lower than the NSCH estimates. There was a slight improvement over the FY 2021 data, except for toddlers 1-2 years. Medicaid is working to improve the quality of these national measures that will yield disaggregated rates by county, race/ethnicity, and insurance plan.

Developmental Screening in First Three Years of Life - Birth to one year	26.43%
Developmental Screening in First Three Years of Life - >1 year to 2 years	24.17%
Developmental Screening in First Three Years of Life - >2 years to 3 years	21.16%
Developmental Screening in First Three Years of Life - Total	24.14%

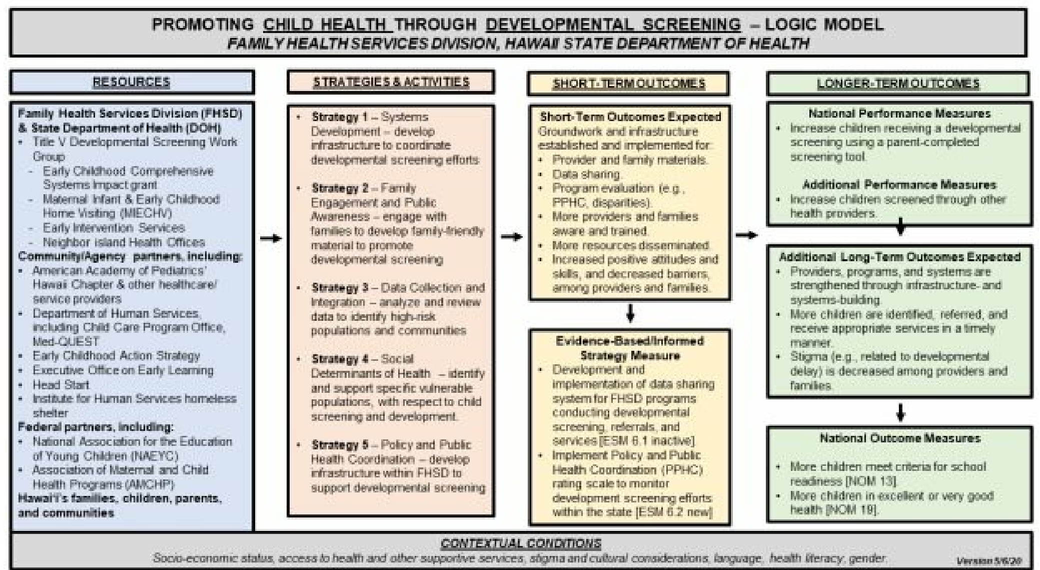
EPSDT Coordinators meeting: Title V plans to partner with Medicaid to help increase these rates. CSHNB staff have presented at the EPSDT Coordinators meeting and continue to attend to share information and provide support. DHS invites direct service health coordinators and program staff to attend these meetings to support Medicaid-eligible children. DOH uses these meetings as networking opportunities to make connections to promote developmental screening activities.

CDC Learn the Signs Act Early: Although federal funding from the CDC Learn the Signs Act Early COVID Response funds ended in June 2022, the Hawaii CDC LTSAE Ambassador, Dr. Jeffrey Okamoto, continues to work with DOH on projects to support developmental monitoring activities and promote the LTSAE material for families and providers. During this time, activities included translating materials for families into Chuukese and Marshallese, convening stakeholder meetings to address developmental monitoring in state programs and healthcare settings, and public awareness events through morning news shows.

Project LAUNCH grant: CSHNB received a Substance Abuse and Mental Health Services Administration Project Linking Actions for Unmet Needs in Children's Health (Project LAUNCH) grant, and one of the strategies is to promote developmental screening and other screens to identify children who might have developmental or behavioral concerns and refer them to services to mitigate severe emotional disturbances (SED).

Review of Action Plan

The logic model for Title V NPM 6 was developed based on the goals of the ECCS Impact Grant that ended in FY 2021. However, the system/community-level strategies remain relevant in FY 2022. The strategies reflected initiatives at the community, statewide, and national efforts and included input from partners and feedback from families and providers solicited at collective impact convenings 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.



Challenges Encountered

In 2022, challenges continue in several key areas.

Timeliness of referrals continues to be a concern. In 2022, the challenge is most impacted by pandemic repercussions on the workforce. Serious concerns have stemmed from workforce vacancies that have left medical providers, childcare, EIS, and Early Childhood Education (ECE) struggling to service community need properly. Though Hawaii's Title V Developmental Screening partners must ensure timely and accessible interventions, connecting families with expert services has become even more strained when concerns arise. Providers conducting screenings must refer children in the "referral range" to EIS within seven days after being identified, per the Federal IDEA statute. Before Covid-19, the seven-day referral standard needed to be more widely promoted and adopted to ensure timely referrals were consistent. The added stress of workforce depletion across sectors has made this standard even more difficult to uphold.

Lack of Coordination. While there is some improvement in referral and intake coordination, infrastructure development to better integrate services is still necessary. With EIS's strict confidentiality standards in conferring with referring providers, the referral process is hampered when signed consents are difficult to attain. The interest in a coordinated intake and referral cross-sector system has stemmed from this statewide challenge.

Access School Services. Once referrals are made, parents of children with developmental concerns have difficulty accessing appropriate school services. In the pandemic recovery, this has become more salient with social-emotional concerns that are more frequently discovered. 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 could improve the process. This and increased training opportunities and system change strategies may help services think through what is required and necessary to properly connect a child with developmental concerns with services.

Data Limitations: Data to help inform system improvement and policy change 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 important, much of the developmental

screening in Hawaii is conducted by family service agencies. Currently, there is no systematic data source to determine the actual number of screens and follow-ups, including proper ethnic/race and geographical breakdowns, conducted by these direct service providers. Improvement in cross-sector screening and referral data collection would reflect the developmental screening efforts in Hawaii more accurately.

Public Awareness: Building public awareness and effective messaging to encourage developmental screening are improving with media messaging and the efforts made through CDC LTSAE and community partners. As mandates were lifted and the workforce returned, prioritizing developmental screens remained challenging given the priorities faced by many families coming out of the pandemic. However, COVID also provided opportunities to create a more responsive and accessible system supported by additional federal funds.

Telehealth Challenge/Opportunity: 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 communities statewide.

Overall Impact

Statewide Partnerships: 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 the 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 continues.

ECCS HIPP Grant: The Hawaii ECCS HIPP grant considers a sustainable and improved integration of the maternal infant health and early childhood system. Developmental screening and referral learned lessons from the ECCS Impact grant continue to inform efforts promoting young children's developmental health.

Providers: Title V continues to progress by working directly with pediatric providers in the AAP-Hawaii Chapter and collaborating with the Hawaii 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. 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 40% of Hawaii's children are insured through Medicaid, with enrollments significantly increasing during COVID. EPSDT office visit data, when available, should 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 Title V needs assessment confirmed that Child Abuse and Neglect (CAN) prevention will continue as a priority under the Child Domain. Child maltreatment continues to be a foremost concern for the state. Community needs span the spectrum, from primary prevention services to support families and improvements to the Child Welfare Service system to promote family unity and prevent children from unnecessarily entering foster care.

Data: The latest data is for confirmed child abuse cases from the 2021 DHS State Child Abuse and Neglect Report, which showed increases in confirmed cases in 2021 over the previous year. The increases may not reflect a worsening trend but rather a return to pre-COVID case levels.

- The number of confirmed duplicative cases for children ages 0-5 increased from 1,276 in 2020 to 1,495 in 2021
- Infants under one year of age continued to account for the highest percentage of abuse (15.7% of total confirmed cases).
- Children five and under accounted for 41.9% of all confirmed cases, a slight decrease from 2020.
- Geographic and ethnic disparities remained: Hawaii, Honolulu, and Kauai counties experienced increases in the number of confirmed cases in 2021, with Maui County indicating a decrease in confirmed cases.
- Hawaiian/Part Hawaiian children continued to be overrepresented among confirmed CAN cases for all age groups, largely due to historical, systemic racism, social factors, historical discrimination policies and practices, and poverty.

All **types** of reported cases of child abuse & neglect increased in 2021:

- Threatened harm remained the most common type of reported maltreatment (5,337),
- Neglect was the 2nd most common type of reported maltreatment (1,080),
- Physical abuse was the 3rd most common type of reported maltreatment (703), and
- Sexual abuse was the 4th most common type of reported maltreatment (294).

Sex trafficking cases almost doubled in 2021, from 60 cases in 2020 to 114 cases.

In 2021, the highest-reported **precipitating factors** of abuse or neglect of children of all ages were:

- inappropriate child-rearing methods (70%),
- inability to cope with parenting responsibility (67.9%), and
- drug abuse (34%).

The number of confirmed cases attributable to mandated reporters increased in 2021 from 2020. This was likely due to 2020 stricter COVID-related policies, such as school closures and use of virtual case management. Other than medical personnel, the sources of mandated reporters increased in 2021, particularly for legal, law enforcement, and criminal justice personnel (388 to 459).

Objectives: After reviewing the baseline data, the objective was a 5% improvement through 2025.

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) within the Family Support and Violence Prevention Section (FSVPS). The section also includes programs: Sexual Violence Prevention, Domestic Violence, Parenting Support, and Maternal Infant and Early Childhood Home Visiting (MIECHV). The CANP-P is funded by the Administration for Children and Families (ACF) Community-Based Child Abuse Prevention (CBCAP) formula grant. Initially, The CANP-P coordinator position was vacant since October 2022 but was filled in April 2023. 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 social and health inequities, unhealthy relationships, and environments. Preventing CAN requires addressing individual, relational, community, and societal factors. For the new period 2021-2025, CAN strategies were revised to reflect more of a 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 systemically addressing disparities in confirmed CAN cases.

CANP-P addresses primary prevention and secondary prevention work. Grant funds are used to support the following activities:

- Community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs, and activities to help 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 crosscutting strategies that leverage partnerships supporting evidence-based/informed CAN programs and practices.

COVID Updates: While life in 2022 largely returned to pre-COVID norms, the social consequences of the pandemic continue to impact Hawaii families, mainly due to rising economic stressors. The social consequences are typically associated with family stress and violence due to under- and unemployment, lack of affordable childcare, housing, and increased financial insecurity. Poor coping strategies, including the increased use of alcohol and other substances, elevate the risk of abuse and neglect. Client contacts with the Domestic Violence Action Center have increased nearly sixfold, from 519 in 2019 to 3,038 in 2020. The Center reported that the need to develop safety plans with clients rose almost twofold, from 692 to 1,066 in the same period.

Updates for 2022 on the three 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 statewide system of services to prevent and address CAN. State, local, and community programs have specific 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 agencies and organizations. Together, these diverse partners help to strengthen and support families by addressing the needs of children and their parents/caregivers. A list of the primary CAN agencies/programs follow.

Department of Education (DOE): DOE is a key agency partner in efforts to identify, report, treat, and prevent CAN. The DOE Trauma Recovery Project ensures that low-income students who have experienced trauma receive trauma-specific mental health services. The Project expands the capacity of DOE counselors and other staff on

using Trauma-Informed Care (TIC) as the standard across the DOE system. TIC practices ensure that agencies and programs serving children and families who experience any form of violence understand the impact of trauma on child development and how to minimize its effects when providing TIC services. DOE staff are regularly invited to participate in CANP-P-sponsored training events.

Department of Human Services (DHS). DHS is a key partner for Hawaii in addressing CAN since it houses Child Welfare Services (CWS) and entitlement programs, such as SNAP, Medicaid, and affordable housing support. The 2018 federal Family First Prevention Services Act (FFPSA) shifted the focus of the child welfare system toward maintaining children's safety within their families via family-strengthening supports. The CANP-P has partnered to develop and implement the State Child and Family Services Plan (CFSP). Efforts focused on improving connections to family strengthening resources, including identifying service gaps and piloting family programs, such as the Zero to Three Family Court and the ‘Ohana Visitation Time System of Care model (‘Ohana means family in Hawaiian).

Family Resource Centers. CANP-P joined in successfully supporting legislation in 2022 to create a 5-year program that coordinates statewide efforts to develop Family Resource Centers (FRC). The FRC program will be located within DHS and coordinate partners across state departments and private providers. FRC are community-based resource hubs where families can access supports to promote health and well-being. FRCs are a critical way to prevent CAN while strengthening families. They have effectively connected families to services, created opportunities for community-level coordination and connections to resources and support systems, and increased family engagement. National research has shown that FRCs have lowered rates of CAN cases, reduced the number of children entering foster care, and decreased parent unemployment.

The new FRC program ensures that community and school-based FRCs coordinate as a statewide network, establishing practice/training standards and developing referral/data protocols to serve families.

CAN-P helped provide training/technical assistance for the four DOE school-based centers established on Oahu and joined the newly-established statewide FRC organization, the Hawaii Family Ohana Support Network: https://www.hawaiiohanasupportnetwork.org/

Office of Wellness & Resilience. Another CANP-related state legislative bill passed in 2022 creates the country’s first statewide Office of Wellness & Resilience focused on promoting wellness and resilience efforts across state departments to develop a trauma-informed service system that better assists Hawaii families while improving community health. CANP-P and several Title V programs are involved in this collaborative effort.

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

Broad public and private sector community collaboration ensured the success of the many CANP Awareness Month events held statewide during April 2022, building awareness about preventing CAN.

Strategy 2: Provide training and technical assistance to community-based prevention programs to strengthen families and prevent child abuse and neglect.

Throughout the 2020-2022 COVID period, the CANP program continued to sponsor and support virtual trainings

open to community partners.

Webinars: CANP-P funded four unique webinars in 2022 that were open to private and public agencies and their staff involved in CANP and family strengthening. The webinar topics addressed included: 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 COVIDwas evidenced in disparities and inequities in the Micronesian community; improving culturally aware services.

Certified Trainings. CBCAP grant funds sponsored FRC Standards Certification Training, developed by the National Family Support Network (NFSN) to build the quality of staff practice as more FRC centers are created in the state.

Parent Leadership Training. The CBCAP supports parent leadership and participation in planning and implementing grant-funded CANP initiatives. In 2022, CANP-P funded two virtual Parent Leadership Training Institute (PLTI) cohorts. PLTI is an evidence-based model that provides parents core technical and practical skills/knowledge to be effective advocates for their children and change agents in their community. Parents attended 20 evening sessions and completed a community project, putting learned skills into practice. Several PLTI community projects addressed CANP, such as creating a peer-peer support group for pregnant women who were abused as children and an indigenous-focused leadership program for mothers and daughters.

Conferences. The FSVPS and MCHB Home Visiting Unit collaborated on a two-day virtual Kahewai Summit in Fall 2021 to provide educational training support for early childhood providers on trauma-informed care. This included culturally-informed approaches to prevent Adverse Childhood Experiences (ACEs) by acknowledging and addressing the historical and generational trauma experienced by Native Hawaiians and other ethnic groups.

Strategy 3: Promote health equity by addressing disparities in confirmed CAN cases.

Each island has pockets of geographic areas with higher numbers of confirmed CAN cases. Based on existing CAN disparities-related data, CBCAP funds were awarded under the American Rescue Plan Act (ARPA) and distributed to community-based providers serving communities and populations at risk, including Native Hawaiians and Micronesians, families with lower income levels, as well as those adversely affected by COVID. Contracts included support for the Maui CAN Prevention Coalition and the Hoʻoikaika Partnership. Additional state general funds were distributed to support neighbor island CAN prevention projects.

In 2021, CBCAP supported launching the new Early Child Action Strategies initiative, *Aloha At Home.* It is rooted in traditional Hawaiian values and the protective factors that can help to guide and ground families as they pursue family resiliency. The first phase of the *Aloha At Home project* 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 alohaathome.org.

Current Year Highlights for FY 2023 (10/1/2022 – 6/30/2023)

Over $600,000 in ARPA CBCAP funds were contracted with community organizations statewide to provide services to help prevent family violence while supporting family strengthening/resiliency. The services help to

promote specific protective factor strategies to prevent CAN. These services include:

- public awareness events and family fun activities
- development of educational materials to support family resiliency, mental health information
- new parent support classes for families with newborns
- neighbor island coalition-building around family violence prevention
- a directory of asynchronous online (self-directed) learning websites, with protective factors serving as the framework
- support for a peer-to-peer support/learning program for families of young children
- media campaigns to promote family support services and resiliency messages
- parent leadership trainings

A contract was also executed with the Department of Education to provide sexual health education training to educators and develop a sexual health curriculum for students and their families.

Funds were allocated to community organizations in all counties to address CAN prevention strategies in collaboration with county public and private partners. CAN prevention initiatives targeted vulnerable populations, such as those with children with disabilities, homeless or at-risk for homelessness, Native Hawaiian/Pacific Island families, and/or families residing in shelters or public housing. The CBCAP funds were supplemented with an additional $200,000 in state general funds.

Family Resource Centers (FRC) FRC are an evidence-based approach to provide coordinated, accessible program supports that target communities/populations. The state FRC Coordinator was hired and convened a cohort of public-private agencies in a team-building process facilitated by One Shared Future (OSF). OSF is a unique firm created by the former state Department of Human Services director to support public professionals (and their community partners) to initiate effective organizational and community change by fostering collaboration and innovation. The 10-session collaborative cohort established strong cross-sector relationships and ideas to lay a strong foundation to drive future FRC work. The FHSD Adolescent Health Coordinator and CSHN lead for developmental screening were part of the cohort.

Nā Kama a Hāloa A group of Native Hawaiian organizations and service providers, Nā Kama a Hāloa, has been meeting since 2018 to improve outcomes for Native Hawaiian children and families involved in CWS. Native Hawaiians are over-represented in the CWS program. The network has improved the child welfare system by:

- Created an advisory council of parents with experience in the CWS system to improve child welfare services.
- Created a peer support program for parents currently in the system and pregnant women experiencing substance use disorder.
- Developed a new hire training on Native Hawaiian history and cultural training module for CWS staff and contracted providers.
- Made practice changes to better support sibling connections for children in foster care.

In FY 2023, FHSD was invited to participate in the network to share information on family support and healthcare services.

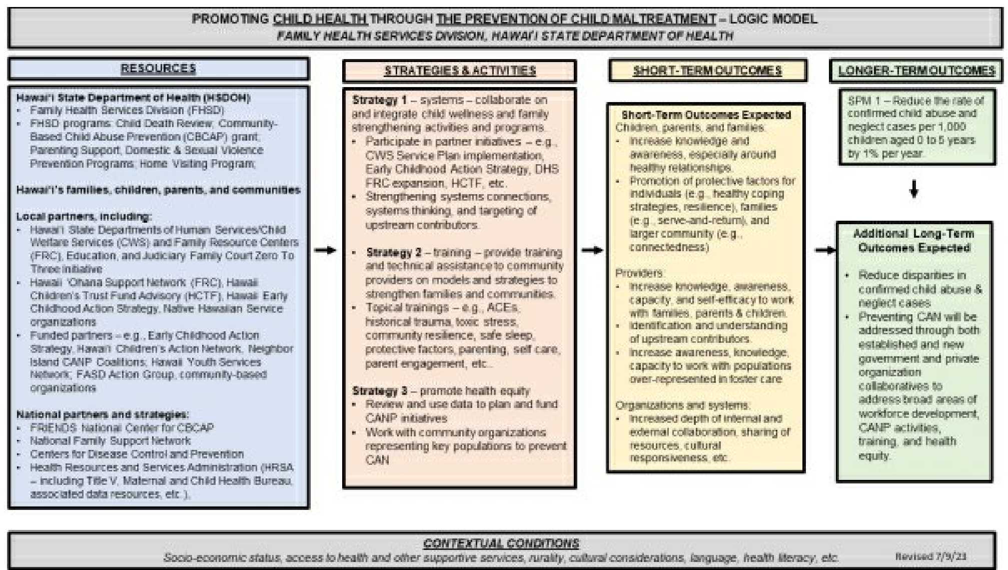
Mālama Ohana Working Group In 2023, the governor signed legislation to establish within the Office of Wellness and Resiliency, the Mālama Ohana Working Group to help transform the existing CWS program and integrate community perspectives and existing work into state government. The focus of the working group will be expanded to include representatives from those representing families who have special needs/disabilities, as well as LGBTQ families.

Conference. The FSVPS and MCHB Home Visiting Unit collaborated on a two-day virtual Summit in April 2023 that focused on wellness and resilience for providers serving children ages 0-5 years.

CBCAP Staffing. In April 2023, the CBCAP vacancy was filled. The new staff person is learning about the position, partners, the CBCAP grant, and the grant service contracts.

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, instead incorporating a diverse 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 family violence prevention.



Challenges and Barriers

Reaching Families during COVID: Services to communities and families were offered online virtually from 2020-2022, resulting in several logistical 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 software programs. In response, federal relief funds were used to support the purchase of IT equipment for selected community providers and families. CBCAP funds were used to support at-risk Micronesian communities to procure IT supplies and subscriptions; help assist children better participate in educational distance learning; and schedule and attend telehealth and related services appointments. Many services/resources continue to be offered remotely; thus, the assistance provided to communities/families continues to expand access.

Workforce Shortages: In 2021, Hawaii Children's Trust Fund Coalition members participated in a workforce development/training survey. Members reported common staff-related recruitment and retention challenges, including;

- Job applicants often lacked the necessary position-related credentials.
- Low salary levels did not attract qualified applicants.
- Staff workload stress grew due to number of agency's staff vacancies.
- Required use of hybrid virtual work scheduling did not always support staff needs.

- Lack of professional development and career pathways for current staff.

In response to the challenges, some organizations expanded professional development trainings and widely share position recruitment announcements. The DHS/CWS expanded online learning opportunities for staff. The CANP is contracting to expand online educational modules for service providers and families.

Overall Impact

Key overall CANP activities and partnerships that are helping to support service system improvements:

- Developing collaborative prevention strategies reflected in the DHS *2020-2024 Child and Family Services Plan*, such as expanding *Ohana Time* with families.
- Continued CAN coalition building and partnerships with state and community-based programs and organizations
- Timely disbursement of federal ARPA funds, supplemented by state funds, to strengthen family services and prevent CAN.
- Sponsoring and expanding accessibility of trainings via virtual platforms, to increase knowledge, skills, and/or attitudes of staff who work with families, including those who may be at risk for CAN.
- Act 129 signed into law in 2023 by the governor established the FRC Pilot Program within the DHS with coordination with DOH and DOE. Requires the Departments of Human Services, Education, and Health to work with 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

For the Child Health domain, Hawaii added this state priority in 2021 to promote child wellness visits and routine immunizations, especially for young children ages birth through five. 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. Initially, the effort was to ensure that families continued with well-child in-person or telehealth visits to ensure medical providers could complete their developmental surveillance of children. The effort continued to focus on well-child visits and ensuring that comprehensive screenings for development, behavior, hearing, vision, obesity, mental health, and oral health were being conducted to identify children in need of more intensive follow-up and services.

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 2022 data shows child wellness visits remained stable over 2021-2022 (63.8%) but did drop somewhat from 73.2% in 2019. Using 2019 data (latest available national data), Hawaii ranked ninth highest among states for CWV, exceeding the national average of 65.6%

A second CMS quality measure for well-child visits for ages 15 to 30 months (with two or more visits) showed 68.6% had a CWV in 2022, slightly lower than 76.0% in 2021. At this time, there is no disaggregated data for these measures and no national comparison data for FFY 2021.

Data from the 2020-2021 National Survey on Children’s Health indicated 75.1% of children 0-17 years had one or more preventive visits in Hawaii, a slight decrease from 79.7% in 2019-2020. An estimated 73,495 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 (from 85.5% in 2020-21)
- 72.9% ages 6-11 years (from 78.2% in 2020-21)
- 66.3% ages 12-17 years (from 73.4% in 2020-21)

All Hawaii rates were comparable to the U.S. estimates, which saw similar decreases in preventive visits.

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 Services Unit Supervisor, the Children with Special Health Needs Branch Early Childhood Coordinator, FHSD Public Information Officer (PIO), and Title V grant coordinator. The PIO, 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 media and community outreach campaign costs.

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 no specific MCH evidence exists on well-child visits, the evidence for Adolescent Well-Visit strategies and Medical Home was 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 emerging evidence for this strategy, especially in reinforcing a mass media campaign with social media and community coordination.

Strategy 1: Collaboration with Pediatric Providers

As part of the initial public health COVID-19 mitigation strategies, mandatory closures meant that services for children and families became virtual and in-person well-child visits to the doctor were limited. Through 2022, the increased availability of adult COVID vaccinations resulted in safety restrictions being removed with services reopening.

In Fall 2021, a workgroup consisting of FHSD, Med-QUEST, DOH's Chronic Disease Prevention and Public Health Promotion Division, AAP-Hawaii Chapter (HAAP), and HCAN convened to develop messaging for the public awareness campaign to encourage more Child Wellness Visits (CWV), especially for young children. While the COVID cases appeared to be decreasing towards the end of 2021, the Delta variant started to surge. Some doctors' offices were reopening for in-person visits with well-established safety procedures and easy access to PPE (initially in short supply); however, the Delta variant heightened concerns for closures again. This partnership with the

HAAP and Med-QUEST Division and Title V continues to meet to support efforts to promote the medical home. Some of the efforts included:

- FHSD established a connection with the HAAP President and Vice-President to serve on the workgroup, which held monthly meetings.
- The HAAP representatives shared information with their chapter members through articles in their newsletter and even identified pediatric champions to be filmed in the Public Service Announcement (PSA) commercials.
- A website, Keiki Check Up (www.keikicheckup.com), was created where families could find information about where to find a pediatrician and other resources.

Strategy 2: Conduct Public Awareness Campaign

Initially, 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 and COVID vaccinations for eligible adolescents (from age 12 at the time). Because of the Delta Variant surge, the campaign was postponed until November 2021 when the COVID numbers started declining. The group decided on the message "Time for a Checkup" after conducting focus groups with families from the Home Visiting program. The following are the activities that were conducted:

- Public Service Announcement (PSA) commercials targeted adults, ages 25-54, in approximately 245,271 households. The paid media campaign included television spots, live morning news interviews, and taped news stories with pediatricians discussing the importance of well-child visits. The radio spots also ran over the two months 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 team relied on media viewership measures (i.e., number of views) and hits to the website 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, as Med-QUEST shared that their data was based on claims data and may not be available until the end of the reporting year.
- The website was launched in November 2021 and had 6,862 page views with 5,197 unique views with 208 clicks on the page (links to other resources we listed).
- The messaging was also shared through the DOH Community Bulletin, 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.
- As more moneys became available, FHSD launched a second campaign that promoted screening efforts using the same footage as the first and updated the website. The script for the second campaign was developed with input from the team and is listed here: *Do you have questions about how your child is developing? The next time you take your child to the doctor, ask them to check their hearing, vision, and behavior. Your child's doctor has the latest information on what to look for. It's a quick way to answer your questions and get support for any concerns. It's time to check up on your keiki! To learn more, visit keikicheckup.com.*

Strategy 3: Build Capacity for Pediatric Champions

Although the project's primary focus 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 producing public service ads (voiceovers, “actors”) and providing live and taped interviews on morning TV shows and news programs. These providers represented diverse populations by race, ethnicity, and gender.

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

- CSHNB worked with AAP-Hawaii Chapter on other medical home messages, COVID-related information, the national CDC Learn the Signs Act Early campaign, and other Title V priority issues.
- The AAP-Hawaii Chapter helped identify a local pediatrician to be interviewed on a morning news television show in a special segment focusing on the well-child visit.

Current Year Highlights for FY 2023 (10/1/2022 – 6/30/2023)

The group continues to meet to work on a toolkit of resources for families and to keep the connection between DOH and AAP-Hawaii Chapter. Some of the activities included:

- FHSD PIO secured media spots to promote the AAP-Hawaii Chapter's work on the CDC Learn the Signs Act Early campaign, which promotes developmental monitoring of children's health. The AAP-Hawaii Chapter's President, who is also the CDC Learn the Signs Act Early Ambassador, was featured on several morning news shows talking about the campaign. This spot was the most clicked link on the homepage on 11/30/2022, which gave the segment more visibility.
- HCAN drafted a magnet with the well-child visit schedules with the website QR code that can be given to families. A frame where parents can insert their child's photo with the well-child visit schedule can be downloaded from the website. These mockups of the magnet and baby photo props would be distributed to families through DOH programs.
- With the news of the COVID Public Health Emergency (PHE) Unwinding, the group decided to continue to meet to monitor the situation to ensure pediatric providers are aware of the situation and continue to monitor children's eligibility. Many of the FHSD programs have assisted by ensuring their families are aware of the important letters from Med-QUEST to ensure they are aware of the situation and to help when needed.
- The website has been updated to provide information about the PHE Unwinding with information from Med-QUEST and other supports for families.

Challenges Encountered

Hawaii is fortunate to work with AAP-Hawaii Chapter and Med-QUEST on these important issues and to help promote the medical home. However, even with these partnerships, challenges remain, such as:

- Lack of access to timely data from Med-QUEST, which usually has a one-year lag to access the data from their claims data. Providers have until the end of the reporting year to enter their claims data, which means there is no timely data available to measure the campaign's effectiveness based on the airing of the PSAs.
- Although Hawaii identified children who are Native Hawaiian or Filipino as having the lowest number of well-child visits based on home visiting data, there is limited disaggregated data on this target population. Fortunately, home visiting data was available to track if there were improvements to the well-child visit. However, the NSCH sample size is too small and FHSD is still waiting to see if race and ethnicity data for pregnant women will be available.

- FHSD has several vacancies that limit connections between community partners and key target populations.

Overall Impact

While launching the public service announcements was a great activity to accomplish with this SPM, the overall impact is the establishment of the workgroup, which continues to support this collaborative partnership. Some of the other impacts include:

- FHSD is still waiting for the data to assess the campaign's effectiveness. It is easy to see the number of views or hits to the website; however, the more important evaluation is whether there was behavioral change because of the PSAs. FHSD hopes that data from Med-QUEST will help to show an increase in well-child visits that may be attributed to this effort.
- There are positive responses from the pediatric community, and many of the champions featured on the news shows continue to get recognized.
- FHSD received many compliments from the home visiting program collective, *Your ‘Ohana*, who was able to recognize their logo on the campaigns.
- The website continues to be updated, and with the campaign, the hope is that it helped increase awareness of the importance of well-child visits and developmental, hearing, vision, behavioral, lead, and oral health screenings.
- The workgroup continues to meet, especially as there is concern that due to the PHE Unwinding, there may be children who lose their healthcare coverage. The members recognize the critical role they can play in supporting these families.
- While FHSD has always had a strong relationship with the Med-QUEST program, the Medical Director made a connection with the Title V Children and Youth with Special Health Needs Section Supervisor and invited her to participate in regular meetings with their EPSDT Medicaid Coordinators.

Child Health - Application Year

NPM 6 - Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool.

For the Child Health domain, Hawaii selected NPM-6 Developmental Screening as a continuing priority, based on the Title V 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 new staffing resources, Hawaii is deleting two strategies, will retire ESM 6.2, and will 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).

ECCS Health Integration Prenatal-to-three Program (ECCS HIPP) grant: The new Hawaii ECCS grant is developing a strategic plan to strengthen integration and promote 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 ensure 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. Hawaii was one of three states to receive additional $750,000 for Early Childhood Developmental Health Systems funding which will help support screening, especially mental health and developmental screening and supports.

Medicaid partnership: With the inclusion of developmental screening as a priority in 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 for Medicaid enrollees in the first three years of life was 22.41%. Collaboration with the Hawaii Medicaid program 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 underserved populations with health disparities and poor health outcomes.

Hiʻilei 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 considering 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 of expanding screening reach.

Project LAUNCH grant: CSHNB will work on implementation of the Substance Abuse and Mental Health Services Administration Project Linking Actions for Unmet Needs in Children's Health (Project LAUNCH) grant to promote developmental screening and other screens to identify children who might have developmental or behavioral concerns and refer them to services to mitigate severe emotional disturbances (SED).

Strategy 2: Data Collection and Integration

The Hawaii Medicaid program data 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 be relaunched to help promote expansion of the Hiʻilei program family and provider screening resources. If possible, messaging may be translated into several languages.

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 a community-based organization.

Using the Survey of Well-being of Young Children (SWYC) developmental screening tool that also examines family well-being and social determinants of health will continue to be promoted with partners to better address the social determinants of health and identify vulnerable at-risk families who may need 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 Title V 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 from 5.9 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.

The strategies may be reassessed and revised with staffing changes and system innovations.

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.

Preventing CAN will be addressed through established and new government and private organization collaboratives addressing 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 to build 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 CAN 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, including the Hawaii State Departments of the Attorney General and Public Safety, the Fatherhood Commission, and the Executive Office on Early Learning. This includes new collaborations around Family Resource Centers and the Office of Wellness and Resiliency to further support the child welfare system.

Expanding the collaboration will support policies, practices, and services that help children and families mitigate risks for CANP, such as lack of housing, need for financial assistance, more parent education, expanded access to substance use and abuse treatment, and prevention of domestic violence. The outcomes of this collaboration are envisioned to include: combined funding streams; defined policies that align with a common vision; diverse community collaboratives addressing common CAN goals and outcomes; and universal tracking and accountability for outcomes.

The CANP Program will continue to collaborate and coordinate 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. The HCTF Coalition will address community-level needs, concerns, and solutions to ensure systemic planning and execution of statewide CANP training and activities.

Public and private collaboration and integration will be supported 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 to be supported by the CANP program funds.

Strategy 2: 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.

CANP Program will continue to support training that focuses on 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). Content will include; building individual and community resilience, trauma-informed and trauma-responsive systems of care, protective factors, and Standards of Quality for Family Strengthening and Support. Trainings offered will use a range of modalities: virtual, on-demand/online, and in-person.

The CANP Program will also partner with internal and external partners on other CAN training topics: safe sleep, safe and effective discipline, and domestic violence. The Hawaii Home Visiting Program will continue to provide quarterly trainings to all CAN- contracted service providers statewide.

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

The data from DHS CWS points to significant disparities among CAN-confirmed cases, specifically by ethnicity, child's age, family income, and geography (rural). These variables are not necessarily mutually exclusive.

CANP will expand its collaboration with Native Hawaiian community organizations by participating in the new Office of Wellness and Resiliency's *Mālama 'Ohana Working Group,* which has been meeting to address the over-representation of Native Hawaiians in foster care by transforming the existing CWS program. The partnership seeks to transform the existing CWS program by helping identify culture-specific needs and gaps in CAN prevention services and identify recommended programmatic strategies to address these disparities.

Many of the service contracts supported by CBCAP funds were disbursed to community-based organizations addressing disparities associated with rural areas and race/ethnicity. The CANP will monitor implementation of these contracts to ensure identified projected outcomes. Based on program evaluations, these efforts are expected to develop into emerging evidence-based interventions and practices.

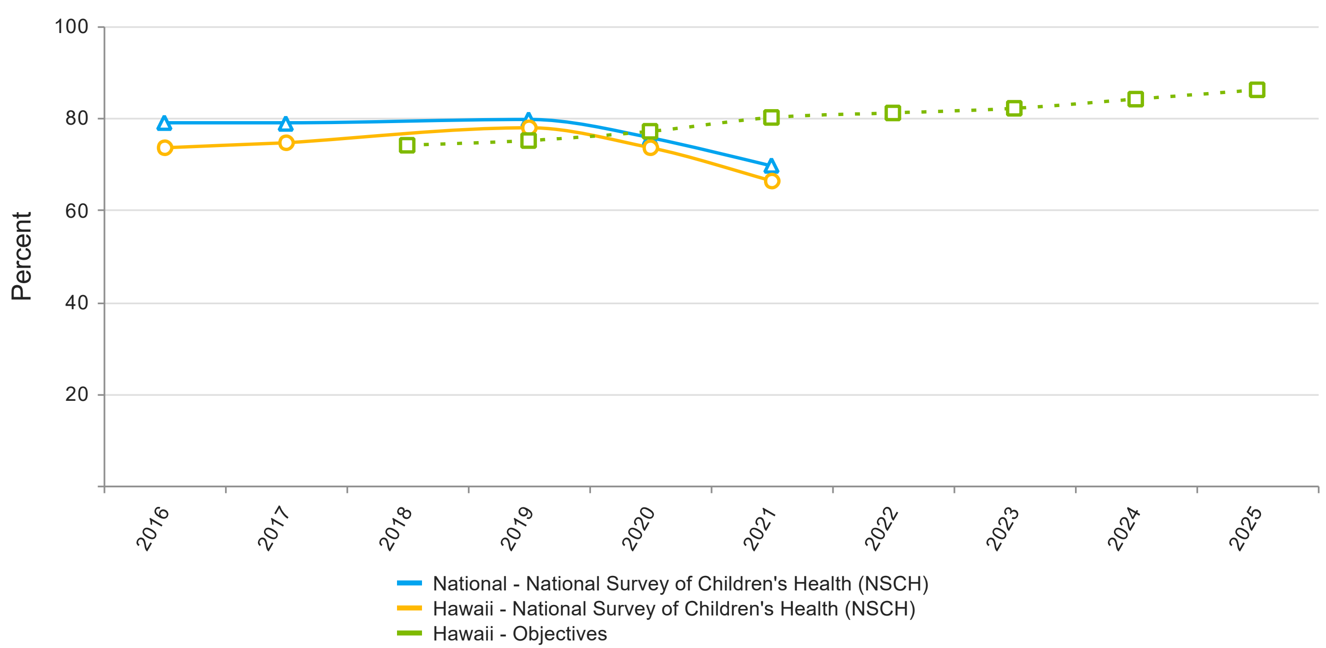
SPM 5: The percentage of Medicaid children receiving six or more well-child visits in the first 15 months of life

While the workgroup will continue to meet, Hawaii plans to end this SPM as the public awareness campaign was the major activity. Hawaii will continue to monitor well-child visits and EPSDT screenings.

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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	74	75	77	80	81
Annual Indicator	74.6	74.6	77.7	73.4	66.3
Numerator	74,226	74,226	76,702	71,318	63,067
Denominator	99,470	99,470	98,664	97,099	95,187
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			18	23	25
Annual Indicator					
Numerator	9	13	20	26	27
Denominator	30	30	30	30	30
Data Source	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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

Develop self-health resources, tools, and services for Pacific Islander teens and young adults and all other Hawaii young adults to address health disparities

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 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
- 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

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 2015 Title V five-year needs assessment findings. The 2025 Title V state objective for NPM 10 is to increase the percentage of adolescents with a preventive medical visit in the past year to 86.0%.

Data: Aggregated data from the 2020-21 National Survey on Child Health (NSCH) indicates that Hawaii (66.3%) did not meet the 2021 state objective (81.0%), but it was closer to the national estimate of 69.6%. There was a significant decline in the 2020-2021 estimate (66.3%) compared to the 2019 estimate (77.7%). The Hawaii estimate also did not meet the related Healthy People 2030 Objective (82.0%). Based on 2020-2021 aggregated data, adolescents of parents who were high school graduates (54.6%) or who had some college education (55.3%) were significantly less likely to have preventive medical visits than those whose parents were college graduates (78.0%).

The 2021 Hawaii Youth Risk Behavior Survey (YRBS) indicated a 1.0% decrease in preventive visits for high school teens. For teens in 2019 who reported seeing a doctor for a check-up or preventive physical exam, visits declined slightly from 64.0% in 2019 to 63.0% in 2021. These numbers may be inflated if adolescent respondent 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 Hawaii County and Maui County youth. Other Pacific Islander high school students had the lowest percentage of preventive visits, followed by Filipino and Native Hawaiian students.

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 administers the federal Personal Responsibility Education Program (PREP) grant and assists with managing state-funded contracts supporting women's reproductive health. The AHU coordinator is partially Title V funded.

Strategies/Evidence: The four 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 that focuses on 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. To promote adolescent wellness visits, provide resources, training, and learning opportunities for adolescent caregivers, community health workers, and other service providers.
- 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 was reviewed to identify any recent additional evidence for Hawaii's strategies. AHU uses several strategies the National Adolescent and Young Adult Health Information Center recommends, 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 and notes that it "is a strong measure of an evidence-based strategy."

Coordination with NPM 12: Transition to Adult Health Care
AHU is coordinating efforts with the FHSD's 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 because it also overlaps with NPM 10 AWV activities.

COVID Impacts: COVID safety restrictions eased in late 2022, with most doctors' offices opening for in-person visits and many continuing to offer remote telehealth options. Next year's NSCH data may help to determine whether AWVs have returned to pre-COVID levels. For some families, daily living priorities focused on more immediate day-to-day needs, such as income/housing stability, access to food, and educational and childcare responsibilities. Existing disparities related to accessing preventive healthcare that existed prior to COVID are believed to have worsened among adolescents in Hawaii.

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
In 2022, the Title V AHU experienced a significant increase in community partnerships with teens, youth service providers, and other community organizations working to promote adolescent health and wellness visits. Existing funds were shifted to devise and support new ways to reach and address youth needs that emerged during COVID. However, some contracted enabling services were reduced and changed during this period due in part to COVID restrictions.

AHU strategically leveraged the partnerships with community-based service providers that work directly with youth to collect input from the teens they serve regarding their perceptions of the impacts of COVID on their personal physical, social, emotional, and mental well-being. AHU used the information to develop more effective outreach messaging. The information also provided insight for workforce training ideas, which 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 in 2022, encouraging parents to schedule back-to-school vaccination and physical examination appointments as healthcare services started to reopen in June 2022.

Coalition for Drug-Free Hawaii (CDFH): CDFH is a critical AWV partner that provides statewide access to youth ambassadors, experienced youth service staff, a well-established statewide website and youth service provider network. CDFH provides 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 the Atherton YMCA provided AHU with improved access to a broad network of 18-to-24-year-old college students that is being utilized to better inform youth and young adult outreach efforts.

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 caregiving 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, the After School Program Alliance, Weed & Seed Hawaii, and the Atherton YMCA.

PREP: The AHU PREP service contracts for improved access to high-risk youth in residential facilities to provide them with 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's "*Footsteps to Transition*" infographic was also incorporated to help initiate conversations about AWV and the importance of scheduling a regular 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).

The YCA targets youth 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 annually,16 to 18 years of age, consistently complete the positive youth development and teen pregnancy prevention TOP curriculum.

The KYFWC is administered by the state Department of Human Services, Office of Youth Services (OYS). The program is a "last resort" residential facility for more than 30 court-involved youth, 16 to 18 years of age, from across the state.

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

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

During COVID restrictions, 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, health care was largely limited to identifying, treating, and mitigating COVID and other acute care issues. Many PSS program outreach staff were furloughed, leaving the neighbor islands with minimal adolescent health wellness outreach. AHU maintained contact with the adolescent outreach workers throughout this extended period via a listserv to inform them about self-care, adolescent resources, tools, and adolescent health training opportunities.

YRBS: 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-specific 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.

This strategy focuses on developing adolescent informational resources (AIR) online to build knowledge, promote healthy behaviors, and improve skills to access healthcare and community resources. 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 surveyed indicated they did not believe an AWV was important, citing barriers like health insurance and additional out-of-pocket costs. The other 95% of respondents noted the benefits of an AWV: knowing your health status and learning ways to improve health. The teens cited doctors as the best source of information for identifying health issues/chronic conditions that may need monitoring. When asked about whom they seek health advice from, 83% responded with their mother first, father second, and physician third. Students reported that the best ways to get reliable and helpful health information were from: doctors, parents, Google Search, and websites. Based on these results, *TeenLink* youth staff developed resource materials on the *TeenLink* website to address these findings.

An additional youth survey was conducted in Fall 2021 to collect more data on the transition to adult healthcare to update the current information materials/planning tools and make them more appealing to youth.

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, 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 reported that they did not know their specific health insurer, did not have their health insurance card, or did not have experience making a doctor's appointment for themselves.

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 highlighted issues identified by teens, which included: managing stress, impaired sleep, anxiety over school grades, healthy eating habits, and concerns over social media use. Two 30-second TV spots were produced, featuring popular Hawaii comedian and social media influencer Tumua Tuinei. The former University of Hawaii football player brought his local brand of comedy to the PSAs, depicting himself as both the teen and his parent/s discussing the importance of communication while directing viewers to the TLH website. The PSAs, which were reformatted for radio and digital media, used humor as a bridge to familiarize teens and adults with resiliency messaging. TLH staff and young adults also promoted the website on several Hawaii TV morning news show appearances.

The reach via TV was estimated to be 98.9% of the target audience of households with children. Combined broadcast and cable TV impressions were estimated at more than 2.1 million views. Total impressions were estimated at nearly 2.4 million for radio, spread across 20 radio 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 ages 35 to 64.

Digital media buys were incorporated through key outlets, including search, keyword, display, retargeting display, a 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 specific mention of how fun and relatable the spots were due to 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 in the months prior to the campaign. Interestingly, visitor 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, including the Philippines, India, the United Kingdom, and the Netherlands.

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-related challenges, the 2021 indicator scored 26 out of 30 points, a 30% increase over 2020. This is credited to significant progress from 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 reflecting the strategy activities' evolution over the past five years. A physical toolkit for health providers was reworked into a youth-driven, youth-developed website still relevant for caregivers/parents and health/service providers.

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	27			

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 and other Title V and DOH programs, community coalitions, and organizations.				X
2. Introduce CSHN's "Footsteps to Transition" to contractors and outreach staff to utilize the infographic to show participants where they are in their transition to adulthood and to direct the warm handout conversation to the topic area needed.				X
3. Update the listserv of adolescent health stakeholders and, if available, collect adolescent-developed information for incorporation into the AIR/TeenLink.				X
4. Develop a local base of speakers on issues affecting adolescent behaviors.			X	
Strategy 2: Engagement: Adolescent Informational Resource (AIR)				
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 ensure the AIR/TeenLink provides useful health and resource information that meets 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			27	

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 to youth and other service providers and continues this training on positive youth development and protective factors as part of the PREP program. During 2021-22, 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 with Instagram Posts, IGTV, TikTok and YouTube videos, print resources, infographics, and more. The site is developed by teens for teens, their caregivers, and youth service providers. AHU sends the recorded introduction to *TeenLink Hawaii* workshop every quarter to neighbor island agencies. In 2022, additional informational resources were added on self-care and wellness, using telehealth services, mental health resources and also shared on social media posts. CSHN’s neighbor island staff utilize TLH

as their transition to adult healthcare information website.

Media: The resiliency media campaign, launched in Fall 2021, helped to publicize the TLH website to teens and young adults. The goal was also to reach more parents and youth-serving providers, agencies, and institutions to increase access to self-help and self-care tools, resources, and services, including the importance of AWV.

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

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 addresses the informational/services needs of Pacific Islands (Micronesian) teens and young adults. AHU solicited bids to work with this community to develop materials to improve engagement with these populations. The Domestic Violence Action Center (DVAC) was awarded the contract and utilized its networks of Pacific Islander teens and young adults to assess their health and wellness needs. These young people will also assist in developing resources, tools, and services (RTS) and identify the most effective media platforms, designs, and tools to engage their Pacific Islander peers on health and wellness issues and AWVs.

The DVAC youth groups will also assist with presenting the RTS information to peers, families, and other youth organizations. The resources, tools, and services will be housed on DVAC's website and digital platforms and included on CDFH's *TeenLink Hawaii* website via a link to DVAC.

Current Year Highlights for FY 2023 (10/1/2022 – 6/30/2023)

Here are some highlights of current adolescent health activities for FY 2023, including continued impacts and changes, due to the changing COVID landscape in Hawaii.

With increased access to COVID vaccinations and reported reduced severity of COVID cases, the state and county emergency orders were lifted in May 2022. Public schools resumed in-person learning with masks and other safety precautions in place. COVID vaccinations were offered through some schools and widely in the community.

Physician shortage: Hawaii's continuing physician shortage was exacerbated by the COVID crisis, adversely impacting access to AWV providers, especially in rural communities statewide. A 2020 assessment of primary care physicians conducted by the University of Hawaii (JABSOM) found that COVID significantly disrupted healthcare provider practices, with reported temporary and permanent clinic closures, more early retirements, increased telehealth practice, altered operating hours and locations, and reduced patient volume. Primary care doctors represent the largest physician workforce shortage on all islands.

PREP: There were some changes in PREP contractors. Due to administrative and staffing shortage issues, the Hawaii National Guard Youth Challenge Academy (YCA) and Residential Youth Services and Empowerment (RYSE) ended their contracts in 2022. Two new contracts were executed with the following agencies.

Parents And Children Together (PACT) – PACT provides afterschool drop-in centers for youth ages 7-18 to promote the development of healthy youth, families, and communities with abundant positive experiences, including educational, recreational, community-building, and support services. PACT collaborated with the AHU in capacity-building activities and identified four certified staff as TOP facilitators, beginning in September 2022.

Hawaii 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 HFRJ staff as TOP facilitators, with services beginning in August 2022.

The Kawailoa Family and Youth Wellness Center (KFYWC) continues participating in PREP. The youth corrections officer (YCO) training coordinator reported 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 facility's average census of 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's monthly hits have tripled since the February 2021 presentation that initiated and promoted this 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.

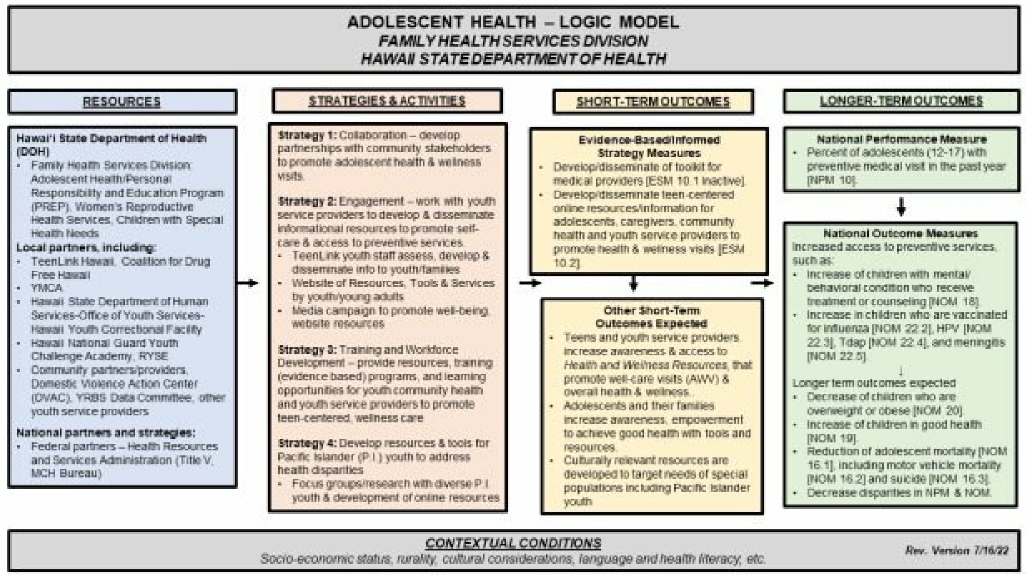
Medicaid AHU met with DHS Medicaid's Quality Assurance nurse, who also helps to convene monthly meetings of the Medicaid EPSDT coordinators. AHU will be invited to present information to the EPSDT coordinators to collaborate on efforts to promote and increase adolescent wellness visits.

Youth Summit To engage more diverse youth populations in the state, the annual youth summit is utilizing a new approach. Hilopa'a Family to Family Information Center will assist this year in planning a youth-driven, retreat-style summit to incorporate a healthy youth development approach. Several events will be held in each neighbor island county: Hawaii, Maui, and Kauai. Youth-serving organizations from each county will be engaged to help select youth participants. The first youth summit will be held in Hawaii County in late summer 2023.

Palama Settlement. Partnering with the Child Abuse and Neglect program, AHU sponsored a youth program at Palama Settlement (PS), an established local community center in Honolulu that serves the urban low-income and immigrant community. PS is located near some of Honolulu's largest low-income public housing developments, with nearly 80% of tenants from Pacific Island jurisdictions. The funds will assist PS to develop its youth programs by incorporating evidence-based approaches to support school, health/well-being, and developing career/personal aspirations. The program hosts a series of business and university leaders to encourage and mentor youth regarding potential academic, personal, and professional career options.

Review of the Action Plan

A logic model for NPM 10 was updated in 2022 to assure alignment among strategies, activities, measures, and desired outcomes. The logic model was also revised to add the health equity strategy for engaging and developing new resources.



Challenges and Barriers

AHU's AIR 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 physicians; develop the ability to schedule well-visits; and link youth to needed health services (e.g., AWVs) and resources.

Data on AWVs remains low, largely due to lack of routine healthcare access, due to 2020-22 COVID-related closure of healthcare provider offices. New challenges were brought on by COVID, including the state's primary care physician shortage and a shifting of family priorities that led to delayed medical visits. Ongoing misbeliefs also persist that doctor visits are for illnesses only, preventive visits require out-of-pocket costs, and 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, but temporary source of acute care, which can undermine the benefits of the more comprehensive AWV provided by a long-term regular medical home.

Working with specific populations to address health disparities has been challenging. While DVAC has Pacific Islander staff, who have worked to engage youth from their communities, the response has not been robust to date. It is unclear to what extent the existing data collection methods have effectively captured Pacific Islander youth's life experiences and attitudes. AHU will continue to explore opportunities to collaborate with Pacific Islander youth to increase understanding of their structural and interpersonal barriers to resources/services, their unique health-related needs/concerns, and strategies to help them improve their health outcomes.

Operationally, AHU was adversely affected in 2021-22 by staffing shortages within the Unit, Section, and Branch. Vacancies include the AHU Supervisor, Reproductive Health Services Manager, and Women's Health Section Supervisor. Efforts to recruit and fill these vacancies are continuing.

Overall Impact

AHU's greatest success is with youth engagement. AHU's commitment to engaging youth in assessing their health concerns and development, as well as disseminating health education and messaging, has culminated in youth-designed information via the statewide *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 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 effectively address health equity issues. The three PREP sites serve some of the state’s most at-risk youth populations, utilizing evidence-based programs to promote adolescent health and wellness visits. In the FY 2022 plans, AHU will address the disparities highlighted by COVID, with projects focused on addressing the needs of Pacific Islander and 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 Title V five-year needs assessment. By July 2025, the state seeks to increase the percentage of adolescents, ages 12 through 17, completing 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; provide insight on how 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, 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 routinely with groups of teens and/or young adults to promote adolescent health and wellness visits.

PREP 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. Existing staff position vacancies may constrain these activities.

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, including working with Medicaid EPSDT coordinators and AAP-Hawaii.
- 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 supporting and promoting 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.

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 regular guidance from teens and young adults. The *TeenLink Hawaii* (TLH) teen leadership groups will utilize their peer survey research findings to develop further 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 various 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. PREP program surveys will also be expanded to collect additional input on health matters to further develop the *TeenLink* resources.
- Collect and analyze and incorporate the evaluation comments on TLH from both adolescents and service providers in further planning.
- Develop and implement a young adult section on the TLH website for young adults 18 to 24 years.

Youth Summit Hilopaʻa Family to Family Information Center will continue to assist AHU in planning and conducting a youth-driven, retreat-style summit on each of the neighbor islands. Usually, the annual summit is held in Honolulu with limited neighbor island participation. Information/input collected from the youth and service providers will help assess ongoing needs and identify innovative ideas, practices, and solutions to improve health and access to care.

AHU will continue work with the CSHN Branch to engage Youth with Special Health Needs and their families and develop informational resources specific to 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 potential PREP contracts are being explored with the Lanai Community Health Center and the Hawaii National Guard's Youth Challenge Academy if administrative barriers can be addressed.

Other adolescent health trainings for 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 stakeholder input on topics of interest and new methods for training delivery.
- Encourage and facilitate the recruitment of TOP graduates to become facilitators and peer support for teen pregnancy prevention 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 its Pacific Islander teens and young adults networks to assess and support 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.

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 included on CDFH's *TeenLink Hawaii* website via a link to DVAC.

AHU will work with PREP sites to collect more data/information/input from our culturally diverse and underserved populations. AHU will work with the Hawaii Friends of Restorative Justice (HFRJ) and the Kawailoa Family and Youth Wellness Center (KFYWC) to gain greater insight into the Native Hawaiian and Pacific Islander youth these programs serve and provide outreach to.

Title V will assess the 2021 Youth Behavioral Risk Survey results to assess the health and social impacts of COVID, as reported by Hawaii middle and high school students. Special attention will be placed on identifying emerging issues and disparities to better target youth-related 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. Concentration on high school graduation, sexual health, positive youth development, and transitioning into adulthood.

Personal Responsibility Education Program (PREP): The grant aims to fund the implementation of evidence-based positive youth development programs that broaden 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 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 high-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 to prevent 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 of infants, children, and youth through multidisciplinary interagency reviews.

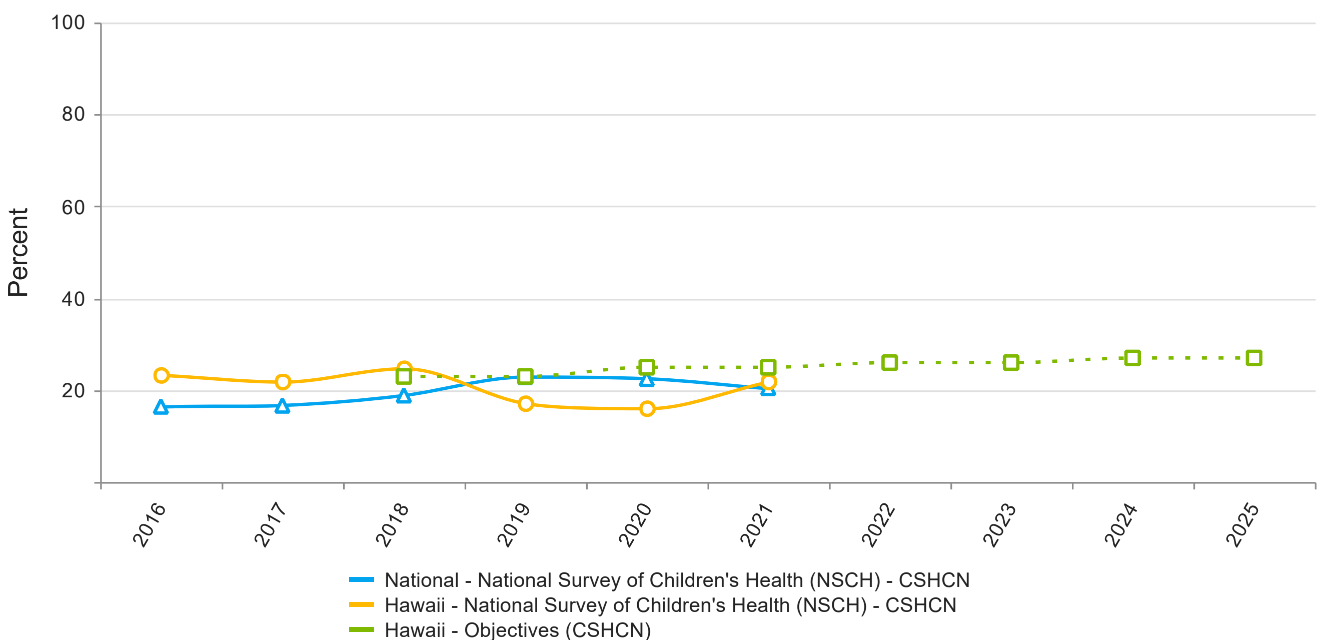
Children and Youth with Special Health Needs: Assists with service coordination, social work, nutrition, and other services for children/youth with special healthcare needs, ages 0-21 years, with chronic medical conditions. It serves children/youth who have or may have long-term or chronic health conditions that require specialized medical care and their families.

Reproductive Health Care & Support Services: Reduces risk factors contributing to infant mortality and provides various 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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	23	23	25	25	26
Annual Indicator	21.9	24.7	17.1	15.9	21.9
Numerator	4,457	5,037	3,214	3,171	4,086
Denominator	20,375	20,412	18,758	19,924	18,629
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	17	21	24	26	28
Annual Indicator					
Numerator	18	22	25	26	31
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	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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 service coordination for youth enrolled in Children and Youth with Special Health Needs Section (CYSHNS) 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 five-year DOH needs assessment results. By July 2025, the State seeks 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 youth with and without special needs, the federally-available data is reported separately for each sub-group of adolescents. The data for special needs youth was used for this measure since it falls in the CSHCN population domain.

The aggregated 2020-2021 data indicates that the estimate for Hawaii (21.9%) did not meet the 2022 state objective (26.0%) but was not significantly different from the national estimate of 20.5% for youth with special health care needs. The increase from 2019-2020 (15.9%) was not significant. The related HP 2030 objective for this measure is under development. The sample size was unfortunately too small for subgroup analysis.

For adolescents with no special health care needs, aggregated 2019-2020 data indicates 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% per year). The related HP 2030 objective for this measure is currently 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. The CYSHNS Section Supervisor provides the leadership for NPM 12 activities. 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 activities promoting adolescent wellness visits. The statewide Transition team meets monthly via Zoom.

Title V does not directly fund transition activities but funds key CYSHNS staff positions, including the CYSHNS Section Supervisor and Nutritionist. 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 who actively support and promote youth transition to adult life include:

- Title V Adolescent Health Program
- American Academy of Pediatrics-Hawaii Chapter
- Hilopaʻa Family to Family Health Information Center (Hilopaʻa 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
- Special Olympics Hawaii
- MedQUEST, Department of Human Services (DHS)
- EPSDT Coordinators (DHS)
- Child Welfare Program for foster children (DHS)
- Maternal and Child Health Leadership Education in Neurodevelopmental and Related Disabilities Program (MCH-LEND)
- Community Children’s Councils, Department of Education (DOE)
- Leadership in Disabilities and Achievement of Hawaii (LDAH)
- No Wrong Door, Hawaii Executive Office on Aging

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 integrating transition planning into the CYSHNS practices/protocol, based on *Got Transition's Six Core Elements of Health Care Transition*™ *3.0,* which currently serves as the NPM 12 strategy measure (ESM 12.1).

Evidence: The first two transition strategies for Hawaii are based on input collected from the 2020 Title V needs assessment; Association of Maternal and Child Health Programs (AMCHP) NPM 12 Toolkit; the MCH Evidence Center; MCH Workforce Development Center technical assistance; *Got Transition* website; and the 2020 Federal Youth Transition Plan and national best practice recommendations from Centers for Medicare and Medicaid Services (CMS) 2014 report titled, *Paving the Road to Good Health*. A third strategy focusing on health equity was added in 2021. Progress on the strategies is described below. The MCH Evidence Center identifies this ESM as an 'innovative tool' to track transition activities and "is a strong measure of an evidence-based strategy."

COVID Impacts: After the dramatic shutdown of in-person services in 2020-21, CYSHNS services began returning to pre-COVID levels in 2022 as restrictions were lifted and vaccinations became readily accessible for all ages. Post-COVID changes remain, including continued use of telehealth visits for families with accessibility issues and families facing economic hardships with the rising cost of living. Medical visits for children continue to lag for some, but most have resumed regular care.

New partnerships established during COVID with state agencies, healthcare providers, and community organizations continue to advance transition planning for youth.

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 all youth and their parents/caregivers receiving CYSHN services.

Core Element 1: Transition and Care Policy/Guide

This element focused on developing a CYSHNS transition policy that was completed in 2019. All CYSHNS staff are educated on transition approach, policy, the Six Core Elements, Title V, and the roles of CYSHNS, youth/family, and pediatric/adult health care teams in the transition process.

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 2019. As a result of the update, transition progress and completion can now be tracked through the database.

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 their health care, starting at age 12-16. This activity was completed in 2022.

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. CYSHNS assisted youth in downloading *Got Transition's* Medical ID phone application onto their mobile phones to store important health-related information that is easily accessible for the user.

Core Element 4: Transition Planning

This core element ensures transition planning is conducted effectively by reviewing and updating individualized transition goals annually with youth/families. This activity was completed in 2022. CYSHNS staff are currently working on developing outreach information on legal changes in decision-making, privacy, and consent issues.

Core Elements 5 and 6: Transition Transfer of Care and Transition Completion
The above activities are intended to culminate in 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. This activity was completed in 2022.

CYSHNS staff assisted with referrals to adult service agencies through the state's *No Wrong Door* program, an integrated person-centered system that supports individuals of all ages, disabilities, and payers. The *No Wrong Door* referral system provides a universal intake point to assist with better access to care.

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*TM *3.0*.

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective		10	17	21	25	27	29	30	33	
Annual Indicator	12	13	18	22	24.5	26	31			

Strategy Measure Progress: ESM 12.1 measures the progress of CYSHNS work under Strategy 1. The rating scale has 11 strategies adapted from *Got Transition's Six Core Elements of Health Care Transition*TM *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^{TM} 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
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
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
4. Utilize individual flow sheet or database to track youth's transition progress.		1 2016-18	2 2019/20	3 2022
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 their health care (self-care).	0 2016	1-1.5 2017-21		3 2022
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	3 2022
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		3 2022
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 2020-22	
9. Develop and implement referral procedures to adult service agencies.		1 2017	2 2018-19	3 2020
Transition transfer of care (core element #5)				
10. Prepare youth and parent/caregiver for transferring to an adult health care provider and planning for health insurance coverage as an adult.		1-1.5 2017-19	2 2020-22	
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 2018-21	3 2022
	2021 TOTAL = 31/33 (93.9% completion)			

The activities for the Six Core Elements are anticipated to be completed in 2023. The focus for 2023 will then be on ensuring that all children aged 12-21 enrolled in CYSHNS receive health transition services. Training and support for

staff will highlight the importance of completing health transition services for their caseload. Currently, a needs assessment of youth with special health needs and their families is being conducted by CDS to identify areas of need and will be used to develop new measures for transition to adult health care for 2024.

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 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 and youth and family members continued to conduct virtual annual educational transition fairs and events in FY2021-22 due to COVID restrictions.

The largest event for youth and families of CSHN is the annual Special Parent Information Network (SPIN) statewide conference, last held virtually in October 2021. SPIN is a statewide parent-to-parent organization established to enhance parents' participation for 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 an estimated 400 family members and service providers who typically attend.

Other in-person family events canceled due to COVID in 2021-22 included: the Hawaii Summer Special Olympics, Malama da Mind (Hawaii Island), Kauai Legislative Forum, Kona Marshallese Day, and Kauai STEPS fair.

Partnerships & Networking: CYSHNS continued collaborating with a broad network of government and community groups that assist with systems coordination and advocacy for youth transition to adult health care. Key planning partners include: 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, Hilopaʻa F2FHIC, Best Buddies Hawaii, MCH-LEND, Community Children's Council Office, Division of Vocational Rehabilitation, TeenLink Hawaii, and other community organizations.

In 2021-22, partnerships with the Kauai, West Hawaii, and Hilo Legislative Disability Forums provided another opportunity to share key transition messages with precinct/district legislators. The forums are sponsored and conducted by the HSCDD.

TeenLink Hawaii: In 2022, CYSHNS extended its contract with *TeenLink Hawaii*, an organization for youth and by youth that provides information and referral services for youth and young adults. Based on results from a needs assessment of youth and young adults conducted in early 2021, the *TeenLink Hawaii* young adult staff developed messaging for their website and Instagram site. Information on children with special health needs and transition to adult health care was added to the *TeenLink Hawaii* website (https://www.teenlinkhawaii.org/). A series of Instagram posts were developed on topics such as how to find an adult health care provider, make a medical appointment, fill out a medical history form, and types of medical specialists.

Kaiser Permanente: Through a partnership with the pediatric providers at Kaiser Permanente Hawaii (KPH), youth transition to adult health care was incorporated into the Kaiser Hawaii HMO system of care. With technical assistance from *Got Transition* and CYSHNS, KPH adopted the *Six Core Elements of Health Care Transition™* into their pediatric department services and used the Hilopaʻa Transition Workbook and CYSHNS TRAC, PATH, and Beach Flyer handouts for transition planning with youth in the KPH health care system. Hilopaʻa Transition Workbook is also used in the Kaiser Genetic Clinic and Behavioral Health Clinic. This partnership has expanded transition planning to a larger number of youth and young adults, as KPH is the second largest health insurer in Hawaii, caring for more than 250,000 members of all ages.

Title V Programs: Transition planning was incorporated into other CSHNB programs, including the Hawaii Community Genetics Clinics, the Early Language Working Group, and neighbor island cardiac, neurology, and nutrition clinics, as well as within MCHB-contracted adolescent programs.

Educational Materials: The CYSHNS Transition workgroup meets monthly to work on transition activities and outreach materials designed for populations with limited English proficiency or educational level limitations.

Strategy 3: Develop and expand efforts to address health disparities in transition services for youth

CDS Needs Assessment. The University of Hawaii Center for Disabilities Studies (UH-CDS) was contracted to conduct a needs assessment on youth with special health needs and their families. The 2018-2019 CSHCN data from the National Survey on Children's Health (NSCH) was analyzed to identify key health issues. The findings were presented at the Pacific Rim International Conference on Disability and Diversity in February 2022 by CDS staff and Title V CYSHN staff.

Since the NSCH does not provide county-level data or detailed Hawaii-based race/ethnicity data, CDS designed a survey to reach out to youth with special health needs, including key underserved populations, to gain more data on these youth. The University IRB approved the survey and follow-up focus group questions, and implementation of the survey began in the summer of 2022. The survey was translated into Tagalog, Ilocano, and Hawaiian to gather more data from Filipino and Native Hawaiian youth.

The findings will be used to inform Title V priorities and strategies. Transition services, messaging, and outreach may 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 recipients and Native Hawaiian/Pacific Islander youth-related organizations. CYSHNS seeks to provide further training to its staff on diversity, equity, and inclusion strategies.

Current Year Highlights for FY 2023 (10/1/2022 – 6/30/23)

Effects of COVID-19: In 2022-23, CYSHNS services resumed with in-person services. Based on family preference, remote services can also be provided. In-person events and clinics that were canceled during COVID were reopened in 2021-22, including the Maui Cardiac Clinic, the Hilo Neurology Clinic, and the statewide Nutrition Clinics.

Online Referral: Referrals for CYSHNS services can now be made on the CYSHNS website. This will increase access to services and resources. Its release is timely to coincide with the Public Health Emergency unwinding.

Medicaid/EPSDT meeting: In January 2023, the state Medicaid program convened regular bi-monthly meetings with Medicaid health insurance plan EPSDT coordinators and state community partners. The CYSHNS Supervisor attends the meetings. An overview of FHSD programs and Title V priorities was presented at the first meeting. In subsequent meetings, CSHNB staff have presented on transition to adult healthcare, lead poisoning prevention, and developmental screening. Discussions have also focused on areas to improve services to CSHN by Medicaid.

Outreach Events: The annual SPIN statewide conference was held at the University of Hawaii at Manoa campus in April 2024 using an in-person and virtual format for the first time. CYSHNS was a member of the SPIN advisory board and helped plan this conference. CYSHNS staff participated as an exhibitor to provide information on healthcare transition, developmental screening, and lead poisoning prevention. There were 351 registered attendees and 52 resource tables. SPIN provided travel scholarships for neighbor island families to attend the conference.

The Footsteps to Transition Fair held in partnership with the Department of Education was virtually held in February 2023. CYSHNS staff participated on the planning committee and presented a session on youth 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 and

appealing to youth. They will also be developing an online toolkit for adult transition information.

UH CDS Permission was secured to field the YSHN survey in state public schools special education classes beginning in the Fall 2022 semester into January 2023. Follow-up focus groups and individual meetings are being conducted to gather more detailed information.

Family Voices & AMCHP Transition Presentations At the national October 2022 Family Voices conference, CYSHNS and AHU, together with Family Voices and the Department of Education, presented on Hawaii's unique agency partnership experience. Driven by traditional Hawaiian values, these dynamic partnerships support and engage youth and families statewide. The transition presentation was also presented at the May 2023 AMCHP conference.

Serteen Club of Hawaii CYSHNS will partner with TeenLink Hawaii and the Serteen Club of Hawaii to work on a project related to healthcare transition and adolescent health. Serteens is a youth group with members statewide focusing on leadership and community service. Planning meetings will begin in July 2023.

Review of Action Plan

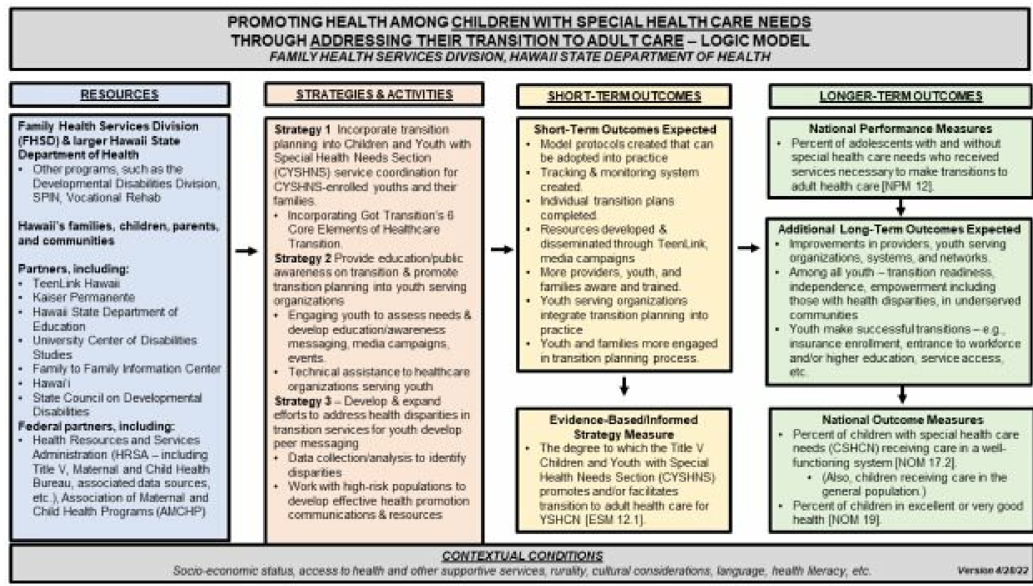
A logic model was developed for NPM 12 to review alignment among the strategies, activities, measures, and desired outcomes. By working on the three strategy areas, Hawaii focused on increasing the percentage of adolescents receiving transition services.

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 and social disparities.

Together, the strategies are designed to improve transition services, with greater adult transition readiness among youth, and increase the number of youths making successful transitions to adult care.



Challenges Encountered

COVID. As COVID pandemic restrictions were eased, then lifted in 2021-22, regular wellness visits returned. Many families attempted to catch up on past delayed medical visits, which included immunizations, developmental and

mental health screenings, and transition to adult health care.

A trend noticed in CYSHNS was the decrease in enrollment during the pandemic. This could be due to more children enrolling in Medicaid. As the primary care provider for children with special health needs enrolled in the health plans, CYSHNS took a secondary role in case management.

With the Public Health Emergency (PHE) for COVID expiring in May 2023, there may be increased CYSHNS enrollment for case management services and financial assistance for medical care. In anticipation, CYSHNS staff have been trained on how to assist families in completing the redetermination process for Medicaid and CYSHNP enrollment. CYSHNS outreached to primary care providers, sending them current program information and resources, and reminding them that referrals can be made to the programs for services and case management. CYSHNS also sent included information from other FHSD programs, such as Home Visiting, Newborn Hearing Screening Program, Hawaii Lead Poisoning Prevention Program, and Early Intervention.

Family 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 limited services to special education students. Several of the larger events relating to outreach were rescheduled and conducted virtually as a result.

Data Limitations: The National Survey of Children's Health (NSCH) data and small sample size continue to be a challenge. The variability in the NPM 12 shows ostensibly substantive changes, but none are statistically significant; thus, it's difficult to determine whether the data reflects real change. At a time when child wellness visits decreased, transition planning data appears to show an increase. As noted in other narratives, the funding, administrative, and epi staffing barriers prohibit Hawaii from pursuing an NSCH oversample that could generate more stable estimates for NPM 12 or data on important ethnic disparities. Concerns were raised to the MCH Bureau for greater investments in the NSCH. Hawaii has pursued other primary methods of data collection.

The partnership with UH CDS will provide more state-specific data to better understand disparities that impact the YSHCN population in the state and consequences of COVID to help develop strategies/partnerships that target those groups and communities of greatest need.

Reaching All Youth. Highlighting the importance of transition planning for all youth, not just those with special health care needs, also remains a challenge; however, partnership with the Title V Adolescent Health Program has helped immeasurably, as well as partnerships with DOE and community youth groups.

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 Hilopaʻa Transition Workbook, these tools have been valuable statewide in 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. 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 family and 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 promoting transition, including the DOE hosted *Footsteps to Transition* fairs. Events are held annually across all counties and have expanded to include a comprehensive array of services and educational providers. In partnership with DOE, the Transition Fairs have created other outreach and educational events for public and adult healthcare providers and workforce training events for service providers. The success of many of these events and trainings involves 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 2020 DOH 5-year needs assessment results. By July 2025, the State seeks to increase the percentage 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

The work for this strategy will focus on assuring transition planning is occurring for CYSHNS enrolled youth and program evaluation. The ESM 12.1 may be inactivated since it is nearly complete. A review of activities and target goals is being conducted to develop a plan for expanding on the Six Core Elements.

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 working with agency and community partners to modify outreach events and methods for effective youth/family engagement and deliver transition information and services. With the COVID endemic in-person gatherings have returned; however, virtual and hybrid engagement will continue since remote events have broadened family and youth participation, especially for neighbor islands/rural areas.

CYSHNS will meet monthly with Medicaid EPSDT coordinators to improve services, including transition planning.

CYSHNS will continue to identify new and emerging community partners to promote transition planning, including the DHS Child Welfare Program, adult healthcare providers, and others.

CYSHNS will continue to engage youth to assess and evaluate appropriate transition messaging through ongoing partnerships with the Title V Adolescent Health Program, TeenLink Hawaii, and the Serteen Club of Hawaii. CYSHNS will continue to partner with youth agencies and healthcare providers to distribute/share adult transition information.

CYSHNS will continue to partner with organizations interested in integrating transition planning into their services, including healthcare provider systems, such as Kaiser Permanente Hawaii and private sector pediatricians.

Strategy 3: Develop and expand efforts to address health disparities in transition services for youth

Needs assessment collaboration 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 (NSCH) and the UH CDS survey and focus group data will yield important insights on emerging access issues and key disparities. The findings will 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 ensure 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 Centers for Disease Control and Prevention (CDC) funds the program.

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.

Hiʻilei 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	2022
Annual Objective			20
Annual Indicator	0	0	98
Numerator			
Denominator			
Data Source	Hawaii Pediatric Mental Health Care Access grant	Hawaii Pediatric Mental Health Care Access grant	Hawaii Pediatric Mental Health Care Access grant
Data Source Year	2020	2021	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			9
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Hawaii Title V Genetics Program	Hawaii Title V Genetics Program	Hawaii Title V Genetics Program
Data Source Year	2020	2021	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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 added a state priority in 2021 to expand children's mental health services in response to emerging concerns due to COVID. Hawaii received a federal 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 in behavioral health care topics and, eventually, data on the teleconsultation model (once established). Training was provided to 98 pediatric or behavioral healthcare providers through the Project ECHO series of webinars, exceeding the year's objective. There were 191 attendees participating in the ECHO training series; however, 93 were not specifically healthcare providers.

Evidence: HRSA promotes the Pediatric Mental Health Care Access Program as a strategy to address the shortage of behavioral health providers by providing pediatric primary care providers with behavioral health training and a telephonic/telehealth consultative warmline. The warmline, staffed by a psychiatrist, psychologist, care coordinator, and social worker, provides teleconsultation, training, technical assistance, and care coordination so that pediatric primary care providers can more effectively diagnose, treat, and/or promptly refer children and youth with behavioral health conditions. The program's overarching goal 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 funds two staff positions to manage and build the program. Although no Title V funds are used to support the program directly, Title V-funded staff assist with data, contractual, and media support. As the grant requires, FHSD's Community Health Center Special Fund is being used as the state's 20% match. Through this funding, FHSD will support and coordinate community mental health needs for children and youth.

Key Partners: This project is a unique collaboration between the Department of Health, John A. Burns School of Medicine (JABSOM), DHS Med-QUEST Division, Project ECHO Hawaii, Hawaii Primary Care Association, American Academy of Pediatrics-Hawaii Chapter, and University of Hawaii Pacific Basin Telehealth Resource Center. This multi-agency collaboration will strengthen pediatric providers' access to needed mental health consultation services in underserved communities statewide.

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.

Strategy 1: Refine, develop, and implement pediatric mental health care access 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 grant aims 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 2022 largely focused on hiring the PMHCA Coordinator and Assistant Coordinator, developing contracts for the training and model, and continuing to support efforts for the three key strategies.

The first strategy focused on the infrastructure to support a model that provides pediatric providers' 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:

- Hiring a Project Coordinator and Assistant to coordinate the project activities within FHSD.
- Convening an Advisory Group to meet quarterly and help advise on project implementation.
- Executing contracts for services to be rendered around provider and family engagement and reviewing existing PMHCA models to develop a state model for implementation.

Strategy 2: Promote Workforce development and training on pediatric mental health care

This strategy focused on identifying providers and providing training 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:

- Partnering with Hawaii's Project ECHO to conduct training for healthcare providers on nine pediatric behavioral health topics: Integrated Behavioral Health in the Primary Care Office, Overview of Child and Adolescent Mental Health Division, Depression, Disruptive Behavioral and Parent Management, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, 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. Trainings began in April 2022 through September 2022 by a host of local Hawaii pediatric and behavioral health experts.
- Evaluating training feedback and revising curriculum for future pediatric behavioral health ECHO series to community providers on mental health topics.

Strategy 3: Support services and linkages in the community

FHSD identified service capacity issues and linkages needed to support children’s mental health. Hawaii continues to look at a coordinated intake and referral system to help promote the coordination of services to ensure 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:

- Partnering with the Hawaii chapter of the Federation of Families, Hawaii Families As Allies (HFAA) to serve on the advisory and represent families with lived experiences of mental health disorders
- Partnering with a local philanthropy organization, Hawaii Community Foundation, which was implementing its Promising Minds initiative to improve early childhood behavioral health in Hawaii.

Current Year Highlights for FY 2023 (10/1/2022 – 6/30/2023)

This section highlights the Year 2 work for the PMHCA grant with the hiring of two key staff to oversee and coordinate

the activities to support children and youth mental health through the warmline and training.

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 developing a pediatric mental health care access model that pediatric providers will access to work with behavioral health providers. Activities included:

- The PMHCA Coordinator and Assistant Coordinator were hired in the Fall of 2022, continued hosting Advisory Committee meetings, and met with stakeholders to promote and develop the model.
- Staff worked with the HRSA Project Officer who provided technical assistance (TA) to connect Hawaii to national consultants who lent their expertise to help develop the Hawaii warmline model.
- The grant Coordinator left the grant for another FHSD position; however, the Assistant Coordinator easily transitioned into the lead and continued the grant work.

- Finalized the logo for the Pediatric Mental Health Care Access model approved by the Advisory Council. The logo is based on the traditional weaving arts, symbolizing the many cultures of Hawaii working together. It represents unity and community within the Pediatric Mental Health Care Access network and the support this network brings to both pediatric providers and their patients. The logo is shaped into a heart to show PMH's support for pediatric providers while highlighting how professionals from differing practices come together to care for patients.
- The Hawaii project merged with efforts in the Pacific jurisdictions. The HRSA Project Officer convened the Pacific Jurisdictions - Palau, Federated States of Micronesia (FSM), and Commonwealth of the Northern Mariana Islands (CNMI) - and encouraged Hawaii to develop a warmline that could be used throughout the Pacific given the severe shortage of behavioral health providers in this region. HRSA hosts quarterly calls among the Pacific Jurisdictions to support this critical partnership.

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 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).

Because of the workforce shortages and increases in youth mental health needs, FHSD focused on offering providers access to timely mental health training. This strategy focuses on workforce training efforts. Highlights of activities include:

- Working with Hawaii's Project ECHO to develop a second round of mental health topics and to provide training to providers starting in the summer of 2023.
- The PMHCA Staff met with The REACH Institute (Resource for Advancing Children's Mental Health) to provide training on evidence-based therapies to better diagnose, treat, and manage child and adults with mental health issues. A contract is being executed to pilot this training in Hawaii.
- The AAP-Hawaii Chapter selected a Pediatric Mental Health Champion to assess provider needs around mental health needs and promote the PMHCA model. With the PMHCA coordinator, focus groups began with pediatricians across the counties. This work is supported through the PMHCA Program Utilization Chapter Funding Opportunity grant submitted collaboratively by HRSA.
- The PMHCA staff is sponsoring a behavioral health track at the next annual Hawaii Health Workforce Summit in September 2023 for approximately 600 participants, including physicians, physician assistants, ARNs, Community Health Workers, Medical Directors, Office Managers, Allied health Professionals, and more.

Strategy 3: Support services and linkages in the community

The PMHCA Coordinator continues to connect with community providers, help learn and support community-based efforts, and identify partnership areas.

- FHSD's Title V Planner and the PMHCA Coordinator worked with the University of Hawaii Office of Public Health Studies to complete a Child and Family Mental Health Data Tracker that includes data on the maternal and child health population. This data tracker compiles local and national data to learn and track mental health issues in Hawaii and was launched in May 2023. Hawaii Health Matters :: Indicators :: Child & Family Mental Health

- The PMHCA Coordinator contracted with the University of Hawaii Center on Disability Studies to conduct a literature review of evidence-based programs that support children and youth mental health.
- The PMHCA Coordinator will be working with a family organization to assist with convening focus groups to develop and promote infographics on mental health messages that will be family friendly.
- The PMHCA Coordinator is partnering with the DOH Child and Adolescent Mental Health Division (CAMHD) and Suicide Prevention Coalition to conduct an environmental scan of existing mental health services statewide, including behavioral health services, inpatient treatment programs, treatment programs, inpatient hospitalization or emergency departments, clinical providers, nonprofits addressing mental health and practicing mental health clinician as part of the CAMHD Needs Assessment.

Challenges Encountered

Some of the major challenges for this priority measure include:

- Although HRSA provided extra funds to support PMHCA efforts in Hawaii, systemic procurement challenges and contracting delays make it difficult to encumber and expend funds promptly.
- Like many other states, Hawaii saw an increase in children and youth mental health needs exacerbated by COVID, which continues to be a problem. Mental health issues existed prior to COVID; however, there is an increase in mental health needs for children and youth due to anxiety and depression caused by social distancing and lack of socialization of youth; increased social media and cyberbullying; and family stress due

to economic concerns.

- Limited mental health services and treatment options are currently available, which often means that children and youth in rural communities and neighbor islands must fly in or drive to Honolulu for services. This is true for both intensive treatment options and preventive services.
- Lack of comprehensive/directory of system services. New federal and state funding for mental health services resulted in new service options.
- Based on the experience of other states, even those with a larger population size than Hawaii, building a well-staffed/costly warmline service for a relatively low call volume is challenging.
- The stigma of mental health impedes assessment and provision of needed care.
- Cultural understanding and responses to mental health need 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 allows FHSD to expand efforts to address critical mental health needs of children, which COVID and its lasting effects have intensified.

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 refocusing some grant activities into systems building. Even with the onboarding of PMHCA staff, there are still challenges with building the warmline and ensuring that pediatric providers will use the curbside consult model.

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 these sites were closed to all outside visitors during the statewide COVID emergency. The DOH sites continue to be closed for telehealth use.

The Library Telehealth Access Project (LTAP) allows individuals and families to access telehealth with telehealth navigators in state public libraries in underserved areas.

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 Hawaii 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), Hawaii State Public Library System, University of Hawaii (UH) Pacific Basin Telehealth Resource Center, and UH John A. Burns School of Medicine.

Objective: By June 2024, 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:
- Library Telehealth Access Project infrastructure development
- Workforce development
- Service Provision

The report for FY 2022 reflects the grant plans and continuing startup activities.

Strategy 1: Telehealth Library Access Project infrastructure development

Activities for FFY 2022 continued formulating/adjusting the project plans, securing key partnerships, and developing/adjusting plans for the three key strategies.

The funding for the new project was awarded to DOH on June 1, 2021. Grant activities for FY 2021-22 included:
- Hired Librarian Project Coordinator in May 2022 who is working on the position descriptions for the staffing of LTAP, scheduling implementation at the libraries, developing the training curriculum for the telehealth navigators, and testing initial pilot library site in Naalehu (Big Island).
- The contract with the Research Corporation of the University of Hawaii (RCUH) was executed to cover hiring of the island program coordinators and telehealth navigators.
- Protocols for the telehealth services were tested and revised as necessary.
- Set up procurement for the private room for telehealth for the two libraries on Hawaii Island and one library on Kauai that don't have any.
- Continue executing contracts for services.
- Continue implementing pilot phases at each library until procedures are finalized before full implementation begins.
- Continue setting up collaboration with the Hawaii State Public Library System, 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 and in FY 2021-22 was still in the planning phase. Activities include:
- Health and digital navigators were changed to be called telehealth navigators.
- Identify and develop training for the telehealth navigators.
- Hire project coordinators on each island as each island enters the project.
- Hire individuals from each community as telehealth 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 focuses on the activities for actual provision of telehealth services, and in FY 2021-22, were still in the planning phase. Activities include:

- Telehealth navigators will help individuals and families locate information about telehealth and make telehealth appointments.
- Telehealth navigators in the libraries will help individuals and families complete the scheduled telehealth appointment.
- Telehealth navigators will have individuals and families who receive services evaluate their experience.

Current Year Highlights for FY 2023 (10/1/2022 – 6/30/2023)

The project received a no-cost extension to May 31, 2024, from the CDC. The library renovations and upgrades to the broadband are complete, and the vacancies in the libraries have reduced significantly. Libraries that are ready to implement the project are identified. This allows the project locations to hire telehealth navigators to start the library services.

Challenges Encountered

Some of the major challenges for the grant include:

- The quantity of paperwork and approvals necessary to implement project activities.
- Competing funded activities (e.g., libraries received funding for major renovations, so the locations could not be used until the renovations were complete)
- Difficulty recruiting appropriate staff.
- Changing priorities for community-based organization partners as the pandemic issues decreased.

Overall Impact

During the pandemic, telehealth proved to be a valuable tool to provide access to healthcare services in Hawaii especially for the neighbor island families. However, the lack of digital literacy and access to devices and broadband/cellular connections was clear for the families that were not able to use telehealth during the pandemic. Many of these families did not have and continue to not have access to in-person healthcare services close to their communities. Providing a safe and publicly accessible space with telehealth navigators, equipment, and internet connection will allow individuals and families to access healthcare via telehealth without leaving their community. Since this project is based in libraries in underserved communities around our state, the greatest impact will be on those who can't access health services.

Cross-Cutting/Systems Building - Application Year

SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide.

For the Cross-Cutting domain, Hawaii 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 developing the mental health care warmline and systems model.

- The PMHCA Coordinator will continue to work on developing the contract and working with partners to develop the warmline model.
- Hawaii will continue working with the federal project officer and the Pacific Jurisdictions to build a model that will work for the Pacific Island communities.

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.

- Evaluation of the first training series has led to additional Project ECHO topics to provide workforce training,
- The PMHCA Coordinator and the AAP-Hawaii Chapter Pediatric Champion will continue conducting focus groups on the PMHCA model and other mental health needs with pediatric providers.
- The PMHCA Coordinator looks for other venues to support training through the REACH Institute pilot, the Hawaii Healthcare Workforce Summit, and other opportunities.
- CSHNB received the Substance Abuse and Mental Health Services Administration's Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant, and one of the strategies is promoting training on behavioral health topics and the use of the PMHCA warmline (once developed) as part of supporting wellness of young children. CSHNB will partner with the PMHCA Coordinator to support consistent training and information about the warmline.

Strategy 3: Support services and linkages in the community

FHSD recognizes the need to support and develop linkages around children's mental health. Mental health services are needed across healthcare, schools, and community settings. To better service children and youth, linkages in the community are important to diagnose, treat, and connect children and families.

- FHSD is working with community health centers (FQHCs) to identify resources in the community to help address rural community needs.
- To ensure availability of mental health surveillance data, the Mental Health Data Dashboard will be able to provide updated data to be used in program planning and community surveillance. The Dashboard may be expanded to include new Title V mental health measures in the proposed 2024 grant guidance.

SPM 4 - Establish 15 new telehealth access points with telehealth navigators in public libraries located in underserved communities statewide.

By June 2024, establish 15 telehealth access points with telehealth navigators in public libraries 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 implementing the grant strategies/activities for the $5 million project.

Strategy 1: Telehealth Library Access Project infrastructure development

- Continue to work with community-based partners to support the project activities.
- The project coordinators on each island will be hired.
- Individuals from each community will be hired as telehealth navigators for each library.
- Each library will have the telehealth equipment set up.
- A 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 ongoing as new staff are hired.
- Continue development and implementation of evaluation of activities.

Strategy 3: Service Provision

- Information about the availability of telehealth navigators and services will be disseminated via social media, healthcare providers/organizations, and community partners.
- Telehealth navigators will help individuals and families locate information about telehealth and make telehealth appointments.
- Telehealth navigators will help individuals and families complete the scheduled telehealth appointment.
- Telehealth navigators will have individuals and families who receive services evaluate their experience.
- LTAPs staff will coordinate with Mobile Clinic Vans Project to maximize referral of individuals/families referred to the libraries for telehealth services.

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 partners help select strategies and assist with implementation and evaluation.

Communications. Because FHSD does not use Title V to fund local health departments or community-based providers, no stakeholders are vested in Title V as a funding source. Thus, general input for the Title V grant is difficult to garner. The extensive scope of the Title V report, compounded by FHSD's numerous and diverse programs, is a challenging informational topic to share publicly.

Most FHSD agency/program partners are vaguely aware of the Title V grant. Since the funds are used primarily for staffing, it is difficult to demonstrate the grant's direct benefits for the MCH population. Moreover, Partners that receive HRSA/MCH Bureau funding also tend to be knowledgeable about the Title V grant.

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 engage the public.

Media outreach has continued as the state moves out of the public health emergency to meet the changing service needs of families along with remote communications. The exponential growth in telehealth visits, virtual webinars, conferences, health fairs, and meetings continues. In-person events/services have been relatively slow to return.

Strong Agency/Program Partners. Hawaii's strength continues to be its work conducted in partnership with agencies, community providers, and families. Being a small island state, Hawaii's local values are strongly influenced by indigenous and introduced immigrant cultures that uphold the importance of community and family. These values are reflected in the many partnerships ingrained in Title V efforts (and those of public health). Public input is largely provided throughout the year through these collaborations.

See the Family Partnership narrative for efforts to solicit and work with parents to improve FHSD programs and services.

Community Input for Title V Strategies and Measures

FHSD program managers reported increased partnerships with community programs and agencies. Examples of community input/coordination that shaped/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, which continue as the primary focus for Title V.

NPM 5 Safe Sleep. The work for this priority is conducted in partnership with Safe Sleep Hawaii (SSH), the

statewide coalition that promotes safe sleep efforts. SSH has a diverse membership, representing government, nonprofits, for-profits, grassroots organizations, individuals, and family champions committed to preventing infant mortality through safe sleep practices. With Title V support SSH just completed a needs assessment and draft work plan that will inform Title V strategies/activities.

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. These 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 the COVID shutdowns. 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.

NPM 10 Adolescent Health. The Adolescent Health Unit (AHU) continued to collect input from youth, 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, managing 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 useful information modes, from classes to resources through school, email, and special events. Youth also appear to use multiple sources for information/learning; thus, a multipronged approach may be needed. The survey data is 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.

The young adult staff at TeenLink Hawaii used the assessment findings to develop transition messaging 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 the 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 in Federally Qualified Health Centers), university researchers, the Native Hawaiian healthcare system, family 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 shared the pervasive misinformation that employed families could not qualify for WIC benefits. It was suggested that outreach via workplaces could be especially effective. Other client input shared the difficulty tracking 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 into service recommendations/plans.

SPM 3: Child Mental Health Access. The major aim of this project funding was to develop a real-time consulting service staffed by mental health professionals, to support pediatric primary care providers in addressing the behavioral needs of their clients. Since Hawaii is a small state, FHSD wanted to ensure community and agency partners supported the project and that 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 for use by pediatric providers and other healthcare/service providers (school nurses, counselors).
- There is a need for improved systems building and coordination around mental health. 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 to include systems-building as a priority and is contracting for an environmental scan to document service availability and develop recommendations to improve service system coordination. The grant also coordinates with other federal SAMHSA mental health service grants on needs assessment.

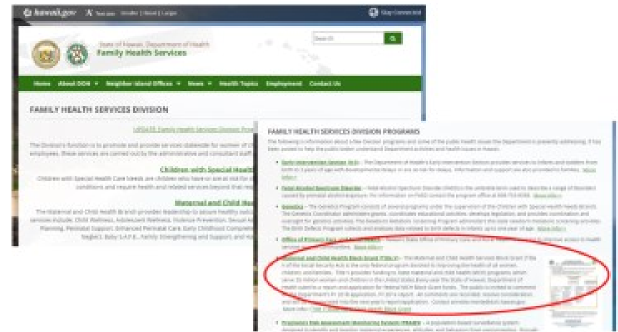
SPM 4: Telehealth Expansion to Underserved Communities. Supported by $7M in Centers for Disease Control Health Equity grant funding, the project will establish 15 new telehealth access points in public libraries in underserved communities statewide. Staffing includes health and digital navigators recruited from the community or island.

The need and support for projects that support digital equity throughout the state have been 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 between the Hawaii State Department of Health (DOH), State Public Library System, and University of Hawaii (UH) Pacific Basin Telehealth Resource Center and John A. Burns School of Medicine. Input from the targeted communities helped to design the healthcare hubs, coordinate services/referrals, and recruit staff.

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 in 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 PPT presentations and videos used during past years' block grant reviews.



Comments can be submitted throughout the year via a return email function on the website. No comments were received on the report submitted in FY 2022, 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.

Workforce data will be further analyzed to identify Division specific training needs. There are no technical assistance requests at this time.

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 - Maps and Policies.pdf

Supporting Document #02 - NPM_NOM_Data_Summary.pdf

Supporting Document #03 - FHSD Program Descriptions (July 2023).pdf

Supporting Document #04 - NPM and SPM 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 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,195,700	
A. Preventive and Primary Care for Children	$ 744,693	(33.9%)
B. Children with Special Health Care Needs	$ 1,171,244	(53.3%)
C. Title V Administrative Costs	$ 3,973	(.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,919,910	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 34,554,745	
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)	$ 18,334,030	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 52,888,775	
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)	$ 55,084,475	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 40,373,086	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 95,457,561	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	$ 434,691
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) > 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) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 275,551
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) > Community-Based Integrated Service Systems (CISS)	$ 255,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	$ 600,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 3,571,081
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	$ 230,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 23,899,293
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) > Newborn Screening State Evaluation Program	$ 150,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 165,389

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
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) > Pediatric Mental Health Care Access Program	$ 445,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Expansion	$ 300,000
US Department of Education > Office of Special Education Programs > Individuals with Disabilities Education Act/ARPA	$ 1,218,273
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > American Rescue Plan Act Funding for Home Visiting	$ 334,763
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > American Rescue Plan Act Funding for Home Visiting (#2)	$ 674,787
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > ARPA Community-Based Child Abuse Prevention Grants	$ 1,000,179
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility	$ 525,745
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Grant Program	$ 130,110
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SHIP COVID Testing and Mitigation	$ 2,583,760

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,319,160 (FY 22 Federal Award: $ 2,195,700)		$ 1,587,890	
A. Preventive and Primary Care for Children	$ 840,886	(36.3%)	$ 496,795	(31.2%)
B. Children with Special Health Care Needs	$ 962,503	(41.5%)	$ 867,611	(54.6%)
C. Title V Administrative Costs	$ 0	(%)	$ 19,577	(1.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,803,389		$ 1,383,983	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 29,759,413		$ 28,217,762	
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)	$ 18,474,919		$ 5,837,054	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 48,234,332		$ 34,054,816	
A. Your State's FY 1989 Maintenance of Effort Amount $ 11,910,549				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 50,553,492		$ 35,642,706	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 40,729,830		$ 35,299,951	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 91,283,322		$ 70,942,657	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	$ 486,403	$ 375,276
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020	$ 158,666
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 250,000	$ 71,316
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	$ 255,600	$ 256,038
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	$ 600,000	$ 655,765
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	$ 3,016,560
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program	$ 150,000	$ 25,953
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 165,389	$ 24,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 51,770
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 29,307,713	$ 22,327,193
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 2,333,044	$ 2,220,948
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 202,198

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 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	$ 259,811
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	$ 381,747
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 245,000	$ 245,888
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	$ 230,000	$ 226,760
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility Program	$ 446,074	$ 411,330
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	$ 128,360	$ 124,186
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Grant- ARPA of 2021	$ 1,001,179	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > American Rescue Plan Act Funding for Home Visiting	$ 334,763	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ARPA Pediatric Mental Health Care Access New Area Expansion		$ 59,839
US Department of Education > Office of Special Education Programs > ARPA IDEA Part C		$ 80,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > COVID State Hospital Improvement Program		$ 505,902
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC General Infrastructure Grant		$ 102,147
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SHIP COVID Testing & Mitigation		$ 1,970,874

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > ARPA WIC		$ 1,255,300
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Breast Feeding Peer Counseling		$ 236,063
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Hawaii Newborn Screening Data Project		$ 53,421

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: The discrepancy between the FY24 budged amount and the FY 22 actual expenditures reflects the difference between our budgeted needs looking forward and the actual expenditures recorded in Datamart, the state's reporting system, during a specific period of time. The expended number does not take into account funds that are obligated but not yet liquidated during this period of time. This discrepancy is related to the timing of the reporting period.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: FY 22 expenditures for this category reflect several Title V funded vacant positions who's work efforts are attributed to Preventative and Primary Care for Children. The positions are expected to be filled for the FY 24 budget period.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: FY 22 expenditures for this category reflect several Title V funded vacant positions who's work efforts are attributed to Children with Special Health Care Needs Expended. The positions are expected to be filled for the FY 24 budget period.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: In FY 22 DOH/FHSD allocated payroll expenditures from the Administrative Officer V position. The same position is now funded through a special fund therefore this discrepancy will fade away by next year's application.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2022**

Column Name: **Annual Report Expended**

Field Note:

The FY 24 budget represents the budget ceiling or appropriation for all DOH/FHSD special funds (program income). The FY 22 expenditures is an accurate reflection of special fund expenditures during the reporting period. Generally speaking, the expenditures will always be less than the appropriation, but the FY 22 expenditures may have been slightly lower than prior years due to the impact COVID 19 had on contract performances.

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 91,050	$ 62,469
2. Infants < 1 year	$ 91,050	$ 62,469
3. Children 1 through 21 Years	$ 744,693	$ 496,795
4. CSHCN	$ 1,171,244	$ 867,611
5. All Others	$ 93,690	$ 78,969
Federal Total of Individuals Served	$ 2,191,727	$ 1,568,313

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 2,197,944	$ 1,360,731
2. Infants < 1 year	$ 2,197,944	$ 1,360,731
3. Children 1 through 21 Years	$ 18,004,725	$ 10,948,451
4. CSHCN	$ 28,221,836	$ 18,649,279
5. All Others	$ 2,266,326	$ 1,735,624
Non-Federal Total of Individuals Served	$ 52,888,775	$ 34,054,816
Federal State MCH Block Grant Partnership Total	$ 55,080,502	$ 35,623,129

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

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 24 Application Budgeted	FY 22 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	$ 106,639	$ 106,325
3. Public Health Services and Systems	$ 2,089,061	$ 1,481,565
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	$ 2,195,700	$ 1,587,890

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 31,381,849	$ 17,584,532
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 6,063,702	$ 2,616,704
B. Preventive and Primary Care Services for Children	$ 3,031,851	$ 1,308,352
C. Services for CSHCN	$ 22,286,296	$ 13,659,476
2. Enabling Services	$ 11,828,809	$ 9,058,656
3. Public Health Services and Systems	$ 9,678,117	$ 7,411,627
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		$ 19,440
Physician/Office Services		$ 642,300
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 831,700
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Primary and Urgent Care in Hana		$ 1,130,000
Waianae Coast Emergency Room Services		$ 1,223,333
Early Intervention Services (POS)		$ 12,351,125
Molokai General Hospital		$ 1,386,634
Direct Services Line 4 Expended Total		$ 17,584,532
Non-Federal Total	$ 52,888,775	$ 34,054,815

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Hawaii

Total Births by Occurrence: 15,354 **Data Source Year: 2022**

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	15,353 (100.0%)	1,425	41	41 (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)	Guanidinoacetate Methyltransferase (GAMT) Deficiency	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 I (MPS I)	Mucopolysaccharidosis Type II (MPS II)
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 2022

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	962	35.0	0.0	62.0	3.0	0.0
2. Infants < 1 Year of Age	1,002	35.0	0.0	62.0	3.0	0.0
3. Children 1 through 21 Years of Age	9,384	33.0	0.0	64.0	3.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	6,768	33.0	0.0	63.0	4.0	0.0
4. Others	20,244	15.0	0.0	81.0	4.0	0.0
Total	31,592					

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	15,620	No	15,354	99.0	15,200	962
2. Infants < 1 Year of Age	15,636	No	15,354	100.0	15,354	1,002
3. Children 1 through 21 Years of Age	353,395	Yes	353,395	99.3	350,921	9,384
3a. Children with Special Health Care Needs 0 through 21 years of age^	48,735	Yes	48,735	99.3	48,394	6,768
4. Others	1,072,348	Yes	1,072,348	62.6	671,290	20,244

^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:	**2022**

Field Note:
Programs that contributed to this count include pregnant women who received Reproductive Health Care and Support Services (provides seamless continuum of care for uninsured and under-insured adolescents, women, and men who seek clinical reproductive health care, perinatal support, information, education, and counseling in reproductive health care. This program replaced Perinatal Support Services and Family Planning since June 2021; 562); 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 2021 National Vital Statistics System for Pregnant Women/Infants.

Note that the 2021 number was used for Safe Sleep (400) this year due to position vacancy.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**

Field Note:
Programs that contributed to this count of infants < 1 year of age include 2022 Primary Care Contracts (596). 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 2021 National Vital Statistics System for Pregnant Women/Infants.

Note the increase in Primary Care from 2021 (265) to 2022 (596) was due to a partial year (7/1/21-12/31/21) reported last year. Also note that 2021 number was used for Safe Sleep (406) this year due to position vacancy.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**

Field Note:
Programs that contributed to this count include 2022 Primary Care Contracts (2,047). Other programs that contributed to this count include Reproductive Health Care and Support Services (provides seamless continuum of care for uninsured and under-insured adolescents, women, and men who seek clinical reproductive health care, perinatal support, information, education, and counseling in reproductive health care. This program replaced Perinatal Support Services and Family Planning since June 2021; 569); and Children with Special Health Care Needs in 3a (6,768). The percentages of primary source of coverage are based on 2021 American Community Survey for Children 1-21.

Note the increase in Primary Care from 2021 (983) to 2022 (2,047) was due to a partial year (7/1/21-12/31/21) reported last year.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**

Field Note:
2022 data for the number of children serviced contributed by CSHNB (6,768) included Children with Special Health Needs Section (provides care coordination and other services for children age 0-21 with chronic medical conditions; 588); genetics, metabolic, hemoglobinopathy, Neighbor Island genetics, telemedicine clinics (provides provides genetic services, information, and education; 818); Newborn Metabolic Screening Program follow-up (detect rare disorders that can cause serious health and development problems; 1,425); Newborn Hearing Screening Program follow-up (identify hearing loss early so children can receive timely early intervention services; 726); Early Intervention Section (provides care coordination, family training, etc for children age 0-3 with developmental delay or at biological risk; 2,911); Hi‘ilei Developmental Screening Program (provides developmental screening via mail or online, and activities to help in children's development; 21); Hawaii Childhood Lead Poisoning Prevention follow-up (aims to reduce children's exposure to lead by strengthening blood lead testing; 242). 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, 2020-2021

Note that the decline in number in Genetics program from 2021 (1,520) to 2022 (818) was due to a reduced number of geneticists.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**

Field Note:
Programs that contributed to this count of others include 2022 Primary Care Contracts (15,613). The count also included Reproductive Health Care and Support Services (provides seamless continuum of care for uninsured and under-insured adolescents, women, and men who seek clinical reproductive health care, perinatal support, information, education, and counseling in reproductive health care. This program replaced Perinatal Support Services and Family Planning since June 2021; 3,493); Maui District Health Office (COVID vaccination and testing; 80); 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=1,058). The percentages of primary source of coverage are based on 2021 American Community Survey for adults 22+.

Note the increase in Primary Care from 2021 (7,615) to 2022 (15,613) was due to a partial year (7/1/21-12/31/21) reported last year. Also note the increase in Reproductive Health Care and Support Services from 2021 (2,026) to 2022 (3,493) was because this program started in June 2021, after Family Planning Services ended. The number provided in 2021 (2,026) was a partial year from June-December, 2021.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**

Field Note:
Overall estimate:
Based on the percentage of pregnant women who received safe sleep education messages at the hospital (99%). Note that the same percentage as 2021 was used due to position vacancy and that hospital outreach remained the same.

Individual program report:
Other programs that served pregnant women included 5a number (962), number of brochures distributed to pregnant women by Reproductive Health Care and Support Services (4,750; may be duplicated as each woman may receive more than one brochure), women who receive mailout resources from PRAMS program (2,400), WIC Program (state provided administrative support, 5,688), and Home Visiting Program (a family support program for pregnant women, mothers, and children under the age of 5 providing regular visits to families to encourage maternal and child health; prevention of child abuse and neglect; promotion of child development and school readiness; promotion of positive parenting practices; and information/referrals to healthcare and community resources; 44), 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; 15) and Kauai District Health Office (outreach activities and education for pregnant women, 400).

2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2022**

Field Note:
Denominator is based on 2022 birth data obtained from Vital Statistics.

3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**

Field Note:
Overall estimation:
Estimated by 2022 percentage of newborn metabolic screening (100%).

Individual program report:
Other programs that served infants included 5a number (1,002), Kauai District Health Office (outreach activities, 400), Maui District Health Office (provided a home visit for a failed metabolic newborn screening done at the hospital, 1); Home Visiting (a family support program for pregnant women, mothers, and children under the age of 5 providing regular visits to families to encourage maternal and child health; prevention of child abuse and neglect; promotion of child development and school readiness; promotion of positive parenting practices; and information/referrals to healthcare and community resources; 205), and WIC (state provided administrative support, 11,283).

4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**

Field Note:
Denominator is based on 2022 birth data obtained from Vital Statistics.

5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

Field Note:
Overall Estimation:
Based on the largest reach by the Keiki Screening Media Campaign, where broadcast TV reached of 243,554 adults 25-54 years old (99.3%). The second largest reach was the TeenLink Stress Reduction Media Campaign, which reached 123,026 households with children (97.8%).

Individual Program Report:
Other programs included 5a number (9,384), participation in WIC Program (state provided administrative support, 17,785), Adolescent Wellness (advances adolescent-centered, capacity building through workforce development training for teen-serving staff, by providing intentional shared teaching moments between caring adults and teens, by assuring access to and the availability of self-care resources, tools and services for adults, young adults and teens, and by engaging teen and young adult voices to inform the DOH's efforts to support Hawaii's families and positive youth development programs; 161), Kauai District Health Office (outreach activities and distribution of educational materials; 4,500), Home Visiting (a family support program by providing regular visits to families to promote positive parenting practices; 326), Sexual Violence Prevention Program (provides primary prevention services through statewide partnerships to prevent all forms of sexual violence and promote healthy, respectful relationships; 60,700), and Children with Special Health Care Needs (25,983).

Note that the large increase in the number reported by Sexual Violence Program (SVP) from 2021 (2,499) to 2022 (60,700) was due to curricula training for middle and high school students on Oahu, Molokai, and Hawaii Island as well as SVP trainings and outreach events throughout the University of Hawaii system statewide. In 2021 not all students returned to campus due to COVID-19 pandemic, which explained the small number in 2021. Also note that there has been a grant change for Early Childhood Comprehensive System, no outreach activities for this program (2021 reported, 970).

6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

Field Note:
Overall Estimation:
Based on the largest reach by the Keiki Screening Media Campaign, in which broadcast TV reached of 243,554 adults 25-54 years old (99.3%). The second largest reach was the TeenLink Stress Reduction Media Campaign, which reached 123,026 households with children (97.8%).

Individual Program Report:
Other programs included 5a number (6,768), outreach activities conducted by Kauai District Health Office (135), and outreach activities (community outreach, advisory groups, social media, brochure distribution, trainings) conducted by Children with Special Health Needs Section (14,000) and Early Intervention Section (5,000). The Hawaii Childhood Lead Poisoning Prevention Program (HI-CLPPP) distributed about 3,544 educational materials, held 3 coalition meetings (66), had outreach events including training and presentation (270), had 1,976 unique website views, had Hawaii Fishing News magazine advertising (69,000) and Hawaii Fishing News calendar advertising (23,000). The Newborn Metabolic Screening Program distributed materials to an estimated 16,000 new mothers; other outreach activities included workgroups (10,729). The Newborn Hearing Screening Program distributed about 154,527 educational materials; conducted training and workgroups (45), and had 500 website hits by providers and the public.

7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**

Field Note:
Numerator: Programs contributed to the numerator (670,996) included 5a number (20,244); Sexual Violence Prevention Program (meetings and trainings; 609), Adolescent Wellness (training for teen-serving staffs; 1,891), WIC services for postpartum women (5,215); Home Visiting (525), Hawaii Public Health Training Hui (education to promote health and well-being; 868), Parent Leadership Training Institute (PLTI) Hawaii (increases the number and skill level of parents and community leaders; 15), 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; 152), Hawaii Medicare Rural Hospital Flexibility Program (Clinical Quality and Financial Improvement Training to critical access hospital staff; 65), Kauai District Health Office (outreach activities; 4,000), Maui District Health Office (Distribution of COVID self-test kits, 5,805), Hawaii District Health Office (provided education to community, 15), Oral Health (oral health meetings, 50), Safe Sleep (distribution of educational material, 162), Domestic Violence Prevention Program (workforce trainings and distribution of materials, 1,682), CMV brochures distributed to adults by Reproductive Health (500), and media campaigns that served a total of 629,263 adults (TeenLink Stress Reduction Media Campaign, 61,519; Safe Sleep Media Campaign, 244,290; Keiki Screening Media Campaign broadcast TV, 243,554, Keiki Screening Media Campaign Oahu radio, 79,900).
Denominator: 2021 Census Estimate (1,072,348).

Note that there has been a change in grant for Early Childhood Comprehensive Systems, no outreach activities were conducted in 2022 (2021 reported, 9,218), Also note that 2021 number was used for Safe Sleep due to position vacancy.

Data Alerts:

1.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Hawaii

Annual Report Year 2022

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	15,086	3,811	313	2,620	11	3,742	1,428	2,989	172
Title V Served	15,086	3,811	313	2,620	11	3,742	1,428	2,989	172
Eligible for Title XIX	8,739	1,157	140	394	238	3,343	1,294	879	1,294
2. Total Infants in State	16,244	2,408	252	2,753	29	3,497	2,051	5,254	0
Title V Served	16,244	2,408	252	2,753	29	3,497	2,051	5,254	0
Eligible for Title XIX	14,888	231	61	296	69	595	180	0	13,456

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Information obtained from maternal race as reported in 2022 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:	**2022**
	Column Name:	**Total**
	Field Note: Used overall estimate of newborn metabolic screening percentage (100%) in 2022 applied to overall total and each race group.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Data Source: Data from Hawaii Medicaid program in 2022 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.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Total number of infants based on 2020 CDC, NCHS, Bridged-Race population estimates from https://wonder.cdc.gov. No further updates beyond 2020. 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.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2022**

	Column Name:	**Total**

Field Note:
Used overall estimate of newborn metabolic screening percentage (100%) in 2022 applied to overall total and each race group.

6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**

Field Note:
Data Source: Data from Hawaii Medicaid program in 2022 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 2022, 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	2024 Application Year	2022 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"		1,058

B. Other Appropriate Methods	2024 Application Year	2022 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"		3,470
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		1,796
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	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 Leader (Optional)	
Name	Susan Wood
Title	Project Coordinator, Hilopa'a Family to Family Inc.
Address 1	PO Box 1104
Address 2	
City/State/Zip	Honokaa / HI / 96727
Telephone	(808) 756-0179
Extension	
Email	susan@hilopaa.org

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Hawaii

Application Year 2024

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
2021	71.6 %	0.4 %	10,338	14,446
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
2020	98.6	8.7	129	13,083
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
2017_2021	16.9 ϟ	4.5 ϟ	14 ϟ	82,691 ϟ
2016_2020	12.9 ϟ	3.9 ϟ	11 ϟ	85,130 ϟ
2015_2019	14.8 ϟ	4.1 ϟ	13 ϟ	87,765 ϟ
2014_2018	13.4 ϟ	3.9 ϟ	12 ϟ	89,518 ϟ

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2022
Annual Indicator	16.1
Numerator	13
Denominator	80,574
Data Source	Vital Statistics
Data Source Year	2018-2022

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
2021	8.8 %	0.2 %	1,381	15,607
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
2021	10.2 %	0.2 %	1,596	15,609
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
2021	29.0 %	0.4 %	4,528	15,609
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
2021/Q1-2021/Q4	1.0 %			
2020/Q4-2021/Q3	1.0 %			
2020/Q3-2021/Q1	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
2020	5.2	0.6	82	15,831
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
2020	4.9	0.6	77	15,785
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
2020	2.9	0.4	46	15,785
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
2020	2.0	0.4	31	15,785
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
2020	145.7	30.4	23	15,785
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
2020	63.4 ϟ	20.0 ϟ	10 ϟ	15,785 ϟ
2019	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2018	111.9 ϟ	25.7 ϟ	19 ϟ	16,972 ϟ
2017	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2016	94.1 ϟ	22.8 ϟ	17 ϟ	18,059 ϟ
2015	76.0 ϟ	20.3 ϟ	14 ϟ	18,420 ϟ
2014	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2013	79.0 ϟ	20.4 ϟ	15 ϟ	18,987 ϟ
2012	63.2 ϟ	18.3 ϟ	12 ϟ	18,980 ϟ
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

ϟ 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
2021	7.4 %	1.0 %	1,127	15,238
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
2020	1.4	0.3	18	13,286
2019	1.1	0.3	15	14,226
2018	1.3	0.3	19	14,468
2017	2.2	0.4	32	14,879
2016	1.1	0.3	16	15,111
2015	NR	NR	NR	NR
2014	1.4	0.3	22	15,358
2013	0.8	0.2	12	15,722
2012	0.8	0.2	13	15,869
2011	0.8	0.2	13	15,757
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR
2008	0.8	0.2	13	16,419

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	10.6 %	1.0 %	29,668	279,240
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
2021	7.7 ϟ	2.2 ϟ	12 ϟ	155,910 ϟ
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
2021	26.3	4.0	43	163,193
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
2019_2021	6.1 ϟ	1.6 ϟ	14 ϟ	230,559 ϟ
2018_2020	6.1 ϟ	1.6 ϟ	14 ϟ	229,290 ϟ
2017_2019	6.5 ϟ	1.7 ϟ	15 ϟ	231,497 ϟ
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

ϟ 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
2019_2021	12.1	2.3	28	230,559
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
2020_2021	13.2 %	0.9 %	39,320	297,640
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
2020_2021	20.1 %	3.2 %	7,884	39,257
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
2020_2021	1.7 %	0.4 %	4,185	244,046
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 % ϟ	0.6 % ϟ	4,558 ϟ	257,036 ϟ

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ 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
2020_2021	5.9 %	0.7 %	14,416	242,480
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
2020_2021	45.4 %	4.9 %	10,507	23,162
2019_2020	46.8 % ϟ	6.7 % ϟ	9,730 ϟ	20,781 ϟ
2018_2019	56.6 % ϟ	8.2 % ϟ	10,655 ϟ	18,809 ϟ
2017_2018	54.4 % ϟ	7.1 % ϟ	10,866 ϟ	19,992 ϟ
2016_2017	45.6 % ϟ	6.1 % ϟ	9,601 ϟ	21,033 ϟ
2016	38.4 % ϟ	7.4 % ϟ	8,494 ϟ	22,150 ϟ

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ 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
2020_2021	92.5 %	0.8 %	274,857	297,296
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
2020	10.7 %	0.3 %	905	8,441
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 <20 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
2021	14.9 %	1.1 %	6,535	43,801
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
2020_2021	17.1 %	1.8 %	21,649	126,503
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
2021	2.3 %	0.4 %	7,076	304,505
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

 Created on 9/28/2023 at 9:39 AM

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
2018	79.2 %	3.4 %	13,000	17,000
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
2021_2022	57.5 %	2.8 %	156,933	272,911
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 % ϟ	6.4 % ϟ	181,808 ϟ	259,726 ϟ
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.

ϟ 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
2021	83.8 %	2.7 %	64,299	76,749
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

 Created on 9/28/2023 at 9:39 AM

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
2021	88.6 %	2.3 %	68,026	76,749
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
2021	88.0 %	2.5 %	67,523	76,749
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
2021	12.3	0.6	463	37,673
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
2021	14.4 %	1.3 %	2,166	15,003
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
2020_2021	3.1 %	0.5 %	9,110	293,852
2019_2020	2.1 %	0.5 %	6,336	298,701
2018_2019	1.6 % ϟ	0.5 % ϟ	4,803 ϟ	300,123 ϟ
2017_2018	1.6 % ϟ	0.5 % ϟ	4,864 ϟ	301,799 ϟ
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

ϟ 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)					
	2018	2019	2020	2021	2022
Annual Objective			77	79	81
Annual Indicator		76.6	78.1	81.1	69.5
Numerator		184,106	185,323	191,337	167,306
Denominator		240,287	237,398	235,933	240,808
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

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

Annual Objectives			
	2023	2024	2025
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80	82	82	85	86
Annual Indicator	81.5	81.5	84.0	80.1	83.0
Numerator	14,376	14,376	6,895	12,016	12,363
Denominator	17,634	17,634	8,212	15,003	14,891
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2015	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective	21	29	30
Annual Indicator	28.7	24.7	27.7
Numerator	2,245	3,565	4,047
Denominator	7,829	14,455	14,591
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		1	21	29	30
Annual Indicator	100	20.3	28.7		
Numerator	1	3,306	2,245		
Denominator	1	16,296	7,829		
Data Source	1	PRAMS	PRAMS		
Data Source Year	1	2016	2019		
Provisional or Final ?	Provisional	Final	Final		

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	30.0	31.0	31.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
1 is entered because PRAMS 2017 data is not available in State

2.	**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.

3.	**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	2022
Annual Objective	33	49	49
Annual Indicator	48.1	45.9	52.0
Numerator	3,755	6,633	7,507
Denominator	7,801	14,447	14,442
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		1	33	49	49
Annual Indicator	100	46.2	48.1		
Numerator	1	5,186	3,755		
Denominator	1	11,228	7,801		
Data Source	1	PRAMS	PRAMS		
Data Source Year	1	2016	2019		
Provisional or Final ?	Provisional	Final	Final		

Annual Objectives			
	2023	2024	2025
Annual Objective	50.0	50.0	51.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
1 is entered because PRAMS 2017 data is not available in State

2.	**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.

3.	**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)					
	2018	2019	2020	2021	2022
Annual Objective	33	39	40	40	40
Annual Indicator	39.1	36.5	31.6	41.2	41.0
Numerator	14,121	13,201	12,899	16,334	15,213
Denominator	36,113	36,145	40,832	39,621	37,098
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	74	75	77	80	81
Annual Indicator	74.6	74.6	77.7	73.4	66.3
Numerator	74,226	74,226	76,702	71,318	63,067
Denominator	99,470	99,470	98,664	97,099	95,187
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	23	23	25	25	26
Annual Indicator	21.9	24.7	17.1	15.9	21.9
Numerator	4,457	5,037	3,214	3,171	4,086
Denominator	20,375	20,412	18,758	19,924	18,629
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		5.9	5.5	5.4	5
Annual Indicator	5.9	5.5	5.7	5	5.8
Numerator	635	584	591	508	587
Denominator	108,119	105,815	104,141	101,271	100,421
Data Source	DHS CAN annual report	DHS CAN annual report	DHS CAN annual report	DHS CAN annual report	DHS CAN annual report
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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:	**State Provided Data**

Field Note:
Baseline Data from 2021 DHS CAN annual report (p.8) http://humanservices.hawaii.gov/reports/child-abuse-and-neglect-reports/
represents a rate of 5.8 per 1,000 children 0-5 years of age (Numerator: 587 unique children confirmed victims; Denominator: 2021 Census Estimate 0-5 years: 100,421)

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**	**2022**
Annual Objective			27,000
Annual Indicator	25,584	25,907	25,855
Numerator			
Denominator			
Data Source	Hawaii WIC Services	Hawaii WIC Services	Hawaii WIC Services
Data Source Year	2020	2021	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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

3. **Field Name:** **2022**

   Column Name: **State Provided Data**

   Field Note:
   Indicator is number of WIC enrollments for 2022

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**	**2022**
Annual Objective			20
Annual Indicator	0	0	98
Numerator			
Denominator			
Data Source	Hawaii Pediatric Mental Health Care Access grant	Hawaii Pediatric Mental Health Care Access grant	Hawaii Pediatric Mental Health Care Access grant
Data Source Year	2020	2021	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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.

3. **Field Name:** **2022**

   Column Name: **State Provided Data**

   Field Note:
   The number of pediatric/mental health providers trained on Pediatric Mental Health Care is 98 for 2022.

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	2022
Annual Objective			9
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Hawaii Title V Genetics Program	Hawaii Title V Genetics Program	Hawaii Title V Genetics Program
Data Source Year	2020	2021	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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:
   This is a new measure. The number of telehealth access point in 2021 is 0.

3. **Field Name:** **2022**

   Column Name: **State Provided Data**

   Field Note:
   This is a new measure. The number of telehealth access point in 2022 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**	**2022**
Annual Objective			75
Annual Indicator	73.2	63.8	63.8
Numerator			
Denominator			
Data Source	Hawaii Med-QUEST	Hawaii Med-QUEST	Hawaii Med-QUEST
Data Source Year	2020	2021	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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: **State Provided Data**

   Field Note:
   Only annual indicator is available. Numerator and denominator are not available for this measure.

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:	Inactive - Replaced				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	31	31	31	31	31
Annual Indicator	31.9	30.9	32.4	33.3	33.1
Numerator	2,773	2,661	2,558	2,614	2,518
Denominator	8,693	8,599	7,903	7,851	7,609
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Provisional

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 vital statistics data file.	
6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Estimate based on 2022 provisional vital statistics data file as final 2022 data file not available	

ESM 1.2 - The number of women aged 18-44 years served through the state MCH reproductive health and wellness program.

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	3,681
Numerator	
Denominator	
Data Source	Family Planning and Reproductive Health program
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	4,000.0	4,200.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Inactive - Completed

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective			11	11	11
Annual Indicator			0	11	11
Numerator					
Denominator					
Data Source			Hawaii Safe Sleep Program	Hawaii Safe Sleep Program	Hawaii Safe Sleep Program
Data Source Year			2020	2021	2022
Provisional or Final ?			Final	Final	Final

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 5.1. 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.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Data was carried forward from last year due to position vacancy. Educational materials are still available in 11 languages.

ESM 5.2 - The number of translated Safe Sleep Guides for Parents that were provided to the agencies, organizations and individuals, on request

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	7,839
Numerator	
Denominator	
Data Source	Hawaii Title V Safe Sleep program
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	9,000.0	10,000.0

Field Level Notes for Form 10 ESMs:

None

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					
	2018	2019	2020	2021	2022
Annual Objective		12	18	24	27
Annual Indicator					
Numerator	19	23	26	26	28
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	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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%	
6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The measure is a scale and the annual indicator for 2022 is 28. Converting to percentage 28/30 = 93.3%	

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	2022
Annual Objective			18	23	25
Annual Indicator					
Numerator	9	13	20	26	27
Denominator	30	30	30	30	30
Data Source	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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%	
5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Converting to percentage 27/30 = 90.0%	

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

	2018	2019	2020	2021	2022
Annual Objective	17	21	24	26	28
Annual Indicator					
Numerator	18	22	25	26	31
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	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	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%	
6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The measure is a scale and the annual indicator for 2022 is 31. Converting into percentage 31/33 = 93.9%	

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

Measure Status:	Inactive - Replaced
Goal:	To support reproductive life planning and healthy birth outcomes by increasing intervals of birth spacing (births spaced from 18 month to next conception).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Births with interval < 18 months between birth and next conception **Denominator:** Total number of Births
Data Sources and Data Issues:	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).
Significance:	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®.

ESM 1.2 - The number of women aged 18-44 years served through the state MCH reproductive health and wellness program.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	By 2025, 4200 women aged 18-44 years will be served through the state MCH reproductive health and wellness program
Definition:	**Unit Type:** Count **Unit Number:** 8,000 **Numerator:** Total number of women aged 18-44 years served through the state MCH reproductive health and wellness program. **Denominator:**
Data Sources and Data Issues:	Family Planning and Reproductive Health program
Evidence-based/informed strategy:	Reproductive health visits not only help women to avoid unintended pregnancies, but also help a women prepare for healthy pregnancies by addressing important preventive care issues among women of reproductive age. The ESM reflects the reach of new state funded contracts to provide services to the most vulnerable population: women who are uninsured and cannot access care. Research provided by the MCH Evidence Center indicates extending services to those without insurance maybe be effective given expanding insurance coverage appears to be effective. Contracted service providers also employ a few clinical practices supported by evidence including extended clinic hours.
Significance:	Based on the newly issued service contracts, a new Evidence based/Informed Strategy Measure (ESM) was selected for women's preventive medical visits: the number of women age 18-44 years served by the state's reproductive health and wellness program. This replaces the former population-based measure on birth spacing, which did not directly relate to the Title V strategies. The ESM relates to the evidence-based strategy Engagement of Other MCH Programs to Disseminate Information and Make Referrals for Well-Women Visits. Providers across the state were sought to offer critical wellness and reproductive health services to those most in need. The FFY 2022 data collected indicates that 3,681 women were served. Contractors are expected to work on increasing the reach of the program; thus, objectives now reflect an incremental increase for each year.

ESM 5.1 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Inactive - Completed
Goal:	Expand outreach to Non-English-speaking families and care givers through translation of educational and general awareness safe sleep messages.
Definition:	**Unit Type:** Count **Unit Number:** 20 **Numerator:** Number of languages Departments of Health (DOH) & Human Services (DHS) safe sleep are available for Hawaii's communities **Denominator:**
Data Sources and Data Issues:	Data will be collected by Safe Sleep Hawaii about the efforts by DOH, DHS and the State Office of Language Access to translate educational materials into other languages for use by non-English speakers.
Significance:	About 3,500 US infants die suddenly and unexpectedly each year. These deaths are referred to as sudden unexpected infant deaths (SUID). SUID is one of the three leading-causes of death among infants nationally and in Hawaii (Hayes DK, Calhoun CR, Byers TJ, Chock LR, Heu PL, Tomiyasu DW, Sakamoto DT, and Fuddy LJ. Saving Babies: Reducing Infant Mortality in Hawaii. Hawaii Journal of Medicine and Public Health. 2013. 72 (2): 246-251). The American Academy of Pediatrics (AAP) recommends a safe sleep environment to reduce the risk of all sleep-related infant deaths. AAP recommendations for a safe sleep environment include supine positioning, the use of a firm sleep surface, room-sharing without bed-sharing, and the avoidance of soft bedding and overheating. Additional recommendations for SUID reduction include the avoidance of exposure to smoke, alcohol, and illicit drugs; breastfeeding; routine immunization; and use of a pacifier. The AAP recommends education should include all who care for infants, including parents, child care providers, grandparents, foster parents, and babysitters, and should include strategies for overcoming barriers to behavior change. Research on health education and SUID outreach has found that response to safe sleep messages differed among different communities and racial/ethnic groups, which may help explain some of the lingering differences in SUID rates. Therefore, campaigns should have a special focus on getting safe sleep messages to parents and caregivers in diverse communities because of the higher incidence of SUID and other sleep-related infant deaths in these groups.

ESM 5.2 - The number of translated Safe Sleep Guides for Parents that were provided to the agencies, organizations and individuals, on request
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Expand outreach to limited English proficiency families and care givers through distribution of translated safe sleep educational materials.
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of translated Safe Sleep Guides **Denominator:**
Data Sources and Data Issues:	Data will be collected by Hawaii Title V Safe Sleep program as reported by the Parent Line program
Evidence-based/informed strategy:	A review of the AMCHP and MCH Evidence Center research indicates that targeting caregivers with safe sleep education is supported by moderate evidence of effectiveness. National campaigns have 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, by targeting key ethnic groups and developing multilingual educational outreach for limited English-speaking families. The strategy was also supported by input from local service providers who workwith underserved, multicultural families.
Significance:	The American Academy of Pediatrics (AAP) recommends a safe sleep environment to reduce the risk of all sleep-related infant deaths. AAP recommendations for a safe sleep environment include supine positioning, the use of a firm sleep surface, room-sharing without bed-sharing, and the avoidance of soft bedding and overheating. Additional recommendations for SUID reduction include the avoidance of exposure to smoke, alcohol, and illicit drugs; breastfeeding; routine immunization; and use of a pacifier. The AAP recommends education should include all who care for infants, including parents, child care providers, grandparents, foster parents, and babysitters, and should include strategies for overcoming barriers to behavior change. Research on health education and SUID outreach has found that response to safe sleep messages differed among different communities and racial/ethnic groups, which may help explain some of the lingering differences in SUID rates. Therefore, campaigns should have a special focus on getting safe sleep messages to parents and caregivers in diverse communities because of the higher incidence of SUID and other sleep-related infant deaths in these groups.

ESM 6.1 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of children receiving developmental screening and referred and receiving services among Hawaii Title V direct service programs.
Definition:	**Unit Type:** Scale **Unit Number:** 30 **Numerator:** Total scale score based on program assessment of 10 steps **Denominator:** 30
Data Sources and Data Issues:	Program Data. The ESM 6.2 is using the Hawaii Title V Developmental Screening Workgroup's Policy and Public Health Coordination (PPHC) rating scale to monitor infrastructure development on developmental screening and services within FHSD. It will be a self-assessment of the team's efforts to improve efforts to develop the infrastructure for FHSD screening and services and will be measured annually.
Significance:	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.

	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

Measure Status:	Active
Goal:	To increase the degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for YSHCN.
Definition:	**Unit Type:** Scale **Unit Number:** 33 **Numerator:** Total Actual Score from Transition to Adult Health Care Data Collection Form **Denominator:** Total Possible Score from Transition to Adult Health Care Data Collection Form (33)
Data Sources and Data Issues:	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.
Significance:	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.

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

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	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	9	Yes	
3) Medicaid	No	No	Never	NA	No	
4) WIC	Yes	No	Annually	6	No	
5) Newborn Bloodspot Screening	Yes	Yes	Monthly	3	Yes	
6) Newborn Hearing Screening	Yes	Yes	Monthly	3	Yes	
7) Hospital Discharge	No	No	Never	NA	No	
8) PRAMS or PRAMS-like	Yes	Yes	Monthly	3	Yes	

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, but linkage was suspended until the vital statistics statute was updated and new administrative procedures established to access and link with birth record data. The linkage was re-established in 2021 with the birth certificate data on a monthly basis.
Data Source Name:	**6) Newborn Hearing Screening**
	Field Note: Newborn screening data was linked to vital statistics in the past, but linkage was suspended until the vital statistics statute was updated and new administrative procedures established to access and link with birth record data. The linkage was re-established in 2021 with the birth certificate data on a monthly basis.
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