Maternal and Child Health Services Title V Block Grant

Hawaii

FY 2021 Application/ FY 2019 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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GOVERNOR OF HAWAII

BRUCE S. ANDERSON, Ph.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
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P. O. BOX 3378
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In reply, please refer to:
File:

September 4, 2020

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) 2021 (October 1, 2020 – September 30, 2021). The FY 2021 application and FY 2019 annual report is submitted via the Health Resources and Services Administration Electronic Handbooks (EHBs).

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

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

Sincerely,

Bruce S. Anderson, Ph.D.
Director of Health

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 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: December 31, 2020.

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: December 31, 2020.

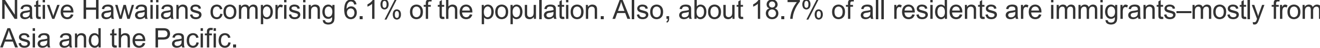
III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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

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



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

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

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

Domain	State Priority Need
Women's/Maternal Health	Promote reproductive life planning.
Perinatal/Infant Health	Reduce the rate of infant mortality by improving breastfeeding rates.
	Reduce the rate of infant mortality by promoting safe sleep practices.
Child Health	Improve the percentage of children age 0-5 years screened early and continuously for developmental delay.
	Improve the oral health of children.
	Reduce the rate of child abuse and neglect, with special attention on 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 12-21 years who receive services necessary to make transitions to adult health care.
Systems Building	Improve access to services through telehealth.

Title V National & State Performance Measures (2019)

The Hawaii national performance measures (NPMs) are:

- NPM 1: Well-woman visit
- NPM 4: Breastfeeding
- NPM 5: Safe sleep
- NPM 6: Developmental screening
- NPM 10: Adolescent well visits
- NPM 12: Transition to adult care
- NPM 13.2: Children's oral health

The current Hawaii state performance measures (SPMs) are:

- SPM 1: Telehealth
- SPM 4: Child abuse & neglect

The key accomplishments for FY 2019 and plans for FY 2021 are summarized below.

DOMAIN: WOMEN'S/MATERNAL HEALTH

Promote reproductive life planning

Accomplishments. Title V is a key partner in the Hawaii Maternal and Infant Health Collaborative (HMIHC), which continues to promote use of the One Key Question® (OKQ®) screening approach and the Long Acting Reversible Contraception (LARC) Program. Both are evidence-based/informed strategies that promote access to healthcare and reproductive decision-making. There are now 850 OKQ® trained service providers statewide. HMIHC received a National Institute for Reproductive Health (NIRH) Grant to identify and address barriers to Medicaid's expanded LARC coverage policy.

Challenges: Acquiring timely Medicaid data to monitor project benchmarks and complete evaluation is challenging. Private insurance and Medicaid claims reimbursement barriers also remain for LARC insertion.

Plans: FHSD will continue OKQ training targeting primary care providers, create a web based OKQ training, complete evaluation of OKQ screening efforts, and address barriers to Medicaid LARC reimbursements. HMIHC will also focus on public awareness and messaging to promote healthy behaviors and promote preventive women's health visits.

DOMAIN: PERINATAL/INFANT HEALTH

Promote breastfeeding

Accomplishments: The HMIHC breastfeeding work group continued implementation of priority projects in the State Breastfeeding plan. WIC Services Branch co-chairs the work group. WIC continued its evidence-informed Breastfeeding Peer Counselor Project and worked with community-based programs to extend WIC's reach to underserved, high-risk populations.

Challenges: Securing additional support/resources for implementation of the state breastfeeding plan has been ongoing. Work also continues with birthing facilities to improve breastfeeding policies, hospital discharge planning support, and assessment of staff competency.

Plans: Three priority projects from the state breastfeeding plan will be implemented: conduct training to increase awareness about insurance reimbursement for lactation support, create a breastfeeding toolkit for service providers, and develop breastfeeding promotion messaging. WIC will seek to expand the Breastfeeding Peer Counselor Project.

Promote safe sleep practices

Accomplishments: The Title V Safe Sleep program, the State Department of Human Services Child Care Program, and Office of Language Access began a joint venture to translate safe sleep provider/parent guides into 11 languages commonly spoken in Hawaii to broaden outreach efforts. The guides will be used to implement mandated safe sleep education for licensed childcare providers. Safe Sleep Hawaii (SSH) continues to convene statewide partners to coordinate services and programs. The annual Safe Sleep Summit was held to share information on current research, best practices, and support skills building. Title V established a "Play yards for Keiki" program to provide at-risk families with education and a safe sleep environment for their newborns.

Challenges: The practice of co-sleeping among local families is often related to ethnic/cultural norms, and small or multi-family living arrangements or homelessness due to high housing costs. These factors must be considered when providing safe sleep education and services.

Plans: Translated safe sleep materials will be broadly distributed. SSH will develop a resource directory and expand membership/outreach to non-traditional partners. The Safe Sleep fact sheet will be updated. The crib distribution program will be evaluated to assure access to families/caregivers in greatest need.

DOMAIN: CHILD HEALTH

Improve early and continuous screening for developmental delay

Accomplishments: The Early Childhood Comprehensive Systems (ECCS) Impact grant continued to establish a community-based model for screening, referrals, and supports for children in Maui County (Maui Island, Molokai Island and Lanai Island). In partnership with the former CDC Act Early Ambassador, resource maps were created with a developmental screening flow chart and resources in Maui county. A developmental screening initiative in WIC waiting rooms was piloted to engage families about their child's development. Developmental screening was integrated as a key strategy to promote young children's health in the Preschool Development Grant Strategic Plan.

Challenges: The need remains for an integrated developmental screening and data system to ensure there are supports available statewide and in each community to identify children who may have a concern and require follow-up.

Plans: ECCS Impact Grant activities will continue with the WIC pilot and a new pilot at a homeless shelter. Work on child development kits for families will be completed (including testing with families). A promotional campaign will be formulated to support kit distribution. Title V will continue to secure new screening data sources, evaluate other screening tools, and partner with state early childhood organizations to promote a system of developmental screening and referral.

Improve the oral health of children

Accomplishments: Due to the loss of funding for the State Oral Health Program, networking and advocacy activities largely continued through the Hawaii Oral Health Coalition (HOHC) which FHSD helped re-establish. The HOHC adopted formal by-laws, elected officers and established a process for online membership registration. Title V activities were reduced to supporting data collection through state surveillance surveys (i.e. Pregnancy Risk Assessment Monitoring Survey and the Youth Risk Behavioral Survey).

Plans: Because there is no program funding or staffing, oral health for children will not continue as a program priority at this time.

Reduce the rate of child abuse and neglect (CAN)

Accomplishments: The Title V CAN Prevention program (CANP) joined a state team tasked to complete the state Child Welfare Services five-year Child and Family Service Plan (CFSP). The plan includes a new focus to *prevent* children from entering the foster care system. CANP is also part of a new public/private effort to develop a state CAN Prevention Plan. CANP sponsored a series of community outreach/education events to support family strengthening in the state's rural areas. The MIECHV program continued to provide evidence-based services to at-risk families.

Challenges: The key challenge for CAN prevention is establishing effective collaboration across complex service systems to strengthen the impact and sustainability of prevention programs including sharing of data and resources.

Plans: Work on implementing CFSP strategies and the development of the state CAN prevention plan will continue. CANP is also participating in state planning and implementation of the federal Family First Prevention Services Act which will fund evidence-based programs to prevent children entering foster care. The Title V violence prevention programs will continue to support workforce trainings on toxic stress, resiliency, and trauma-informed care. The Early Childhood Action Strategies collaborative will launch a family violence prevention messaging campaign.

DOMAIN: ADOLESCENT HEALTH

Improve adolescent health and well-being

Accomplishments: Adolescent health and promotion of annual wellness visits was integrated into the federal Personal Responsibility and Education Program (PREP) evidence-based teen pregnancy prevention program. An Adolescent Resource Toolkit (ART) is being developed with youth input to distribute health information to the community. Workforce trainings were conducted to service providers—including staff at the youth detention center—to ensure health assessments were provided upon facility entry.

Challenges: Engaging more adults and service providers to help adolescents understand the importance of an annual wellness visit and encourage teens to independently seek care.

Plans: The PREP curriculum will continue to promote adolescent health and wellness visits including a new program site at the Youth Correctional Facility. Statewide youth leadership groups for the Coalition for a Drug Free Hawaii will design an ART for youth including messaging on the importance of annual wellness visits.

DOMAIN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Improve transitions to adult health care

Accomplishments: The Title V Children and Youth with Special Health Needs Section (CYSHNS) improved transition planning services for enrolled youth using the evidence-based Six Core Elements of Health Care Transition. The CYSHNS database upgrade was completed to permit tracking of client transition plans. Outreach and assessment materials were finalized as part of Hawaii's project for an MCH Workforce Development Center cohort. Education and public awareness efforts continued through transition fairs, conferences, and other events in collaboration with agency and community partners.

Challenges: Establishing partnerships with adult health care agencies and providers to promote transition planning is a challenge given shortages of adult health care providers, especially for CSHCN. Developing methods to measure the effectiveness of education/outreach activities is also a challenge.

Plans: Work will continue to improve transition readiness, planning, and transfer of care for CYSHNS-enrolled youths and their families. Education and public awareness activities on transition to adult health care will also continue.

CYSHNS will partner with pediatricians and health centers to increase the number of youths successfully transitioning to adult health care and work with the Title V Adolescent Health Program to increase outreach to all adolescents.

DOMAIN: CROSS-CUTTING/SYSTEMS BUILDING

Promote telehealth

Accomplishments: FHSD continued to increase telehealth activities for workforce training, and for direct services to the community (e.g., genetics, newborn screening, early intervention, WIC services, and MIECHV activities). Project ECHO Hawaii continued to use videoconferencing to build health care workforce capacity while improving patient access to specialty health care in rural communities. FHSD staff continued to use videoconferencing daily for communication among programs and community partners.

Plans: This state measure will be retired due to the significant progress accomplished. Telehealth activities will be integrated into the plans for the remaining Title V priorities and other Division operations.

Needs Assessment

Every five years, FHSD conducts a state-level needs assessment of the health of women, children and youth including children with special health care needs, and their families to guide state priorities and meet the Title V Block Grant requirements. The goal of the assessment is to gather information to understand the issues facing this population and to identify priorities than can be positively addressed by public health over the five-year period.

Changing population demographics, emerging health trends, and shifting program capacity make it necessary to regularly assess the state's MCH program. It is also an opportunity to review collaborations with other entities that serve the MCH population and identify how partnership projects can meet the needs of Hawaii's families. The assessment was comprised of four major components: an environment scan, a capacity assessment, community surveys, and data review. Two other needs assessment components (health equity briefs and focus groups) will be completed next year as part of ongoing assessment activities.

The selection criteria for priorities:

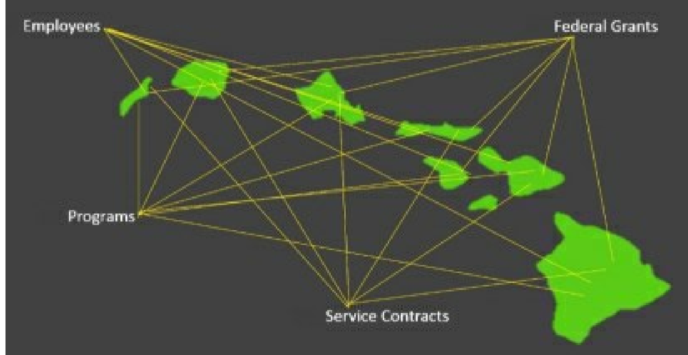
- Data showed a need
- FHSD has a major role to impact this issue
- FHSD has resources to address the issue (staff and funding)
- Community alignment & support exist as reflected in other (federal, state, community) needs assessments reports, plans, initiatives, and validated by stakeholder and family input.

The assessment was completed in January 2020 with the final selection of priorities for 2021-2025. Most of the priorities will continue except for children's oral health (NPM 13.2) and telehealth promotion (SPM 1). Several priority strategies, activities, and measures were revised in the new state plan. Program staff continue to review and consider community input collected through the assessment. Because the stakeholder input and the data reviews were completed before the start of the COVID pandemic, priorities and plans may change next year. Ongoing needs assessment efforts will continue to capture/monitor health impacts of the pandemic. Technical assistance and guidance for this activity is requested.

III.A.2. How Federal Title V Funds Support State MCH Efforts

FHSD provides all levels of service delivery: direct, enabling, and infrastructure building. One of the largest Divisions in DOH, FHSD is comprised of 3 branches – Maternal and Child Health (MCH), Children with Special Health Needs (CSHN), and Women, Infants and Children (WIC) Services. Together, the Division administers 30 programs, 21 federal grants, approximately 150 service contracts with community-based organizations totaling roughly $50M, all with 283 FTE positions statewide.

In 2019 the FHSD budget was $95.2M. Nearly $2.3M was provided by Title V, with $41.6M state matching funds, and an additional $51.3M in other federal funds. Of the state's overall population, FHSD programs reached an estimated 99% of pregnant women, 99% of all infants, 18% of children 1-21 years of age, 19% of children with special health needs, and 4% of others (general adult population).



To support the infrastructure needed to administer MCH programs statewide, Title V funds are used for key staff positions (21.15 FTE) including epidemiologists, research statisticians, MCH and CSHN program managers, a part-time Pediatric Medical director, nurses, a nutritionist, an audiologist, and contract manager. 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 4) improving quality to assure services are family-centered, culturally relevant, and community based.

III.A.3. MCH Success Story

In March 2020, the COVID-19 pandemic led to a stay-at-home order for Hawai'i residents, prompting FHSD's Family Support program to create three sets of 15-second TV spots and display ads with messaging to help family strengthening and help prevent child abuse and neglect. The call-to-action directed viewers to TheParentLine.org website and hotline that offer free statewide resources for parents/caregivers.

The recently hired Information Specialist III, funded by the Title V MCH Block Grant, negotiated media buys with the major broadcast and cable stations to reach the MCH population, particularly adults 18+ with children in the household. A comprehensive digital advertising package was included in the media buy to add display, pre-roll, and search. The Information Specialist negotiated added value to include production and 10 TV morning show interviews at no charge.

Stay Connected TV spot

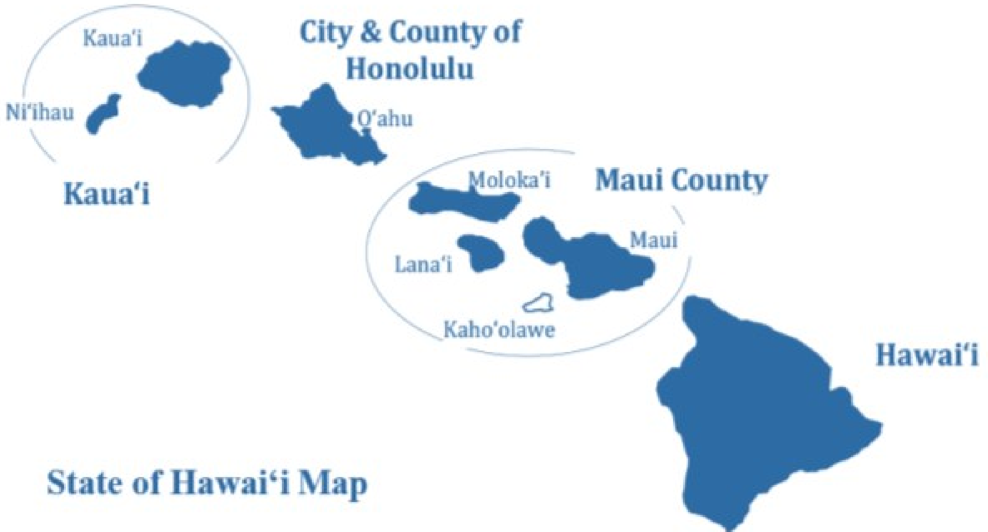
The average reach of the target audience on broadcast TV was 98.7% with an average frequency of 16.7 views, providing an average of 4.23 million impressions. The cable TV and digital ad package provided another 1.37 million impressions and 898 site visits.

Based data provided by The Parent Line, there was a 74.4% jump in new users to their website from April 2020 to May 2020, going from 580 to 2,264. All users jumped by 74%, 598 to 2,297, and page views jumped by 67.9%, 1,501 to 4,672. Calls to the hotline increased by 21.4% from April 2020 to May 2020, going from 59 to 75.

III.B. Overview of the State

GEOGRAPHY

Hawaii is situated almost in the center of the Pacific Ocean and is one of the most isolated yet populous places on Earth. The west coast of North America is 2,400 miles from Honolulu, roughly a 5-hour flight by air. Five time zones separate Hawaii from the eastern U.S. This means 9 am in Washington, D.C. is 6 am in Los Angeles and 3 am in Hawaii. Nationally, Hawaii is the 11th smallest state by population size and 4th smallest by land area.



The State is composed of 7 populated islands in 4 major counties: Hawaii, Maui, Oahu, and Kauai. The county is the lowest civil subdivision in the state. As a result, counties in Hawaii provide some services, such as fire and police protection, that in other states are performed by cities or towns. Counties also elect a mayor and council. Likewise, the state government is responsible for functions usually performed by counties or cities in other states. Hawaii is the only state, for example, with a single unified public-school system. Similarly, Hawaii has no local health departments, but district health offices for each of the three neighbor island counties.

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

Only 10% of the state's total land area is classified as urban. The City and County of Honolulu is the most urbanized with a third of its land area and 96% of its population in urban communities. Most tertiary healthcare facilities, specialty and subspecialty services, healthcare providers are located on Oahu. Consequently, neighbor island and rural Oahu residents often travel to Honolulu for these services. Interisland passenger travel to and from Oahu Island is entirely by air. Air flights are frequent, but comparatively expensive. Airfare costs can be quite volatile based on varying fuel costs. This creates a financial barrier for neighbor island residents since round-trip 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 including primary care, hospital, specialty, and subspecialty services. Because of the mountainous nature of the islands, road networks are sparse and, in some places, limited to a single highway near the coast. Access to emergency care on neighbor islands often requires the use of helicopters or fixed-wing aircraft.

DEMOGRAPHICS

The estimated 2018 state population is 1,420,491 residents, the 30th most populous state in the U.S. Oahu is home of 69.0% (980,080 residents) of the state's population, while 14.1% (200,983 residents) live on the Big Island, 11.8% (167,207 residents) in Maui County, and 5.1% (72,133 residents) in Kauai County. Compared to 2017 (1,427,538), there was a 7,047 (0.5%) population decline in the state.

ETHNIC DIVERSITY

Hawaii is one of the most ethnically diverse states in the U.S. with no single race majority. According to the 2018 American Community Survey (ACS), 24.3% of the population reported two or more races, and the following single race proportions: White=24.3%; Asian=37.6%; and, Native Hawaiian or Other Pacific Islander (NHOPI)=10.2%. The largest Asian single race subgroups were Filipino (15.5%), and Japanese (11.5%) and the largest NHOPI single race sub-group was Native Hawaiian (6.4%). The individual Asian and NHOPI subgroups are listed in the table below and show the heterogeneity of these aggregated Race groupings.

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

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

Sources: US Census Bureau. The Asian Population: 2010. 2010 Census Briefs. Issued March 2012; C2010BR-11.
US Census Bureau. The Native Hawaiian and Other Pacific Islander Population: 2010. 2010 Census Briefs. Issues May 2012; C2010BRF-12

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

Race Group	Resident Population in the State of Hawaii (N)	Percent of State Population (%)	Proportion Reporting at least one other Race (5)
White Alone	345,652	24.3%	0
White Alone or in Combination	600,675	42.3%	42.4%
Native Hawaiian or Other Pacific Islander (NHOP) Alone	144,971	10.2%	0
NHOPI Alone or in Combination	383,172	27.0%	62.2%
Native Hawaiian Alone	91,442	6.4%	0
Native Hawaiian Alone or in Combination	315,616	22.2%	69.2%
Asian Alone	534,479	37.6%	0
Asian Alone or in Combination	807,332	56.8%	33.8%
Filipino Alone	220,315	15.5%	0
Filipino Alone or in Combination	367,952	25.9%	33.6%
Japanese Alone	163,174	11.5%	0
Japanese Alone or in Combination	313,596	22.1%	36.9%
Chinese Alone	82,123	5.8%	0
Chinese Alone or in Combination	*210,573*	*14.8%*	*60.9%*
Source: U.S. Census Bureau. 2018. American Community Survey Calculations by Hawaii Department of Health, Family Health Services Division			

Those that report two or more race groups are not included in the single race groups commonly reported. Due to the large proportion with more than one race, recommendations are to report race as “alone” or “alone or in combination” with another group. For example, Native Hawaiian accounted for 22.2% of the state population when reported as “alone or in combination”, compared to just 6.4% when Native Hawaiian is reported singly. There is also variation among race subgroups an overall estimate of 33.8% of those in the Asian Alone or in combination reporting another race but variation in the 3 largest subgroups range from 33.6% in Filipino to 60.9% in Chinese. The other Asian subgroups are likely newer immigrants to Hawaii compared to these three and have smaller numbers reporting more than one race group.

Given the state’s unique characteristics, particularly the diversity in ethnicity, language and cultural practices, many best practices may not translate well to Hawaii.

Immigration

Hawaii is considered a gateway to the U.S. for immigrants from Asia and the Pacific and has a sizeable immigrant community. As of 2018, there were 266,147 immigrants in Hawaii, or nearly one-in-five (18.7%) of all residents. This is the 6th-highest of all states. The ACS reports 54.5% of Hawaii's immigrants are women and 5.8% are children (under 18 years old). The top countries of origin are:

- Philippines (45%),
- China (9%),
- Japan (8%), and
- the Marshall Islands (4%).

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

Undocumented Immigrant Estimates

According to the Pew Research Center, there are an estimated 45,000 undocumented immigrants in Hawaii (3.3.% of the population).[1] The majority are from the Philippines. Hawaii is the only state where undocumented women (55%) outnumber men. The following table summarizes characteristics of Hawaii's undocumented immigrant population compared to the U.S.

Unauthorized Immigrant (UI) Characteristics	Hawaii	US
Unauthorized population	45,000 (3.3% of population)	10.7 million (3.3% of population)
Proportion of all immigrants that are undocumented	17.0%	24.0%
Proportion of adults that have been in the US for 5 years or less	34%	18%
K-12 students with unauthorized immigrant parent(s)	7.0%	7.6%
Proportion of labor force that is unauthorized	4.5%	4.8%
Industries and occupations with most unauthorized immigrant workers	Leisure/hospitality, service; Agriculture/farming	Construction, Service, Farming

DACA (Deferred Action for Childhood Arrivals)

As of 2019, 340 active DACA recipients live in Hawaii, with 1,201 people granted DACA status since 2012.[2] An estimated 11% of those eligible in Hawaii applied for DACA.

Compact of Free Association (COFA)

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

There are reports of high rates of morbidity due to chronic disease, reports of communicable diseases (tuberculosis, Hansen's disease/leprosy), and other medical concerns which may be related to U.S. nuclear tests conducted in the Pacific nations (i.e. cancer). Challenges also exist due to language and cultural barriers within the population. In

2018, there were approximately 16,680 COFA migrants in Hawaii. Estimates indicate roughly 1,000 migrants are homeless. Migrants account for about 2-3% (400-600) births annually in Hawaii, with low rates of prenatal care utilization, high rates of low birth weight, and recent concerns about high rates of NICU admissions.[3]

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

Languages Spoken

Because of Hawaii's ethnic diversity, limited English proficiency may impact access to healthcare for immigrant communities. An estimated 26.1% Hawaii resident ages 5 years and over spoke a language other than English at home, compared to 21.5% nationally. An estimated 12.1% of Hawaii residents reported limited English proficiency (4th highest state ranking), compared to 8.5% nationally. The most common languages spoken at home other than English include Other Pacific Island languages, Tagalog, Japanese, and Spanish, followed by Chinese, Korean, and Vietnamese.[4]

In School Year 2015-16, 8.3% (13,619) of the state's public-school students were enrolled in English Language Learner Program.[i] The top five languages spoken by Hawaii public school students are Ilokano, Chuukese, Marshallese, Tagalog, and Spanish.

Military

Other sub-populations within the state include U.S. Armed Forces personnel and their family members which, in 2018, comprise an estimated 7.4% of the state's population (105,669 people).[5] There are several major military health facilities to serve this population located on Oahu. The Tripler Army Medical Center is the only federal tertiary care hospital in the Pacific Basin. It supports 264,000 local active duty and retired military personnel, their families, and veteran beneficiaries. Medical services are also available on military bases through several clinics for active duty members and their family members.

Homelessness

Hawaii's 2019 Point-in-Time homeless study estimates the total number of homeless individuals statewide at 6,448. The proportion of unsheltered individuals (56.4%) was higher than sheltered individuals (43.6%). The trend of homeless declined from 6,530 in 2018. About 31.5% (2,028) of the homeless were part of families, including 18.2% (1,176) children under age 18 years.[6]

Maternal and Child Population

The 2018 estimates show that there were 264,071 women of reproductive age (15-44 years old) a 0.7% increase from 2010, representing 18.6% of the entire state population.

During the last 24 years, the number of births in Hawaii varied from about 17,000 to 20,500 annually. There was a steady increase in the number of births since the late 1990's with about 18,000 births every year in the state over the past 5 years.

The 2018 population estimates show that there were 171,871 children 9 years of age or younger in Hawaii, which represents a 0.6% increase from 2010. This group represents 12.1% of the state population. There were 159,029 children 10-19 years of age in Hawaii, which represents a 3.0% decrease from 2010. This group represents 11.4% of the state population.

Based on the 2018 National Survey of Children with Special Healthcare Needs (CSHCN), there are an estimated 38,816 CSHCN, representing 12.8% of all children ages 0-17 years old.

Older Population

Hawaii's population, like the U.S., is aging. Based on 2018 population estimates, persons age 65 years and over comprised 18.4% of the population, compared to 14.3% in 2010. Nationwide, this population comprised 16.0% in 2018 compared to 13.0% in 2010. There are more older people in proportion to younger ones.

ECONOMY

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

Economic Growth

The Hawaii State Department of Business, Economic Development and Tourism (DBEDT) first quarter 2020 outlook report suggested positive growth for Hawaii's economy in 2020-21, based on national and global economies, the performance of Hawaii's tourism industry, labor market conditions, and the growth of personal income and tax revenues.[7] Hawaii's economy, as measured by real gross domestic product (GDP), was projected to show a 0.5 percent increase in 2020 pre-COVID. The real GDP growth forecast for 2021 is 1.5 percent, 0.2 of a percentage points above the previous forecast. The per capita real GDP in Hawaii was $55,418 in 2018 (in 2012 dollars), $972 or 1.8% higher than the U.S. average.[8] Hawaii ranked 18th among the 50 states.

Unemployment

Hawaii unemployment rates reflect the state's economic recovery. The state's unemployment rate peaked at 7.4% after the 2009 recession with a record 47,000 individuals unemployed. The annual average unemployment rate in Hawaii was 2.7% in 2019, 1.0% points lower than the U.S. average of 3.7%.[9] Hawaii ranked the 5th lowest among the 50 states.

State Budget

The State Council on Revenues lowered its forecast for growth in the State General Fund tax revenue in FY 2020 from 4.1% to 3.8%.[10] The Council's decision to lower the estimate was based on the deterioration of the economic outlook due to the COVID-19 virus. The Council lowered the FY 2021 forecast from 4.0% to 0.0% in an expectation of an economic downturn. The Council raised the forecast for FY 2022 to 5.0% and forecasted that General Fund growth would be 4.0% for FY 2023-2026, if the effects of the COVID-19 virus would not be long-term.

Tourism

In 2019, Hawaii experienced another record-breaking year for tourism with 10.4 million travelers coming to the islands and visitor expenditures of $17.8 billion. Spending by visitors generated $2.07 billion in state tax revenue in 2019, an increase of $28.5 million (1.4%) from 2018. Hawaii's tourism is expected to decrease in 2020 due to the impact of COVID-19.

Poverty

Based on 2018 estimates, Hawaii's poverty rate was 8.8% (all ages in poverty), lower than the U.S. rate of 13.1%. This represents an estimated 122,143 individuals living in poverty in the state; over 35,368 or 11.9% of those under 18 years of age live in households below the Federal Poverty Level (FPL). Like unemployment rates, poverty rates are variable across counties: Honolulu 7.8%; Maui 7.1%; Kauai 6.4%; and Hawaii 16.2%.

The official FPL obscures the struggles faced by many families in Hawaii because of the high cost of living in the state and the generally low wage structure given the dependence of service industry jobs in tourism. The Census Supplemental Poverty Measure, which considers factors such as the cost of living and entitlements, reports that the 2018 poverty rate for Hawaii was 12.8%, 1.0 percentage points higher than the official poverty rate of 11.8%.[11]

Wages

Average annual wages for employees in Hawaii was $50,977 in 2018, $6,289 or 10.9% lower than the U.S. average of $57,266. Hawaii ranked 24th among the 50 states. Among private sector employees only, the situation is worse. Average annual wages for employees in the private sector was $48,376 in 2018, $8,822 or 15.4% lower than the U.S. average, ranking Hawaii 30th.

ALICE Report

Hawaii's United Way Agency tracks working residents who live just above poverty and unable to afford basic necessities through a survey titled - Asset Limited, Income Constrained, Employed (ALICE).[12] In 2018, there were an estimated 33% of ALICE households in Hawaii that struggled to meet expenses for housing, child care, food, transportation, and healthcare. These are in addition to the 11% of households below the Federal Poverty level. The reason for the high percentage of ALICE households are:

- low wage jobs dominate the economy and
- cost of living outpacing wages.

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

HIGH COST OF LIVING

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

Housing Costs

The primary driver for the high cost of living is Hawaii's housing costs which are the highest in the U.S. Hawaii's high housing costs create a burden for families, resulting in less income available for other critical household expenses, and for some families living in overcrowded, substandard housing, and homelessness.

In April 2019, the median housing cost for a single-family dwelling on Oahu was $810,000 and for a condominium was $435,000. The median monthly owner mortgage cost in 2018 was $2,354, $788 or 50.3% higher than the U.S. average. Among these homeowners, 29.5% spent *35% or more of their household income*, which was higher than the U.S. average of 20.9%. Hawaii ranked the 3rd highest in the nation for this indicator. Not surprisingly, the homeownership rate in Hawaii in 2018 was one of the lowest in the U.S. (47th among the 50 states) at 58.3%, which was lower than the U.S. average of 63.9%.

Rental Costs

For working families, the high cost of fair market rent is out of reach. In 2018 an estimated 41.7% of Hawaii residents rent (compared to 36.1% nationally). The median monthly gross rent for the renter-occupied units (excluding units not paying rent) was $1,613, $555 or 52.5% higher than the U.S. average of $1,058. Hawaii has the highest cost among the 50 states.

Multi-generational Households

Another consequence of high housing cost is the high number of multigenerational households. Based on 2018 ACS estimates, the percentage of multigenerational family households among all family households in Hawaii was 11.1%, which was higher than the U.S. average of 5.3%. Hawaii has the highest rate among the 50 states.

Cost of Health Insurance

Health insurance premiums continue to increase annually and can comprise a significant amount of an individual or family's budget. According to the Hawaii State Insurance Commissioner,[13] the average increase for health insurance group plan premium rate significantly declined from 2011 to 2014 to a 4% average annual increase compared to 9.3% average annual increase between 2007 and 2010. The impact of the Affordable Care Act (ACA) on individuals and family budgets/expenses has yet to be determined.

Health Services Infrastructure

There are about 100 health facilities in the state.[14] Of the State's 29 hospitals: 12 are labor and delivery hospitals. There are 3 pediatric hospitals with Neonatal Intensive Care Units on Oahu while other hospitals have less acute pediatric services. Hawaii has 15 federally qualified health centers, 11 rural health clinics, 7 Native Hawaiian health systems sites. Maps of these facilities are in the "Supporting Documents" section.

There are 420 family and general practitioners, 210 obstetricians and gynecologists, and 190 pediatricians in the State.[15] Based on the 2018 population estimate (1,420,491), there are 14.8 per 100,000 population obstetricians and gynecologists, which is significantly higher than the national rate (5.7 per 100,000 population). There are 13.4 pediatricians per 100,000 population, which is like the national estimate (8.7). The rate for family/general practitioners (29.6 per 100,000 population) is similar to the national rate (34.9). Despite Hawaii's high ratio of providers to population many of the state's medical and specialty providers are located on Oahu and many of the State's rural areas are designated as shortage of medically underserved.

Healthcare Shortage Designations

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

Health Professional Shortage Areas

A Health Professional Shortage Area (HPSA) is a geographic area, population or facility with a shortage of primary care, dental, or mental health providers. Hawaii's primary care HPSA cover nearly all major islands and include Kauai, Maui, Molokai, Lanai, the Big Island, and the rural northern half of Oahu. Hawaii's mental health HPSA include the six major islands of Kauai, Maui, Molokai, Lanai, the Big Island, and Oahu. Hawaii's dental health HPSA include Maui, Molokai, Lanai, the Big 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 which has insufficient health resources (manpower/facilities/services) to meet the medical needs of the resident population. Hawaii's MUA include Kauai, Molokai, the Big Island, and the East area of Maui, which includes Hana.

Medically Underserved Population

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

HEALTH INSURANCE & HEALTHCARE REFORM

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

In conjunction with the Affordable Care Act (ACA), Hawaii implemented a state-run health insurance marketplace and adopted Medicaid expansion. The marketplace transitioned to a federally run exchange in 2017. Nothing changed for state Medicaid coverage with the switch to Healthcare.gov; the expanded Medicaid eligibility guidelines are still in effect. Through its efforts, Hawaii consistently has low uninsured rates and high overall health scores, although disparities remain.

Hawaii is one of the few states where enrollment in Health Plans through the exchange increased every year. In 2018, 20,193 people enrolled, a 2% increase over the previous year (19,799). The major gains in coverage occurred through Medicaid expansion. Under the Medicaid expansion provision of the ACA, coverage increased to 138% of FPL. The number of people on the program rose significantly from 292,000 in 2013 to about 345,709 in 2018.[16] This mirrors the national average of roughly 25% Medicaid coverage of the state population. In Hawaii, Medicaid covers more than 40% of the state's children. Under ACA more than 20,000 people enrolled in private insurance and about 50,000 people enrolled in Medicaid.

With the possible repeal of the ACA, state lawmakers in 2018 integrated some of the significant pieces of the legislation into the Prepaid Healthcare Act. Act 111 ensures the following benefits remained available under Hawaii law:

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

The ACA provided state-level and provider organization-level demonstation models around innovation. Nearly 100 practices which represent several hundred primary care physicians are participating in the Comprehensive Primary Care Plus innovation program. While this is primarily a Medicare program, the impact of practice transformation occurs for all patients, regardless of the payor. The focus of the program is on screening, prevention, and care coordination.

Hawaii Medical Service Association (HMSA), the state's largest insurer, continues its effort in Payment Transformation. A majority of the state's primary care providers, as of July 1, 2019, receive capitated rates. This new payment model continues to receive mixed reviews from the provider community with pediatricians expressing the most concern given the intensive schedule of visits needed for infant care.

MEDICAID

The Department of Human Services (DHS) Med-QUEST Division (MQD). QUEST administers the State Medicaid program. QUEST is an acronym that stands for: Quality Care, ensuring Universal Access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way healthcare is provided. QUEST has 2 basic objectives: to expand medical coverage to include populations previously ineligible for Medicaid and to contain costs by shifting fee-for-service to a managed care delivery system. Savings realized from such a shift would be used to expand coverage. Under this waiver all Medicaid eligibles, excluding those with disabilities and over 65, received their services through managed care.

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

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

As of August 2019, The Hawaii Medicaid Progam provided coverage to 341,346 individuals with 107,444 of them being children through traditional, SCHIP, and current and former foster care eligibility rules.[17] Additionally, the program continues to support medically needy children who are determined to need nursing home level of care.

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

The state continues to provide COFA migrants; the aged, blind, disabled; children and pregnant women, with full state-funded Medicaid coverage. COFA adult migrants must enroll through Healthcare.gov. However, the state-funded Medicaid Premium Assistance Program may help, by paying the premiums for eligible COFA migrants and legally permanent residents who have incomes less than 100 percent of the FPL.

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

CMS approved the Hawaii State Plan Amendment which eliminated restrictions to telehealth services. Since January 1, 2017, providers deliver and bill for telehealth services through Medicaid. This puts Medicaid in alignment with commercial insurance.

GOVERNMENT

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

The DOH is the only public health agency for the state. There are no local health departments in Hawaii. The state's three neighbor island counties (Hawaii, Maui and Kauai) are represented by District Health Offices that oversee

DOH staffed services at the county level. Contracted services on the neighbor islands are handled directly by the central Title V programs on Oahu.

The Governor appoints all state department directors; the Director of Health reports directly to the Governor. The DOH is divided into 3 major administrations: Health Resources Administration (HRA), Behavioral Health (BHA), and Environmental Health (EHA). There are 6 major divisions within HRA including the Family Health Services Division (FHSD), which is responsible for the administration of all Title V funding. The three branches within FHSD are the Maternal and Child Health, Women Infants and Children (WIC) Services, and Children with Special Health Needs Branches.

Democratic Governor David Ige was re-elected to a second term in 2018. Dr. Bruce Anderson, PhD, serves as Director of Health. The former FHSD Chief, Danette Wong Tomiyasu is the Deputy Director for HRA. Matthew Shim, PhD, is the FHSD Chief/Title V Director.

STATUTORY AUTHORITY

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

COVID Pandemic

In March 2020, Hawaii implemented strict preventive measures including stay at home orders, travel restrictions on out-of-state and inter-island travel (14-day quarantine), closure of business, schools, and public spaces (including parks and beaches), limitations on social gatherings, and wearing of masks. Hawaii's isolation and the shutdown orders succeeded in halting the spread of the coronavirus in Hawaii. In July Hawaii reported a total of 1400 cases and 25 deaths.

However, the economic impacts of these measures are devasting to the state economy largely dependent on tourism. Hawaii is getting 99.5% less travelers, with daily visitors declining from about 30,000 to between 600 and 800 on average. The unemployment rate went from the lowest in the U.S. to the highest 23.5%. Although Hawaii received $7.7 billion in federal COVID aid it will not make up for an anticipated $2.3B in FY 2021 revenue shortfalls. [18]

COVID measures were relaxed in June and July and Hawaii is experiencing a surge in new COVID cases largely on Oahu, resulting in reinstituting emergency restrictions.

2020 Cost of Living Initiative

In response to several reports outlining the adverse impacts of the state's high cost of living; in January 2020 the Governor, legislative and business leaders announced an unprecedented joint legislative package aimed to address financial hardships on Hawaii families. The package focused on increasing minimum wage, tax credits for working families, expanding affordable housing, improving aging school facilities, and expanding pre-K education statewide.

Unfortunately, with the advent of COVID the Legislature adjourned in March 2020, reconvened in June with an abbreviated session. Only a limited number of bills were heard with greater focus on the passage of the state budget and COVID-related items. Of the cost-of-living package, only school facilities and pre-K education bills passed.

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[1] Pew Research Center. (2019). https://www.pewresearch.org/hispanic/interactives/u-s-unauthorized-immigrants-by-state/

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

[3] COFA reports (2018) https://www.doi.gov/oia/reports/Compact-Impact-Reports.
[4] Hawaii State Department of Education, English Language Learners, P. 48 of the Consolidated State Performance Report for school year 2015-16 https://www2.ed.gov/admins/lead/account/consolidated/sy15-16part1/index.html
[5] Number of armed forces residents and military dependents at http://dbedt.hawaii.gov/economic/databook/2018-individual/_01/
[6] https://homelessness.hawaii.gov/point-in-time-count/
[7] Report on Hawaii's economy http://dbedt.hawaii.gov/economic/qser/
[8] http://dbedt.hawaii.gov/economic/ranks/
[9] 2019 unemployment rate is found at https://www.bls.gov/lau/lastrk19.htm
[10] General fund forecast on March 13,2020, http://tax.hawaii.gov/useful/a9_1cor/
[11] Supplemental Poverty Measure is found on https://www.census.gov/library/publications/2019/demo/p60-268.html

[12] https://www.auw.org/alice-study-financial-hardship-hawaii
[13] Department of Commerce and Consumer Affairs news release http://cca.hawaii.gov/ins/news-release-insurance-commissioner-reduces-hmsas-rate-increase-request/
[14] Based on the facility address provided on https://health.hawaii.gov/shpda/agency-resources-and-publications/health-care-utilization-reports-and-survey-instructions/2018-data/
[15] Based on 2018 state data provided in Form 11.
[16] Based on Department of Human Services, State of Hawaii, 2018 Annual Report found on http://humanservices.hawaii.gov/reports/annual-reports/
[17] Based on the 2019 enrollment report from https://medquest.hawaii.gov/en/resources/reports.html
[18] https://www.civilbeat.org/2020/07/hawaii-has-huge-stake-in-negotiations-over-federal-covid-19-aid/

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

III.C.2.a. Process Description

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

Goal, framework, and methodology

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

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

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

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

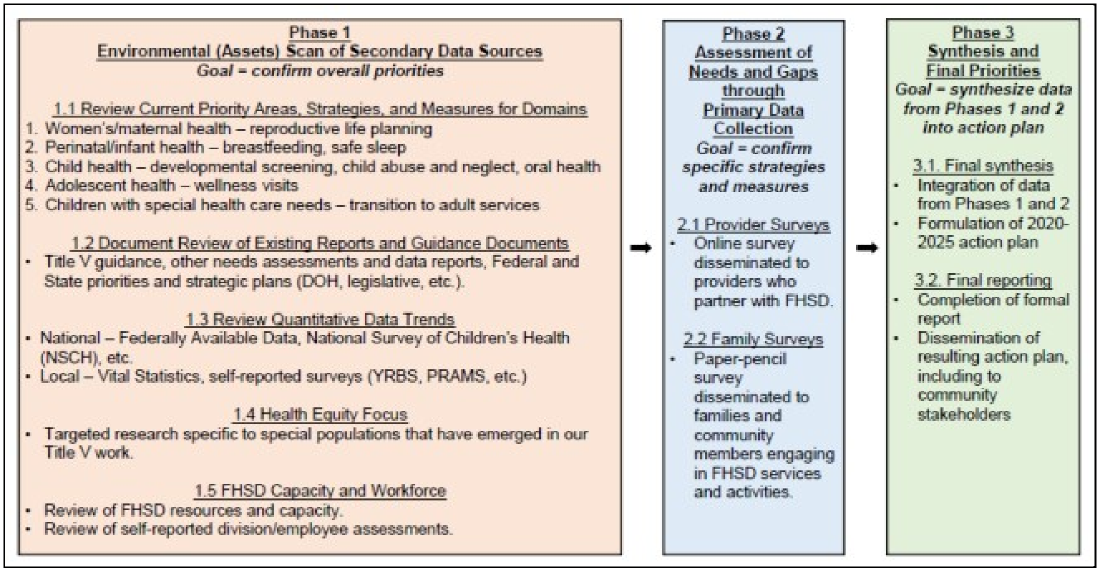


Figure 1. Overview of Hawaii's five-year needs assessment framework and process

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

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

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

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

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

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

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

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

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

Phase 1, Component 1 – program reviews with staff

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

Phase 1, Component 2 – document review

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

Phase 1, Component 3 – data review

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

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

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

Phase 1, Component 4 – Health Equity Focus

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

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

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

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

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

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

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

Phase 1, Component 5 – FHSD capacity and workforce

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

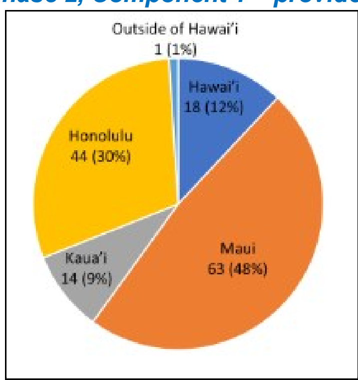
Quantitative surveys:

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

Qualitative interviews:

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

Phase 2, Component 1 – provider surveys



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

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

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

<u>Providers Surveys – Additional Demographics</u>

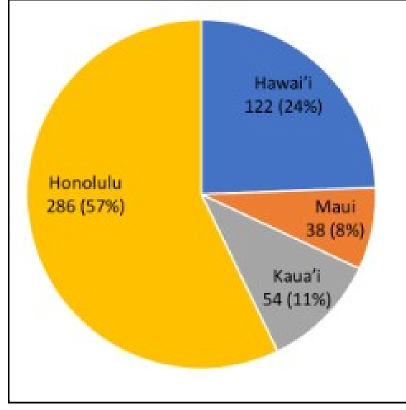
(red – top 3 for each questions)

How would you describe the **organization/setting** you currently work in (select all that apply)?	
State agency	**33 (22%)**
County agency	3 (2%)
Health center	13 (9%)
Hospital	12 (8%)
Private practice	5 (3%)
Insurance provider	3 (2%)
Childcare provider	10 (7%)
Youth services provider	11 (7%)
K-12 education	9 (6%)
Higher education	3 (2%)
Non-profit	**63 (43%)**
Native Hawaiian organization	7 (5%)
Community-based organization	**15 (10%)**
Faith-based organization	2 (1%)
Other	5 (3%)
Not presently employed	1 (1%)

Which group(s) of **people do you serve/** provide services for (select all that apply)?	
Women	83 (56%)
Pregnant women	82 (55%)
Children 0-5 years	**105 (71%)**
Children 6-12 years	74 (50%)
Teenagers/adolescents	**86 (58%)**
Children with special health care needs	72 (49%)
Families	**102 (69%)**
Other	30 (20%)

- Adults - 5
- Adults with special needs - 4
- Single adults - 1
- Males - 4
- Fathers - 1
- Elders - 4
- Educators - 2
- Service providers - 2
- Policymakers - 1
- Low income/Quest - 4
- Homeless/houseless - 2
- Trans - 1
- Permanent residents/aliens - 1
- Former incarcerated - 1
- HS dropout - 1
- Foster youth – 1
- "Community" - 3
- "Cohort-based" - 1
- Dental - 1

Phase 2, Component 2 – family/community surveys



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

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

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

The comprehensive NA led to identifying Title V priorities for which the Action Plan was developed. This was the focus of Phase 3 of the NA – final synthesis, action plan development, and reporting. The process included:

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

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

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

III.C.2.b. Findings

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

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

Title V Needs Assessment Surveys – Current Priorities

(red = top 3 in each column)

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

Women's health – population domain overview

An estimated 300,000 women aged 15-49 years live in Hawaii, making up 43% of the female population in the state (Census data). The demographic characteristics of this group generally reflect those of the US, except the state's race groupings, which has a high proportion of Southeast Asians, Native Hawaiians and Other Pacific Islanders (NHOPI). Thirty percent of

Women of Reproductive Age (WRA) in Hawaii are White, followed by Filipino (20%) and Native Hawaiian (17%), with all other races being less than 10%, respectively. Most WRA are married (46%), heterosexual (90%), a high school or college graduate (31%, respectively), and employed (62%) with an annual household income of $75,000 or more (36%).

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

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

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

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

Pregnant women & Infant health – population domain overview

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

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

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

Breastfeeding, or at least breastfeeding initiation, is common in Hawaii and is essentially unchanged for eight years. In 2016, 89% of infants were ever breastfed (FAD data). A lesser proportion of mothers continue to breastfeed exclusively through six months at 33%; however, it is higher than the U.S. estimate (25%). The latest 2016 PRAMS data showed that 78% of infants

are placed on their backs to sleep, but only 20% are placed on an approved sleep surface, and 32% are placed to sleep without soft objects or loose bedding. Disparities in infant safe sleep practices exist for mothers who were 20 years or younger, at or below the 185% of the federal poverty level, and Native Hawaiian.

An assessment of Hawaii's maternal and child health indicators suggest that pregnant women and their infants are faring as well as those nationwide. However, there are observed differences between subgroups that require close examination and focused public health efforts. These data show that health disparities are commonly highest among low-income individuals, younger mothers, those with a high school education or less, and those who are uninsured or on public insurance. Racial variations exist depending on the indicator, but in general, poorer outcomes are experienced by NHOPI and Blacks.

Child health – population domain overview

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

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

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

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

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

Adolescent health – population domain overview

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

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

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

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

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

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

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

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

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

improvement.

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

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

Survey results for the five domains

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

Domain	NPM and current strategies	Are these the right/best strategies?	Categories of open-ended comments
Women	Promoting wellness check-ups for women. • Use evidence-based strategies including One Key Question, to engage women in reproductive health planning. • Expand access to long-acting reversible contraception.	Yes = 128 (86.5%) No = 15 (10.1%) Blank = 5 (3.4%)	• Support for/expansion of OKQ and LARC. • Suggestions on encouraging women to go to their check-ups, and for providers when conducting visits. • Reducing insurance and financial barriers. • Important sub-populations (e.g., LGBTQ+, youth, women with mental health concerns, etc.).
Infants	Promoting breastfeeding & supports for new mothers • Partnering with Women, Infants & Children (WIC) programs. • Working with the Hawaii Maternal & Infant Health Collaborative to implement the State Breastfeeding Strategic Plan.	Yes = 130 (87.8%) No = 15 (10.1%) Blank = 3 (2.0%)	• Access to lactation consultants and supports (e.g., at hospitals), including those who don’t qualify for WIC. • Programs such as provider education and establishing a milk bank.

			• Policy issues (e.g., insurance coverage for breastfeeding supports, workplace culture). • Incorporation of cultural practices, and family-based approaches (not just targeting mothers).
Infants	Promoting safe sleep for infants. • Expanding outreach to non-English speaking families. • Ongoing data surveillance. • Workforce training (e.g., through annual Safe Sleep Summit).	Yes = 132 (89.2%) No = 10 (6.8%) Blank = 6 (4.1%)	• Expansion of outreach efforts (e.g., home visiting, targeting non-English-speaking families). • Education for families. • Allied programs (e.g., cribs for kids).
Children	Early screening of children for developmental delays. • Developing family-friendly messaging. • Working with early childhood providers to ensure systematic efforts for screening, referral to services, and follow-up.	Yes = 121 (81.8%) No = 20 (13.5%) Blank = 7 (4.7%)	• Brining screening to various settings (e.g., schools, doctors' offices, early childhood providers, etc.). • Ensuring appropriate services are available if/when identified through screening. • Continue to build systems and collaborations around screening.
Children	Promoting oral health among children. • Maintaining data surveillance. • Promoting greater access to prevention services (e.g., through teledentistry). • Supporting coalition-building and community planning efforts.	Yes = 120 (81.1%) No = 22 (14.9%) Blank = 6 (4.1%)	• Addressing dietary habits and choices (e.g., beverage choices in schools). • Expanding partnerships (e.g., PCPs, mobile outlets, schools, teledentistry). • Policy issues such as expanded insurance

			coverage, cost of living (expensive to eat healthy), water fluoridation.
Children	Child abuse and neglect prevention • Supporting home visiting services. • Continuing outreach and education (e.g., parent supports, community education, workforce trainings). • Building a child abuse and neglect data system.	Yes = 123 (83.1%) No = 22 (14.9%) Blank = 3 (2.0%)	• Further engaging parents and families (e.g., addressing parental stress, support services, etc.). • Further training for providers. • Improvement of current CWS infrastructure and CAN data/tracking system. • Allied services such as home visiting and substance use programs. • Need to address economic and policy challenges.
Adolescents	Promoting adolescent annual medical wellness check-ups. • Developing a teen-centered Adolescent Resource Toolkit and incorporating youth voice through focus groups. • Workforce training for youth service providers and community health workers.	Yes = 126 (85.1%) No = 13 (8.8%) Blank = 9 (6.1%)	• Expansion of outreach and programs in the school setting. • Suggestion of related topics such as mental health, resilience, and coping skills. • Suggestions for partnerships with allied services (e.g., teen clinics, rural health, LGBTQ+, etc.).
Children with special health needs	Ensuring children transition smoothly to adult health care • Incorporating transition planning into Children with Special Health Needs programs. • Working with agency partners for community outreach (e.g., through transition fairs).	Yes = 120 (81.1%) No = 18 (12.2%) Blank = 10 (6.8%)	• Expansion of transition planning to other settings (e.g., medical homes, schools). • Increasing education for the child and family. • Continuing to build systems and programs to support and complement

			transition.

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

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

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

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

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

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

Family Health Services Division Programs By Title V Population Health Domains

WOMEN/MATERNAL HEALTH
Family Planning
Hawaii Home Visiting Network*
Parenting Support Program*
Perinatal Support Services
Maternal Mortality Review*
PRAMS*
WIC Services*
Sexual Violence Prevention*

PERINATAL/INFANT HEALTH
Birth Defects Program
Breastfeeding
Child Death Review
Children&Youth w/ Special Needs*
Early Childhood Comp. Systems*
Early Intervention*
Hawaii Home Visiting Network*
Maternal Mortality Review*
Newborn Hearing Screening
Newborn Metabolic Screening
Parenting Support Program*
Perinatal Support Services*
PRAMS*
WIC Services*

CHILD HEALTH
Child Abuse Prevention
Child Death Review
Children&Youth w/ Special Needs*
Early Childhood Comp. Systems*
Early Intervention*
Hawaii Home Visiting Network*
Child Lead Poisoning Prevention
Parenting Support Program*
Sexual Violence Prevention*
WIC Services*

ADOLESCENT HEALTH
Adolescent Program
Child Death Review
Children&Youth w/ Special Needs*
Parenting Support Program*
Sexual Violence*
Teen Pregnancy Prevention

CHILDREN & YOUTH WITH SPECIAL HEALTH CARE NEEDS
Birth Defects Program*
Children and Youth with Special Health Needs Section*
Early Intervention Services*
Newborn Hearing Screening*
Newborn Metabolic Screening*

CROSS-CUTTING OR LIFE COURSE
Critical Access Hospitals
Domestic Violence (DV)Prevention & DV Fatality Review
Genetics Program
Hawaii, Maui, and Kauai District Health Offices
Oral Health Program
Primary Care Uninsured/Under-insured Service Contracts
Primary Care Office
Rural Hospital Subsidy Contracts
State Office of Rural Health
State System Development Initiative
Title V MCH program

Preconception | Prenatal | Early Childhood | Childhood | Adolescence | Adulthood

LIFESPAN

*LISTED IN SEVERAL DOMAINS

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

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

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

**Includes vacant positions.*

FHSD's administration, branches, and programs include:
FAMILY HEALTH SERVICES DIVISION: Matthew Shim, PhD, MPH. Dr. Shim holds degrees in Psychology, Public Health, and a Doctorate in Epidemiology. He has served as Division Chief since 2016.
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH: Patricia Heu, MD, MPH, pediatrician, has served as Branch Chief since 1997.
MATERNAL AND CHILD HEALTH BRANCH: Kimberly Arakaki, MSCP, has served as Branch Chief since 2016, and prior to that was the DOH Case Management and Information Services Branch Chief from 2007. She has nearly 30 years of experience working with individuals with developmental disabilities and their families.
WIC SERVICES BRANCH: Melanie Murakami, MPH, RDN, has been with the Branch since 2000, and has served as WIC Director and Branch Chief since 2018.

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

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

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

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

Quantitative surveys:

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

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

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

Council of State and Territorial Epidemiologists (CSTE) – In 2019, FHSD participated in CSTE's nationwide survey to assess states' MCH service capacity during a time of crisis/disaster. At the time of the survey, two full-time epidemiologists were affiliated with FHSD. They are generally supported by the larger DOH and external partners but may not be routinely activated during preparedness drills and activities. However, this may be reflective of the funding supporting each position (e.g., funding may be specific to evaluation of FHSD programs).

Qualitative interviews:

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

- Current training opportunities within FHSD are either standardized (e.g., HR requirements) or highly specific to the responsibilities and subject matter of staff or units. Current trainings were valuable, but also time-consuming and expensive. Additionally, challenges with dissemination of opportunities, as well as format, were found to limit participation. A few of the standardized trainings emerged as opportunities for coordinated division-wide growth, if redesigned/redeveloped.
- There is a need to build public health competencies at all staff levels. Many employees come from a clinical or service delivery background, often with degrees in social work, psychology, or a related field. While these experiences are valuable, these professionals may be unfamiliar with core public health concepts such as the social determinants of health, research methods, data analytics, and epidemiology. Interviewees also stressed the importance of building strategic and cross-cutting skills, including leadership training opportunities. Several

managers expressed that it can be difficult to gauge leadership skills in the hiring process and challenging to teach these skills on the job. Other identified areas for skills-building included budgeting, project management, policy engagement, data translation, and communication.
- The interviews also revealed some challenges with recruitment into the workforce. For example, there is no clear pathway for recent MPH graduates to enter lower-level positions, which is a barrier for cultivating the next generation of public health professionals.

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

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

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

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

	Women's Health	Infant Health	Child Health	Adolescent Health	Children with Special Health Needs
Programs within Department of Health (not including FHSD and Title V programs)					
Chronic Disease Branch				x	
Developmental Disabilities Division			x		x
EMS and Injury Prevention System Branch		x		x	
Other local government-affiliated organizations					
Department of Education		x	x	x	x
Department of Human Services (e.g., Medicaid program; Office of Youth Services)	x	x	x	x	x
Executive Office on Early Learning (including Early Head Start and Head Start programs)	x	x	x		
Hawaii National Guard's Youth Challenge Academy					
Hawaii State Council on Developmental					x

	Women's Health	Infant Health	Child Health	Adolescent Health	Children with Special Health Needs
Disabilities					
Office of Language Access		x			
University of Hawaii at Manoa – John A. Burns School of Medicine	x	x	x	x	x
University of Hawaii – Maui College			x		
University of Hawaii at Manoa – Office of Public Health Studies	x	x	x	x	x
University of Hawaii at Manoa – School of Nursing and Dental Hygiene	x	x	x		
Healthcare organizations (hospitals, clinics, insurance carriers)					
Adventist Health Castle		x			
AlohaCare Insurance			x		
Bayada Home Care	x	x			
Federally Qualified Health Center network (coordinated by the Hawaii Primary Care Association)	x	x	x	x	x
Hawaii Community Genetics Clinics					x
Hawaii Dental Association			x		
Hawaii Dental Hygiene Association			x		
Hawaii Dental Service			x		
Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH-LEND)					x
Kaiser Permanente		x			x
Kapiolani Medical Center for Women and Children	x	x			
Kona Community Hospital	x	x			
Queen's Medical Center		x			
Shriners Hospital for Children		x			
Tripler Army Medical Center	x	x			
Waianae Coast Comprehensive Health Center		x			
West Hawaii Community Health Center			x		
Wilcox Medical Center		x			
Professional organizations					
American Academy of Pediatrics – Hawaii Chapter	x	x	x	x	x
American College of Obstetricians and Gynecologists – Hawaii Chapter	x	x			
Community-based organizations, non-profits, and networks					
Aging and Disability Resource Center					x
Best Buddies Hawaii					x
Breastfeeding Hawaii	x	x			
Child and Family Services		x			
Children's Community Councils		x	x		x
Coalition for a Drug-Free Hawaii				x	
DentaQuest Foundation			x		
Early Childhood Action Strategy	x	x	x		
Family Hui Hawaii	x	x	x		
Family Support Hawaii	x				
Hawaii Children's Action Network	x	x	x	x	x
Hawaii Community Foundation			x		
Hawaii Health Data Warehouse	x	x	x	x	x
Hawaii Health Survey Committee				x	
Hawaii Maternal and Infant Health Collaborative	x	x	x	x	x

	Women's Health	Infant Health	Child Health	Adolescent Health	Children with Special Health Needs
Hawaii Mothers Milk	x	x			
Hawaii Oral Health Coalition			x		
Hawaii Partnership to Prevent Underage Drinking				x	
Hawaii Project Extension for Community Healthcare Outcomes (ECHO)		x			
Hawaii Public Health Institute	x	x	x		
Hawaii Youth Services Network				x	
Healthy Mothers Healthy Babies	x	x			
Hilopaa Family-to-Family Health Information Center	x	x	x	x	x
Institute for Human Services		x			
Keiki Injury Prevention Coalition		x			
La Leche League	x	x			
Legislative Disability Forums					x
March of Dimes	x	x			
Mental Health America of Hawaii				x	
PATCH (people attentive to children)		x			
Perinatal Action Network	x	x			
Perinatal Nurse Managers Task Force		x			
Prevent Suicide Hawaii Taskforce				x	
Safe Sleep Hawaii		x			
Special Olympics					x
Special Parent Information Network					x
Youth Tobacco Prevention Coalition				x	
National agencies (not including HRSA)					
Centers for Disease Control and Prevention	x		x		
Department of Agriculture	x	x			
National Association for the Education of Young Children		x			
Office of Adolescent Health				x	
US Breastfeeding Coalition	x	x			

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

Identifying priorities and linking to measures

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

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

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

As each priority area and its strategies/activities were confirmed, measures were selected which aligned with the inputs (resources and activities) and desired outcomes. Logic models were developed for each priority area to guide this alignment process (drafted during the 2015-2020 grant cycle and updated during the current NA). The logic model organizes the components of a project including resources, activities, and outcomes/impacts, in addition to showing the interactive relationships among components. *Resources* are the assumptions underlying a program, and the necessary infrastructure

for implementation. *Strategies/Activities* were developed with feedback from stakeholders, and when implemented, result in *Short-Term Outcomes* (including the Strategy Measure). *Longer-Term Outcomes* (including the National Performance Measure and National Outcome Measures) refer to the intended effects of cumulative program components and describe the targeted population and system changes for each program. *Contextual Conditions* refer to considerations such as culture, rurality, health and service gaps, and socioeconomic conditions that must be considered as we work to engage stakeholders and develop/implement the program components.

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

Changed and emerging issues/needs

During the 2015-2020 funding cycle, Hawaii's Title V program included telehealth and children's oral health as priorities. Developing telehealth capacity across Hawaii Title V programs was a state performance measure which achieved substantial success over the last five-year period. Consequently, this priority will not be carried into the 2021-2025 funding cycle. Staff and stakeholders are grateful for the telehealth infrastructure put into place, especially given the recent move to online/virtual activities during the pandemic. Telehealth activities will now be incorporated into the remaining Title V priorities.

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

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

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

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

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,176,627	$1,998,893	$1,989,226	$1,882,488
State Funds	$29,083,184	$24,722,002	$28,414,686	$27,324,746
Local Funds	$0	$0	$0	$0
Other Funds	$75,000	$47,719	$63,078	$0
Program Funds	$16,745,817	$10,892,484	$16,422,876	$11,056,301
SubTotal	$48,080,628	$37,661,098	$46,889,866	$40,263,535
Other Federal Funds	$55,420,856	$44,210,716	$49,970,074	$39,143,194
Total	$103,501,484	$81,871,814	$96,859,940	$79,406,729

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

	2021	
	Budgeted	**Expended**
Federal Allocation	$2,083,027	
State Funds	$31,499,929	
Local Funds	$0	
Other Funds	$0	
Program Funds	$18,439,145	
SubTotal	$52,022,101	
Other Federal Funds	$37,230,305	
Total	$89,252,406	

III.D.1. Expenditures

The Hawaii State Department of Health (DOH), Family Health Services Division (FHSD) promotes and provides 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 300 employees, these services are carried out by the administrative and program 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.

Program Income

As noted earlier, the DOH is the only public health agency in the state. Unlike most states, FHSD must provide all levels of service delivery: direct, enabling, and infrastructure building for all state and counties. As one of the largest Divisions in DOH, FHSD's 3 branches – Maternal and Child Health (MCH), Children with Special Health Needs (CSHN), and Women, Infants & Children (WIC) Services - together addressed this need with a FFY 2019 Program Income amounted to $13.2M. 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 birth certificate fee)
- Domestic Violence & Sexual Assault Special Fund (funded from a percentage of fees generated from birth, marriage and death certificate fees)
- Community Health Centers Special Fund (funded through a portion of cigarette taxes)
- Early Intervention Special Fund (funds received through Medicare, Tricare, and the Random Moments Survey)
- State Agency transfer 'U' fund (funds received from other state agencies, such as the Department of Human Services that contributed to the Child Death Review program) – from FFY 2020 forward this fund will no longer be included in FHSD's budget and is anticipated to phase out of the Tile V application.

Clients Served. Form 5a reports on the number of clients receiving direct or enabling services with Title V and state matching funds. The total served is 38,754, broken out as follows:

Pregnant Women: 939
Infants 1 < 21 Years of Age: 544
Children 1 through 21 Years of Age: 12,824
Children with Special Health Care Needs: 7,442
Others: 24,447

Form 5b estimates FHSD programs using all funding sources reached: 99% of the Pregnant Women, 99% of all Infants < 1 year of age, 18% of Children 1-21 years of age, 19% of Children with Special Health Needs and 4% of Others.

Use of Title V Funds. To support the infrastructure needed to administer FHSD programs statewide in FFY 2019, Title V funded key staff positions (21.15 FTE out of a total of 286.5 FTE) including an epidemiologist, branch research statisticians, MCH and CSHN program managers, a pediatric medical director, nurses, a nutritionist, an audiologist, contract specialists, and general office support staff. These positions are critical to securing, leveraging, and managing FHSD's statewide services, its broad array of funding sources, addressing statewide surveillance needs, developing critical statewide partnerships, improving quality to assure services are family-centered, culturally competent, and community based.

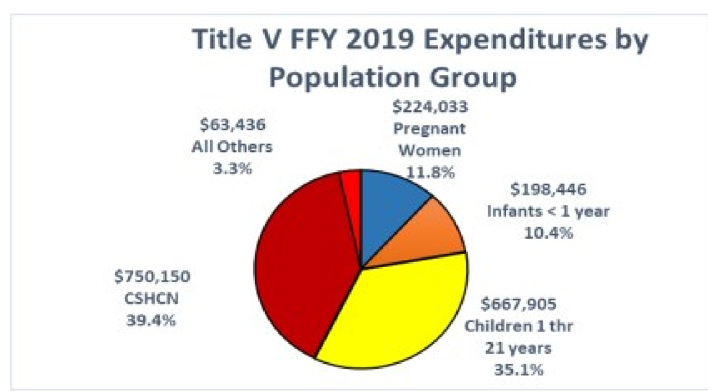
Legislative Requirements Met. The State maintains expenditure and budget documentation for all MCH Block Grant funding allocations for tracking and reporting. Consistent with the requirements in the Title V legislation, expenses are tracked through the state's accounting system, *Datamart*, and carefully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

The Title V legislation requires a minimum of 30% of block grant funds to be used for preventive and primary care services for children and at least another 30% for services for CSHCN. No more than 10% of the grant may be used for administration. Form 2 reports that Hawaii met these requirements for FFY 2019 expenditures. The table below outlines the FFY 2019 budget and expenditures across these categories. Preventive/Primary care for children was 32.9% of FFY 2019 Title V expenditures; while CSHCN received 36.9% of Title V funds in the same year. Hawaii was able to keep administrative costs relatively low (6.1%) because DOH waives all indirect costs for the Title V grant.

Category	FFY 2019 Budgeted		FFY 2019 Expended	
Preventive and Primary Care for Children	$728,721	**30.4%**	$667,905	**32.9%**
Children with Special Health Care Needs	$776,638	**32.4%**	$750,150	**36.9%**
Title V Administrative Costs	$68,095	**2.8%**	$123,538	**6.1%**

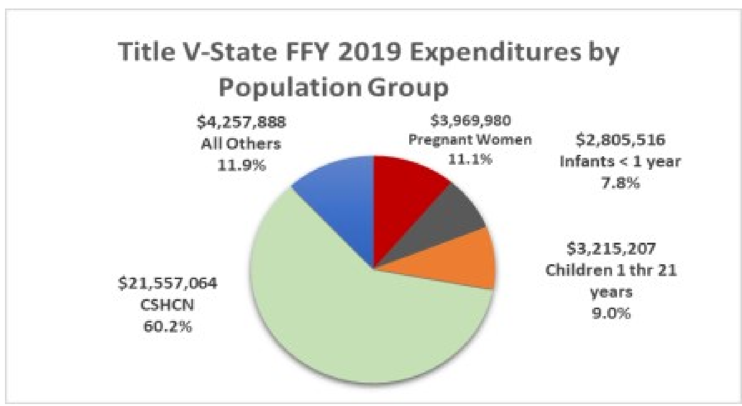
Lastly, the state must meet a maintenance of effort with a state match equal to levels in 1989 ($11,910,549). With the exponential growth of FHSD since 1989, the FFY 2019 state expenditure match of $35.8M far exceeds the match requirement.

Expenditures by Population Group. The chart below shows how the FFY 2019 $2.4M Title V funds were expended to serve the five Title V population groups. The amounts reflect expenditures for Title V funded personnel (21.15 FTE in 2019) to support FHSD programs across the state and $10,000 for the state MCH hotline. No Title V funds were used for direct services. The breakouts confirm Hawaii expended over 39.4% for CSHCN, 35.1% for Children 1 through 21 Years, 10.4% for Infants < 1 year, 11.8% for Pregnant Women and 3.3% for All Others.

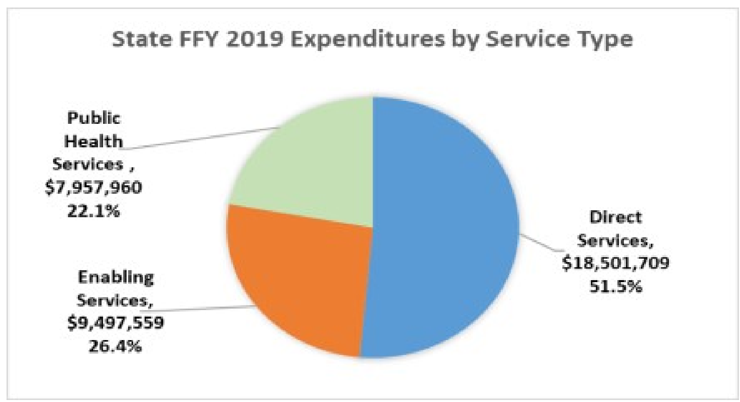


The chart below shows how the FFY 2019 $35.8 state matching funds were expended to serve the five Title V population groups as reported on Form 3a, IB, Non-Federal MCH Block Grant. The amounts reflect costs for both personnel and operating (including contracts for service delivery). Over half of FHSD's state funds were dedicated to serve CSHCN (60.2%). The remaining budget was divided by the remaining four populations groups: All Others

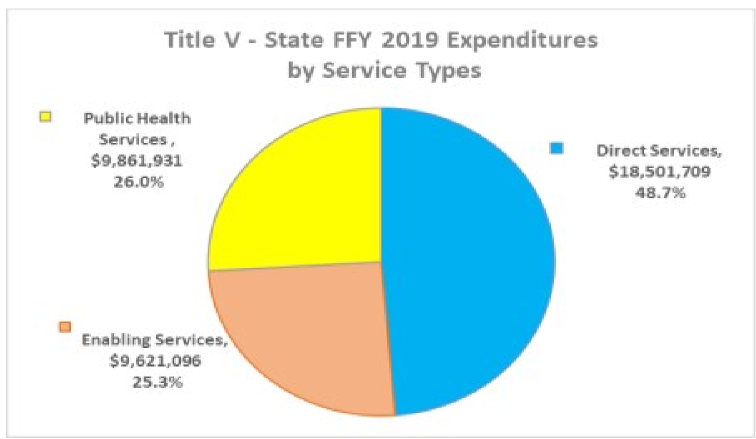
(general adult population/families), pregnant women, children and infants.



The chart below Illustrates how both Title V and State matching funds in FFY 2019 $36M state matching funds were expended by type of service as reported on Form 3b, IIB, Non-Federal MCH Block Grant. The amounts reflect costs for both personnel and operating (including contracts for service delivery). Services for CSHCN made up about half of all FHSD Direct Services. Direct Services made up 51.5% of expenditures of Non-Federal funds. The remaining state expenditures were divided between enabling (26.4%) and public health services (22.1%). Hawaii clearly relied on Title V funding to provide infrastructure support for its MCH programs.



The chart below shows how both Title V and State matching funds in FFY 2019 ($38M) were expended by type of service as reported on Form 3b. Close to half of FHSD's state funds were dedicated to Direct Services (48.7%). The remaining budget was divided by Public Health Services (26.0%) and Enabling Services (25.3%).



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 this list includes programs funded by the Title V-State partnership and other federal grants.

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

Significant Variations - Form 2 and Form 3 (Federal Fiscal Year 2019) – Expenditures

Form 2, Item 1C. Title V Administrative Costs. The amount budgeted in this category for FFY 2019 was $68,095, however the amount actually expended was $123,538, a difference of $55,443. This variance is primarily due to a change in the methodology used to calculate this category. The Administrative Officer V position accounts for 100% of this category's budget/expenditures. In FFY 2019, only a portion of the position contributed to the budget while from FFY 2021 FHSD plans to dedicate 100% of this position's salary and fringe benefits to Title V administrative costs.

Form 2, Item 6. Program Income. The budgeted amount for program income was $13,205,575 but expenditures were only $7,672,215. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and the Domestic Violence and Sexual Assault Special Fund is higher than the revenues being deposited into these accounts. Annual expenditures are roughly aligned with the revenues being deposited and are not aligned with the authorized budget ceilings for these special fund accounts. The legislative authorized budget ceiling will continue to differ from actual expenditures moving forward. Note that this disparity proportionally affects the budgeted vs. expended reporting on Form 2, Items 7 and 8 which both incorporate Program Income into their overall calculations.

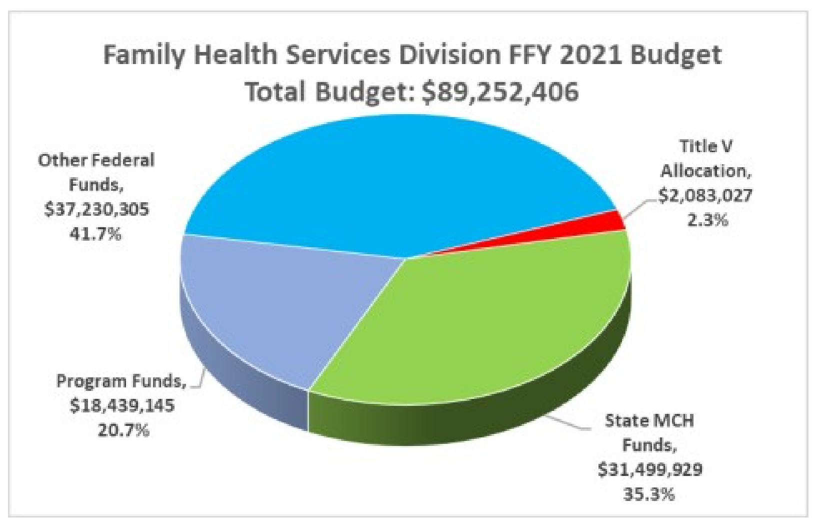
Form 2, Item 10. Other Federal Funds. The amount budgeted for this category in FFY 2019 was $51,294,329 and the amount expended was $38,374,744. The difference between budgeted and expended is primarily due to the Title V budget period not aligning with many of FHSD's federal grant budget periods. Only federal expenditures that fall during the Title V budget period will be reflected in the Title V application where the $51M captures all annual federal funds budgeted. Note that a similar disparity exists between budgeted and expended for the State MCH Budget/Expenditure Grand Total as reported on Form 2, Item 11.

III.D.2. Budget

Every day, the Hawaii State Department of Health (DOH), Family Health Services Division (FHSD) works to improve the health of women, children and families throughout the state. FHSD achieves this work through its Division, Branch, and District Health Offices which consists of 30 programs, nearly 150 service contracts, and in Federal Fiscal Year (FFY) 2021, a $89.3M total State MCH Budget funding 19.3 Title V positions out of a total of 283.0 FTEs.

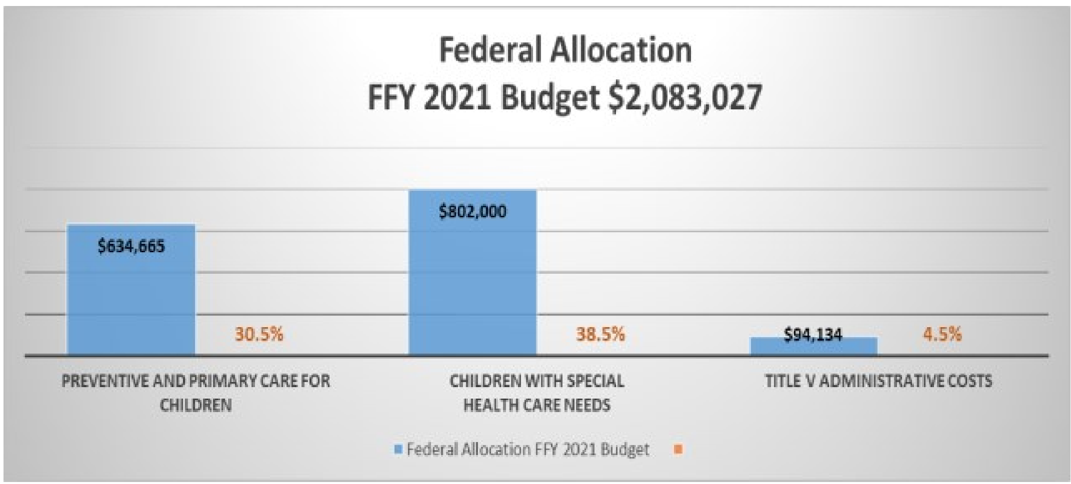
Budget Overview

The chart below provides a quick overview of FHSD's FFY 2021 Budget as reported on Form 2. The $89.2M FFY 2021 budget is comprised of $2,083,027 from Title V; a state match of nearly $50M (which includes Program Income of $18.4M) and Other Federal Funds totaling $37.2M.



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's accounting system, *Datamart*. FHSD will comply with the state annual audit.

FHSD is committed to comply 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 CSHCN; and no more than 10% of the grant may be used for administration. For FFY 2021, Hawaii is allocating $634,665 (30.4%) for Preventive and Primary Care for Children, $802,000 (38.5%) for CSHCN, and $94,134 (4.6%) for Title V Administrative Costs as reported on Form 2, Lines 1. A, B, and C.



Federal Funds. The FFY 2021 Other Federal Funds budgeted includes 21 federal grants totaling $37.2M (excluding Title V). The Title V allocation is $2.1M, roughly 5.6% of all federal funds and 2.3% of the total FHSD budget.

The overall FHSD FFY 2021 federal fund budget decreased by $8.5M (-23%) from FFY 2020 due to a $3.7M decrease of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant, a nearly $3M decrease in the Women, Infants and Children (WIC) grant and from March 31, 2020 HDOH/FHSD Family Planning Program participation as a Title X grantee ended which reduced federal funding by approximately $2M. A list of the FFY 2021 federal grants budgeted by agency can be found on Form 2.

As in years past, FHSD relies heavily on federal funding (44% of total budget). Most grants are used to fund positions which manage and administer federally funded programs. In FFY 2021, consistent with recent trends, most of the federal grant's funding amounts are level which creates budget challenges as program costs increase. Operating and personnel costs for federal grants like Title V, and Primary Care Office (PCO) are stretched very thin from rising operating and personnel costs. For example, consistent increases in collective bargaining agreements for public employees contributes to steady increases in salaries and fringe benefits. The FFY 2020 indirect cost rate (percentage charged of total salary and fringe) was 18.0% and the fringe benefit rate was set at 63.08%. 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 which ensures maximum use of the grant dollars for personnel and operating expenses. FHSD also leverages its funding from other grants to support programs and continues to seek state funds through the budget process. Because costs are rising and funding remains level, programs intentionally postpone filling positions when they are vacated through retirement or attrition as a cost savings measure. 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 led FHSD personnel numbers to shrink from 337.5 FTE in FFY 2018 to a projection of 283.0 FTE or less for FFY 2021.

Finding creative ways to maximize and leverage FHSD federal and state resources will remain a challenge in FFY 2021. While still too early to determine what the extent of state and possibly federal fund restrictions and/or reductions lie ahead, the COVID-19 pandemic crisis crippled Hawaii's and the Nation's economy. The economic fallout is enormous in Hawaii as the state's tourism-based economy came to a complete standstill from March 2020

and unemployment rates per capita skyrocketed and remain among the highest in the nation. This will greatly affect the State's tax revenue which will in turn impact the State's budget moving forward. Restrictions and severe funding cuts are anticipated for the foreseeable future and FHSD's state funded position count and operating budget is anticipated to decrease from the beginning of the state fiscal year 2021 (July 1, 2020).

State Funds. FFY 2021 state funds budget total is $31M. Additional state funds, Program Income, is budgeted at $18.4M in FFY 2021. This is a substantial increase from FFY 2020 attributed to a decision to change the methodology of reporting from revenue driven to legislative appropriation based. This methodology will remain consistent moving forward. Due to COVID-19, the 2021 state budget bill may reduce these numbers, however, it isn't known at this time the specifics of any reductions.

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 provide public health infrastructure services for FHSD's programs. The 19.3 Title V funded FTE positions are critical to securing, leveraging, and managing a broad array of funding sources, addressing statewide surveillance needs, developing critical statewide partnerships, 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 support, epidemiology/data assistance, and technical assistance through collaboration with other FHSD programs.

By leveraging the MCH Block grant funds through Title V funded personnel, FHSD has and will continue to serve and improve the health and well-being of Hawaii's mothers, children (including children with special needs), and their families. The Title V program efforts and outcomes discussed in the State Action Plan and other sections of this application could not be achieved without federal MCH Block Grand funding support. All Division and Branch programs will continue to focus on their targeted service population group(s) through contracts and project agreements. FHSD programs are effectively addressing the needs of those we serve and using all capacities to increase awareness and promote family, community, and partnership engagement activities.

Because the DOH is the only public health agency in the state, the absence of local, city, and county health departments in Hawaii requires a disproportionate amount of infrastructure personnel within FHSD to strategically plan and administer resources statewide. The Title V MCH Block Grant provides a critical source of funding for FHSD infrastructure positions. In FFY 2020, for example, a Title V funded position helped facilitate use of state funds to administer the Child Death Review and Maternal Mortality Review. Title V funded staff also assisted the Lead Poisoning Screening and Prevention program to complete an application for renewed CDC.

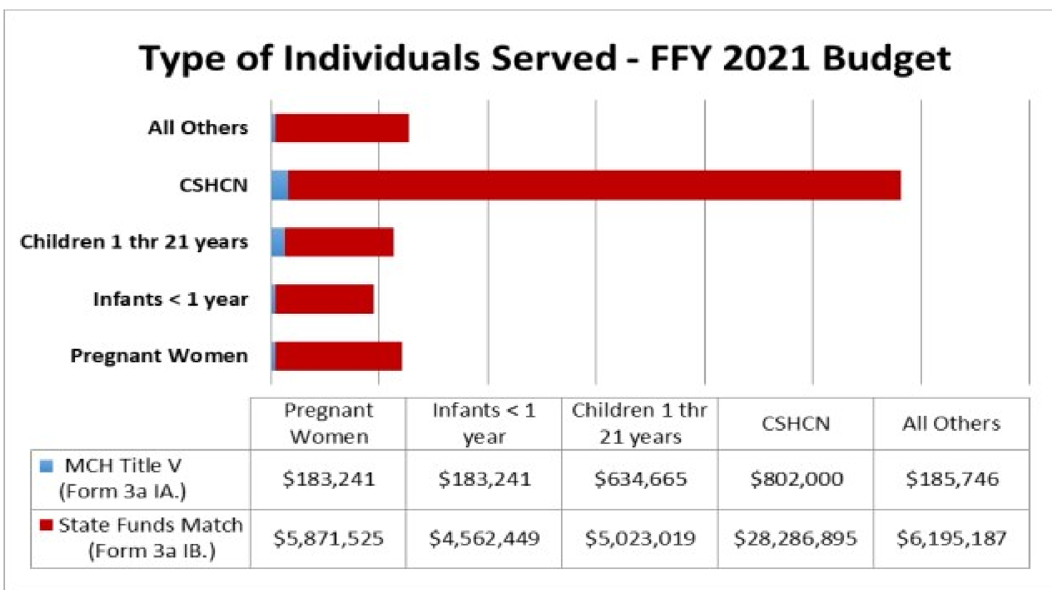
Title V funding is used to support key management positions within FHSD. The CSHN Branch Chief, a pediatric M.D., is 75% funded with Title V and 25% IDEA Part C funding. The Hawaii IDEA Part C Early Intervention Services program is part of the CSHN Branch which also include Newborn Screening, Genetics, Birth Defects, and Lead Poisoning Prevention. Combining funding from both grants allows Hawaii to offer salaries to attract and retain highly qualified professionals that would be challenging to support using only state funds.

The program and staff support for the Title V priorities reflect the diversity in the FHSD budget and the importance of leveraging program funding to support the priorities. FHSD uses both state and federal funding to support the work on the priority issues. The table below summarizes the funding for the program leads dedicated to each Title V priority NPM and SPM. All Title V priorities are also supported with technical assistance for evaluation and planning funded through the State Systems Development Initiative grant.

Title V Priority	Program Lead Funding	Key FHSD Partnerships
Women's Wellness Visits	Women's Health Section (Title V)	Title V – Data/Epi Support Family Planning
Breastfeeding	WIC Services (USDA)	Title V – Data/Epi Support Early Childhood Comp Systems Perinatal Support Services (State)
Safe Sleep	PRAMS (CDC)	Title V – Data/Epi Support Early Childhood Comp Systems Child Death Review (State)
Developmental Screening	Early Childhood Comp Systems (HRSA)	Title V – Data/Epi Support Maui DHO (State) EIS (Part C/State) MIECHV Hi`ilei Developmental Screening (State)
Children's Oral Health	Oral Health Infrastructure grant (CDC)	Title V – Data/Epi Support DOH Developmental Disabilities Dental Program (State)
Child Abuse & Neglect	Community based Child Abuse Prevention Program (ACF)	Title V – Data/Epi Support MIECHV Preventive Health & Health Services Block Grant (CDC) 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 (HRSA)	Title V – Data/Epi Support Rural Health

The 5-year plan narratives describe the program staffing and plans for each priority and their primary sources of funding. Partnerships within FHSD, the DOH, and the community are described in the plan narratives as vital resources to assure program progress.

Form 3a, Budget and Expenditure Details by Types of Individuals Served, FFY 2021 application budgeted, demonstrates the federal and non-federal FFY 2021 application budget. The chart below shows the state and federal breakout of planned resource allocation for each of the five population health domains. The 2021 Title V Federal Allocation budget of approximately $2M and a State Match of $49.9M create a Federal-State Title V Partnership budget of approximately $51.9M. The combined resources form the funding base for strategic collaborations with other federal grant funds, 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, local hospitals, private and non-profit providers in urban and rural communities throughout the state. The funds play a key role in building statewide capacity to assure the availability of services for all of Hawaii's families.



FHSD will continue efforts to ensure statewide infrastructure for needs assessment, surveillance, planning, evaluation, systems/policy development, training, and technical assistance to assure quality of care into the FFY 2021 budget year.

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

Form 2, Item 1C. Title V Administrative Costs. The amount budgeted for this category in FFY 2020 application was $72,424, and the amount budgeted for this category in FFY 2021 application is $94,134. The increase of $21,710 is due to FHSD budgeting 100% of the Administrative Officer V position rather than a percentage of the position as in FFY20.

Form 2, Item 5. Other Funds. The category "Other Funds" decreased 100% from $203,441 in the FFY 2020 application to $0 in the FFY 2021 application. In years past, the practice was to include these funds in the "Program Income" category but technically, the funds represent an annual interdepartmental funds transfer from the Department of Human Services (DHS). The funds were completely expended and FHSD does not anticipate further funding transfers in FFY 2021 moving forward.

Form 2, Item 6. Program Income. The amount budgeted on the FFY 2020 application was $13,584,510 but in FFY 2021 FHSD will budget $18,439,145. The notable difference is attributed to a change in the methodology of reporting this category from revenue driven to legislative appropriation based. This change in methodology will remain consistent moving forward. The $4,854,635 difference will also proportionately affect Form 2, Item 7, Total State Match.

Form 2, Item 10. Other Federal Funds. The "Other Federal Funds" category decreased by about 22% in FFY 2021 from what was budgeted in FFY 2020. The decrease is largely due to a decrease in MIECHV, WIC funding and no longer participating as a Title X grantee.

Form 3a, IA. 1 and 2. Pregnant Women and Infants < 1 year. Both categories are budgeted lower in FFY 2021 than on the FFY 2020 application. The reason for the budget decrease in FFY 2021 is primarily due to the vacant Physician and CDC Epidemiology Assignee positions which contribute to the allocation of both referenced categories. FHSD anticipates holding these positions vacant in FFY 2021 due to funding shortages.

Form 3a, IB. Federal State MCHB Block Grant Partnership Total. The amount budgeted in FFY 2021 is $4,635,406 more than FFY 2020. The increase is attributed to the change in methodology in calculating Program Income (see Form 2, item 5) which contributes to this category.

Form 3b, IIB. 1. Direct Services. The FFY 2021 budget for Non-Federal MCH Block Grant direct services is nearly $1M more than budgeted in FFY 2020. The increase, again, is attributed to the change in methodology of calculating program income allocated to direct services.

III.E. Five-Year State Action Plan

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

State: Hawaii

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

In Hawaii, the Family Health Services Division (FHSD) serves as state Title V MCH agency. FHSD is committed to improving the health of women, infants, children including those with special health care 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.

The FHSD programs work to ensure statewide infrastructure for data collection, needs assessment, surveillance, planning and evaluation, systems and policy development, and the provision of workforce training and technical assistance to assure quality of care.

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

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

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

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

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

- Children & Youth with Special Health Needs Section: Children with Special Health Needs, Early Childhood, Hiʻilei Developmental Screening, and Childhood Lead Poisoning Prevention Programs.
- Genomics Section: Genetics, Birth Defects, Newborn Hearing Screening, Newborn Metabolic Screening Programs.
- Early Intervention Section (EIS), with mandated early intervention services provided through 3 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 $29M 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, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. The WIC Branch of the Family Health Services Division administers the USDA FNS WIC program for the State of Hawaii.

III.E.2.b. Supportive Administrative Systems and Processes

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

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

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

As part of the 2020 needs assessment Hawaii reviewed the results from the Hawaii State Department of Health (DOH) national Public Health Workforce survey (PH WINS). The 2017 survey results, conducted nationally by the Association of State and Territorial Health Officials (ASTHO) and the de Beaumont Foundation, were released in 2019. The survey helps public health agencies understand workforce strengths, gaps and opportunities to improve skills, training and employee engagement.

Similar to national findings, Hawaii public health workers have high job satisfaction (80%), low pay satisfaction (50%), and slightly better than average satisfaction with the organization (65%). Nearly, 60% of workers report intent to leave with roughly half those due to retirement. The top three areas for employee engagement reflect the strong mission-driven purpose of public health workers:

- Recognizing the importance of the job (94%)
- Willingness to do the best work possible (93%)
- Understanding how the work relates to the department's larger goals (88%)

The top three opportunities to improve employee engagement were:

- Improving communication between senior leadership and workers (43%)
- Assessing training needs (42%)
- Encouraging and rewarding creativity and innovation (40%)

There were five areas that emerged for training needs:

- Systems and strategic thinking (54%)
- Budget and financial management (52%)
- Developing a vision for community health (48%)
- Change management (46%)
- Cross-sector partnerships (42%)

Overall, recommendations for DOH improvement were:

- succession-planning
- assessment and investment in training
- workplace policies/practices that support employee engagement and organizational satisfaction

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

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

to COVID.

FHSD uses Title V as an opportunity to build public health capacity for program staff. In 2015, FHSD formalized a Title V Leadership Committee to guide and support the Title V reporting process. The Committee is comprised of program staff leading efforts for the Title V NPM/SPM, FHSD management, neighbor island nurses, Division epidemiology/data staff, and a representative from Hilopaa Family to Family Information Center (HF2FIC) and MCH LEND faculty. HF2FIC's participation ensures family perspectives are considered in decisions regarding Title V planning. MCH LEND's participation allows Title V to leverage training resources/faculty from the Hawaii LEND program.

The Committee serves as a unique platform to promote Division wide collaboration. The meetings are used to share information, resources, identify needs/problems, develop and implement new ideas and innovations. There are few forums to support this type of cross-program discussion.

In FY 2018, FHSD partnered with Dr. Jeanelle Sugimoto-Matsuda, to provide TA for program staff to address the new Title V guidance focus on planning, evidence-based practices, and evaluation. Dr. Sugimoto-Matsuda is a faculty member with the University of Hawaii, Office of Public Health Studies. Trained in public health and translational research, she brings formal background in assessment and evaluation methods. With this TA, FHSD priority leaders developed logic models for each national and state priority area. Through the logic models staff were able to review program progress, achievement of short- and long-term outcomes (evidence-based strategy measures), and align strategies with Title V performance and outcome measures.

The logic models are particularly helpful with refining and updating the plan strategies and strategy measures based on progress made. The Georgetown University Evidence Center also used the logic models to assist with evaluation of Hawaii strategy measures. The logic models are included in the 5-Year state plan narratives and the Supporting Documents. The logic models were used to collect input on Title V activities as part of the needs assessment.

Through individual meetings with program staff throughout the year, Dr. Sugimoto-Matsuda provided valuable TA to strengthen staff public health knowledge and skills. SSDI grant funds supported Dr. Sugimoto-Matsuda's TA services.

The Title V Review exemplifies the type of innovation that typically emerges from the Title V Planning Committee. As part of Hawaii's grant presentation, a short video is used to succinctly present the Hawaii Title V priorities, accomplishments, challenges and plans. The video is well received at the Reviews and was also highlighted in a 2018 AMCHP conference panel presentation on communications. Other states continue to contact Hawaii to access the latest video and use the same video software for their Title V reviews.

Title V continues to use national MCH and AMCHP professional development resources including the MCH Workforce Development Center (WDC). Staff participated in two WDC cohorts to date. Hawaii participated in the Spring 2019 WDC cohort focusing on building transition efforts. The Hawaii cohort team provided state-funded CSHN staff access to travel and TA opportunities largely reserved for federally-funded grant staff. The team also used the opportunity to establish collaboration between the Hawaii CSHN and adolescent health programs.

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

Another workforce development effort supported by FSHD is the Hawaii Public Health Training Hui (HPHTH)

steering committee. The HPHTH is a group of individuals and organizations established to provide statewide leadership, coordination, and collaboration to meet identified common public health training and TA needs. FHSD's Rural Health coordinator serves on the HPHTH steering committee that provides general oversight and direction for the annual training series. Training topics are based on surveys disseminated online to employees in both the public and private sectors and guidance from the Western Region Public Health Training Center which funds the Hui. In 2019, the HPHTH completed seven online public health trainings on Advanced Care Planning, Opioid Treatment and use in Hawaii, Vaping 101, Native Hawaiian Health, Professional Ethics Guiding Dementia Care, and Getting Ahead of Holiday Stress. Training sessions are recorded and posted on the HPHTH website https://www.hiphi.org/phth/.

FHSD programs also support training for the MCH workforce statewide. Several federal grants include workforce development as a key strategy/activity including:

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

Programs also conduct presentations about health topics and Title V services. Examples include:

- Genetics offers webinars on current issues in genetics to providers
- The Child Abuse and Neglect (CAN) Prevention program conducts presentations on Adverse Childhood Experiences, Trauma-Informed Care, Protective Factors to prevent CAN
- WIC staff conducted breastfeeding training seminars to community providers
- Adolescent Health partners with community health workers and youth service providers to promote healthy youth development and adolescent wellness visits

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

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

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

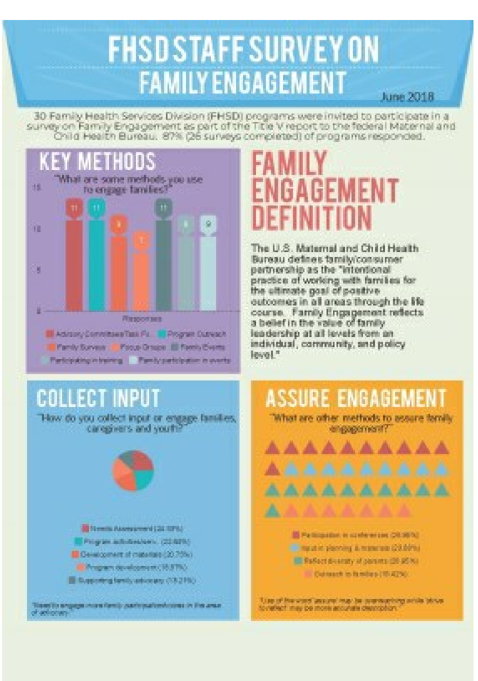
Hawaii remains committed to increase engagement of families across Title V programs. In this complex and evolving health care environment, FHSD recognizes the importance of parental/consumer involvement and hopes to build Title V staff and program capacity in this area.

In the spring of 2018, FHSD convened a family engagement (FE) workgroup to identify potential strategies to assess and support integration of families into Title V programs. Participants in the group included a few Title V staff (CSHN and Early Childhood programs) and two key partners:

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

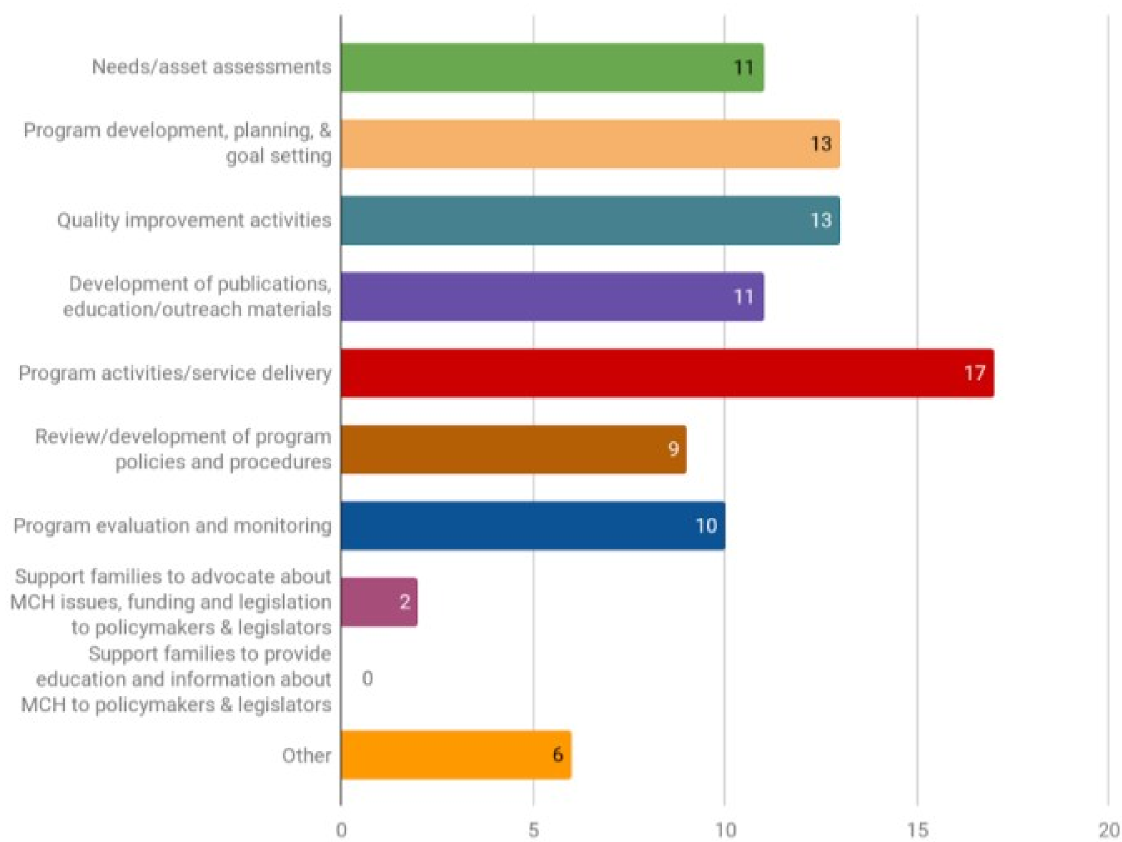
The workgroup developed an initial FE survey of Title V programs to:

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



HCAN conducted the survey and analyzed results. FHSD reported the findings to staff through a two-page infographic fact sheet. In Spring 2019 a follow-up program survey was fielded to develop outreach materials to inform families about partnership opportunities and to identify specific ongoing family engagement support needed across the Title V programs (i.e. number of families needed, types of families, period of time required, and description of activities). HCAN was contracted to conduct the survey. Key findings are presented next.

FHSD programs were asked about the types of input collected or information provided for families, caregivers, and youth. The three most collected type of input or information were to inform families about program activities/service delivery (17), followed by program development, planning and goal setting (13), and quality improvement activities (13). The areas programs are least likely to collect family information concerned policy development and supporting families to advocate for MCH programs and concerns.



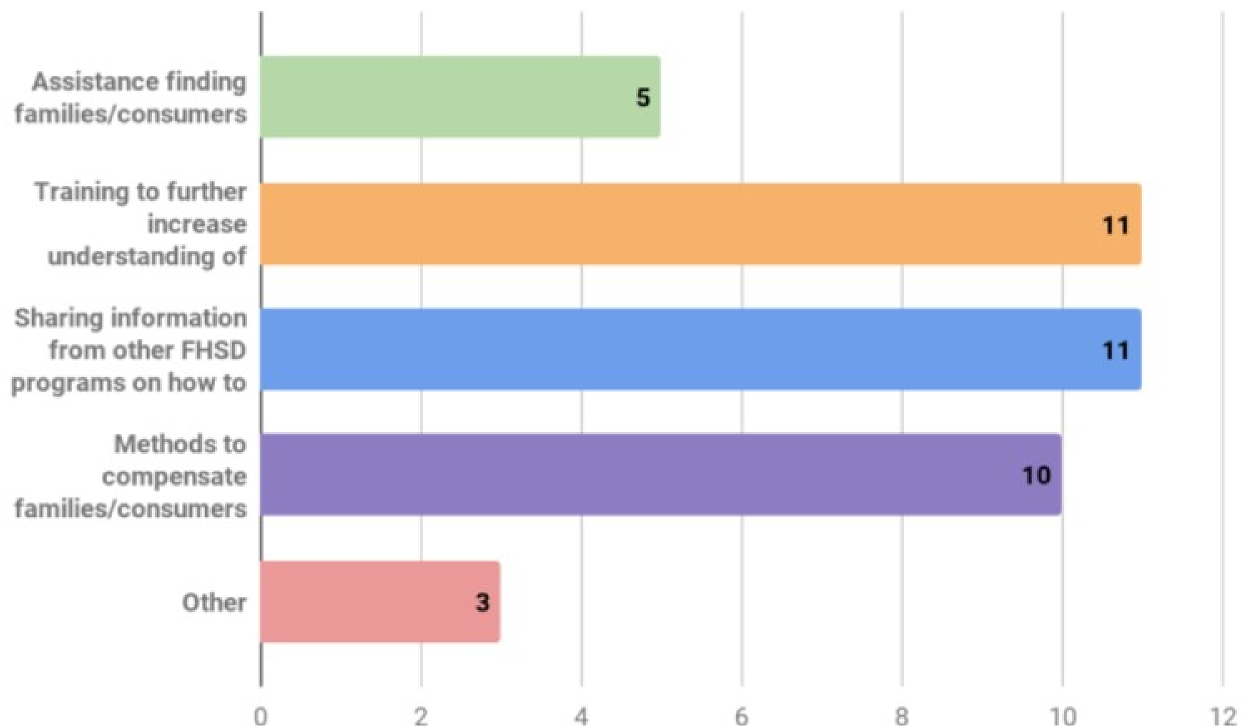
FHSD staff were asked about opportunities for parent, family or community to volunteer. The areas of opportunities identified were 1) advisory committees or task forces, 2) program outreach efforts, 3) family surveys, 4) family events, and 5) participation in program activities with staff.

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

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

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

- sharing information from other FHSD programs on engaging families (11)
- training in further increasing the understanding of family engagement (11)
- methods to compensate families/consumer for their time (10)



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

The FE workgroup will reconvene to follow-up on the assessment results.

Parent Leadership Training Institute (PLTI) Hawaii

FHSD continues to provide technical assistance and financial support to the Parent Leadership Training Institute (PLTI) Hawaii, an evidence-based parent leadership curriculum which is now administered by HCAN. FHSD also serves on the PLTI advisory board.

PLTI Hawaii Cohort #4 launched in 2019 on Oahu Island. Cohorts were offered on Maui Island and a new cohort is planned for Hawaii Island that will be conducted remotely (vs. in person). 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.

PLTI Hawaii alumni continue to remain active and serve as mentors for new cohorts. The alumni group convenes in-person twice a year and communicates via social media. HCAN recently provided opportunities for the alumni to use their new skills by participating on agency boards/commissions, and providing testimony on legislative bills. HCAN is working with FHSD to integrate graduates into Title V programs. Information about PLTI Hawaii is available on the website http://www.hawaii-can.org/plti.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The primary purpose of 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 key MCH datasets identified in the SSDI grant are used for surveillance, needs assessment, planning, public education, and evaluation. The table below shows the accessibility of each dataset by the Hawaii Title V programs as of FY 2019.

Data Sources	State Has Consistent Annual Access to Data Source	State Has Direct Access to an Electronic Database	State Has Consistent Annual and Direct Electronic Access to Data Source	Describe Periodicity (if available more often than annually; does not need to be direct)	Indicate Lag Length for Most Timely Data Available in Number of Months	Data Source is Linked to Vital Records Birth
1. Vital Records Birth	Yes	No	No	Annual	9	N/A
2. Vital Records Death	Yes	No	No	Annual	9	Yes
3. Medicaid	No	No	No	Never	-	No
4. WIC	Yes	No	No	Annually	6	No
5. Newborn Bloodspot Screening	Yes	Yes	Yes	Quarterly	3	No
6. Newborn Hearing Screening	Yes	Yes	Yes	Quarterly	3	No
7. Hospital Discharge	No	No	No	Never	-	No
8. PRAMS	Yes	Yes	Yes	Annual	24	N/A

The change to the table from last year is Hawaii Title V's direct access to WIC data. 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.

Hawaii used its SSDI funds to support the work of the Hawaii PRAMS program in additional to meeting data requirements for the Title V needs assessment and annual report. SSDI funding is critical to sustain PRAMS operations and staffing. The total annual costs of the Hawaii PRAMS Program increased significantly, while the Centers for Disease Control and Prevention (CDC) PRAMS funding continues to decline. In FY 2019, FHSD reorganized the PRAMS program to contract for operational services and reduce personnel costs. As of April 2019, SSDI funds are no longer used to support PRAMS.

In 2017, enforcement of a Hawaii Revised Statutes law related to data sharing policies for the Hawaii vital records office severely limited and stopped data sharing from the Hawaii Vital Records office for PRAMS. During the 2018 legislative session, FHSD worked with the Office of Health Status Monitoring to pass legislation to allow department of health employees access to vital records data. Since July 2018 DOH employees may request and receive individual record level vital statistics data after approval from the Department of Health (DOH) Institutional Review Committee.

The restricted access to vital statistic data resulted in temporary suspension of Hawaii PRAMS program data collection which relies on birth records to draw its monthly sample. With the law change, Hawaii PRAMS data collection resumed in December 2018. In February 2019, the Institution Research Committee and the Director of Health approved FHSD's ongoing access to birth, death, and fetal death records.

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. 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.

At this time Hawaii is not seeking to establish linkage between the key MCH datasets and vital statistics given the recent restrictions to vital statistic data. Newborn screening data was linked to vital statistics in the past and may explore linkage again when feasible. Hawaii SSDI linkage activities are focused instead 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.

SSDI data activity is limited due to the departure of the Hawaii program's two epidemiologists. Dr. Don Hayes, MPH, M.D., the CDC MCH Epidemiology Assignee accepted a position at CDC Atlanta and Dr. Tiana Garrett-Cherry, PhD, MPH relocated back to Virginia. Hawaii continued to recruit for the position vacancies but was unsuccessful to date. FHSD is working to contract with Dr. Garrett-Cherry to provide epidemiology services to complete Title V needs assessment data reporting and development of data products/reports.

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

In 2015, Hawaii switched to a federally run health exchange, Healthcare.gov, after difficulties sustaining the Hawaii-based exchange. Two insurers offered plans in the Hawaii exchange in 2017: Kaiser Permanente, and Hawaii Medical Service Association (HMSA), the Blue Cross, Blue Shield affiliate. Hawaii's enrollment numbers for private plans offered through the exchange remains relatively small. In 2017, 18,938 people enrolled in private plans through the exchange during open enrollment, which ended January 31st. This was a 30% increase over the previous year, when 14,564 Hawaii residents enrolled. Across all states that use HealthCare.gov, there was an average *decrease* in enrollment for 2017, making Hawaii's enrollment increase significant.

The Title V agency continues to work on advancing the implementation of the Affordable Care Act (ACA) in Hawaii. Most Hawaii Title V programs that provide direct and enabling services encouraged families and individuals served to enroll for health insurance through the federally run exchange.

The Title V agency's role in ACA is focused on working with stakeholders (including Medicaid) to promote expanded preventive benefits under ACA among consumers and service providers and assure continued access to care.

The state expanded Medicaid under the ACA. Total net enrollment in Hawaii's Medicaid program grew by over 50,000 people from the fall of 2013 through 2018—an 18.4% increase.

Hawaii's uninsured rate has long been lower than the U.S. average, due to the Hawaii Prepaid Health Care Act. Enacted in 1974, the Act requires employers to provide a group health plan for employees working at least 20 hours a week for at least four straight weeks and earn a minimum of $542/month. The law also mandates a generous set of benefits that must be provided.

- Hawaii's Medicaid eligibility levels for children are much higher than the national average and about average for pregnant women and parents. Children ages 0-18 qualify with family income levels up to 308 of the federal poverty level (FPL)
- Pregnant women qualify with family income up to 191 percent of FPL
- Parents and other adults qualify with family income up to 138 percent of FPL.

Hawaii also uses Medicaid funds to help cover premium costs for Hawaii residents who are not U.S. citizens but who are citizens of states that are part of the Compact of Free Association (COFA) with the U.S. There are roughly 3,500 COFA Hawaii residents who purchase coverage in the Hawaii exchange with the assistance of Medicaid funding.[1]

Hawaii lawmakers passed Act 111 (2018) to ensure that the following ACA benefits, which may not otherwise be available under the State's Prepaid Health Care Act, remain available under Hawaii law:

- Extending dependent coverage for adult children until the children turn twenty-six years of age
- Prohibiting health insurance entities from imposing a preexisting condition exclusion
- Prohibiting health insurance entities from using an individual's gender to determine premiums or contributions

Act 55 (2018) is another critical policy passed that will improve Hawaii's healthcare system. This Act establishes a new Health Analytics Program in the state Medicaid Office and allows the Medicaid program to maintain an All Payers Claims Database (APCD). The APCD is a joint initiative started in 2016 by the DOH, the Office of Enterprise Technology Services, the Department of Human Services, the State Health Planning and Development Agency, the Hawaii Employee-Union Health Benefits Trust Fund, the Department of Commerce and Consumer Affairs Insurance Division, the Department of Budget and Finance, and the University of Hawaii. The database will house information from insurers contracted to provide health benefits financed by the State, primarily health care claims for public

employee unions and Medicaid beneficiaries. Act 55 creates the dedicated health analytics capacity needed to analyze the data to improve transparency in the healthcare sector and improve understanding of healthcare costs, quality, population health conditions, and healthcare disparities.

As part of the Department of Human Services (DHS) health transformation efforts Ohana Nui (ON), the state Medicaid program ('QUEST') released a new waiver application/plan for public review and input: the Hawaii Ohana Nui Project Expansion (HOPE) program. The HOPE plan is a five-year initiative to develop and implement a roadmap to achieve the vision of healthy families and healthy communities. To accomplish this overall goal, it was necessary to align government agencies and funding around a common framework: a multigenerational, culturally appropriate approach that invests in children and families over the life cycle to nurture well-being, and improve individual and population health outcomes. In vison and purpose, the HOPE plan mirrors the DOH strategic plan. The following guiding principles describe the overarching framework that will be used to develop a transformative healthcare system that focuses on healthy families and healthy communities:

- Assuring continued access to health insurance and health care
- 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

FHSD is aligning Title V goals and objectives with the Medicaid program around this initiative. FHSD will continue to explore opportunities for collaboration and partnerships around the four strategic areas and three foundational building blocks. Examples of Title V partnerships activities in 2019 include:

<u>Agreements</u>

- CSHNB/Early Intervention Services (EIS) worked with DHS/Med-QUEST Division (MQD) to amend/update the DHS-DOH MOA related to Medicaid payment for early intervention (EI) services
    - Amendments included telehealth coding
    - The MOA covers the period from July 1, 2018 through December 31, 2020
- CSHNB/EIS collaborated with DHS/MQD on guidelines and role delineation for collaboration between EIS and QUEST Integration (QI) health plans
    - A 3/3/17 DHS 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 the QI health plan Service Coordinator
- DHS/MQD clarified in its 5/31/17 memo that EIS may provide Intensive Behavioral Therapy (IBT) services to

EI Medicaid children and will transition EI Medicaid children to QI health plans to cover Applied Behavior Analysis (ABA) services for Autism Spectrum Disorder (ASD)
    - An EI Care Coordinator and QI health plan Service Coordinator will collaborate on the transition

Activities

- In 2017, MQD issued two provider memos supporting best practices promoted by the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the DOH Strategic Plan
    - Memo # QI-1613 supports the One Key Question® (OKQ) screening approach, Long Acting Reversible Contraception (LARC), and expanded access to contraception
    - Memo QI-1612 supports prenatal Screening, Brief Intervention and Referral to Treatment (SBIRT) pilot project requiring training and reimbursements for participating obstetricians. MQD is now assisting with evaluation of the policies
- FHSD requests to DHS/MQD for data for Title V annual report/application
- FHSD participates as a member of the EPSDT Advisory Committee
- With the inclusion of the Project ECHO telehealth program in the HOPE plan, several Medicaid plans invested funding to sustain and expand the telehealth curriculum offered to rural health providers
    - In FY 2019 a new training series on pediatric health issues was developed with this new funding for implementation in 2020
    - The project is supported by the FHSD Rural Health office and State Rural Health Association

Opportunities

- Medicaid completed a cost analysis to reinstate adult preventive dental benefits
- 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
- Medicaid payment for childhood lead poisoning prevention activities such as follow-up of elevated blood lead levels
    - Two states are using Medicaid funding for the state childhood lead funding (http://www.astho.org/Programs/Environmental-Health/Built-and-Synthetic-Environment/Healthy-Communities/State-Stories--Medicaid-Reimbursement-for-Childhood-Lead-Poisoning-Services)
    - Texas has Medicaid reimbursement for childhood blood lead surveillance, data management, case coordination, provider and parent education and environmental lead investigation
- A new Title V - Title XIX agreement is being developed with the State's Medicaid agency (DHS/MQD)
    - The last agreement was dated 1995
    - A draft is attached in section IV

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[1] https://www.healthinsurance.org/hawaii-medicaid/

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

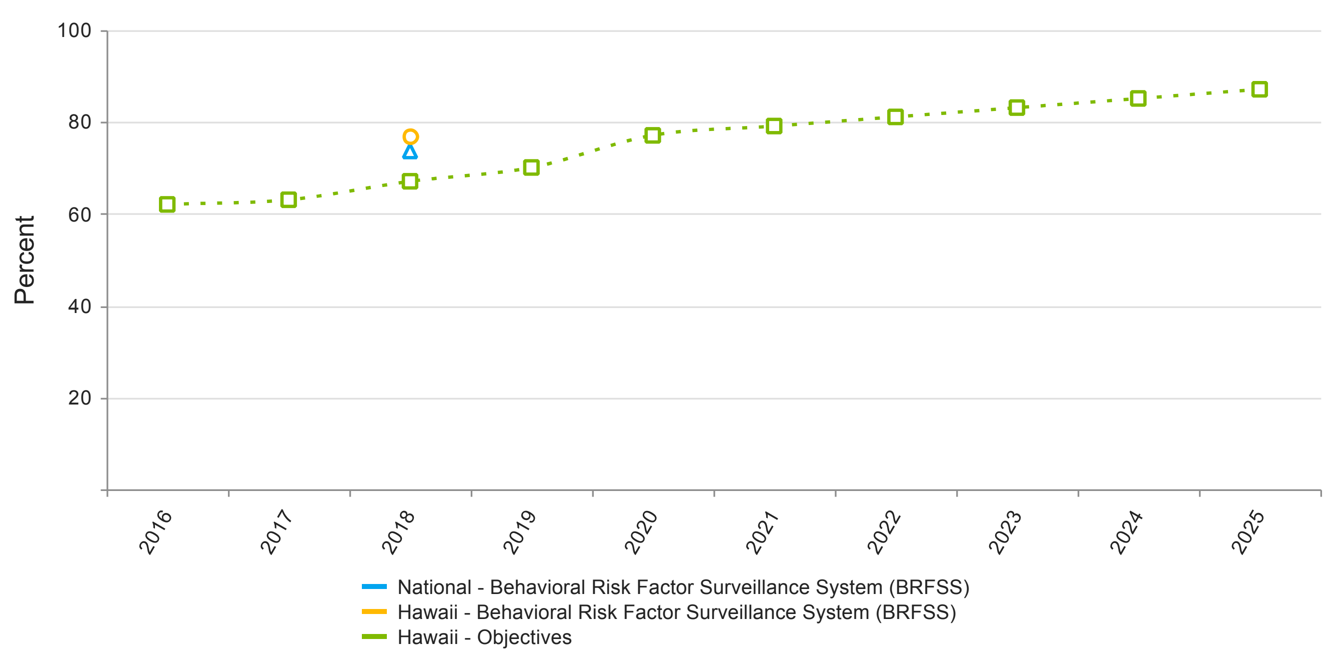
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2017	82.6	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	13.4	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	8.3 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	10.3 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	28.5 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	6.3	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	5.4	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	3.8	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.6	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	222.6	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	8.7 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2017	2.2	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	17.2	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	9.0 %	NPM 1

National Performance Measures

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



Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	62	63	67	70
Annual Indicator	63.0	66.7	69.4	76.6
Numerator	152,559	161,334	167,372	184,106
Denominator	242,088	241,941	241,254	240,287
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	77.0	79.0	81.0	83.0	85.0	87.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	**Active**

State Provided Data

	2016	2017	2018	2019
Annual Objective		34	31	31
Annual Indicator	32.7	31.8	31.9	30.9
Numerator	3,020	2,851	2,776	2,661
Denominator	9,237	8,975	8,698	8,599
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Provisional	Provisional	Provisional

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	31.0	31.0	31.0	32.0	32.0	33.0

State Action Plan Table

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

Priority Need

Promote reproductive life planning

NPM

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

Objectives

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

Strategies

Promote women's wellness through systems building efforts

Promote pre/inter-conception health care visits

Promote reproductive life planning

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

NOMs

- NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
- NOM 3 - Maternal mortality rate per 100,000 live births
- NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
- NOM 5 - Percent of preterm births (<37 weeks)
- NOM 6 - Percent of early term births (37, 38 weeks)
- NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
- NOM 9.1 - Infant mortality rate per 1,000 live births
- NOM 9.2 - Neonatal mortality rate per 1,000 live births
- NOM 9.3 - Post neonatal mortality rate per 1,000 live births
- NOM 9.4 - Preterm-related mortality rate per 100,000 live births
- NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy
- NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births
- 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

2016-2020: National Performance Measures

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

Introduction: Preventive Medical Visit

For the Women/Maternal Health domain, Hawaii selected NPM 1 Well-Women Visit based on the results of the 2015 five-year needs assessment. The 2020 Title V state objective was set to increase the number of women who have a preventive medical visit to 72.0%. The FY 2019 indicator showed 76.6% of women in Hawaii received a preventive medical visit, which met the 2019 state objective of 70.0% and the national estimate of 73.6% (2018 Behavior Risk Factor Surveillance System). The survey question used for this measure was changed in the survey and the 2019 data is not comparable to previous years. Based on the 2019 data and in consultation with program staff, the state objectives from 2020-2025 were updated to reflect an annual increase of 2 percentage points. There were no significant differences in reported subgroups by race/ethnicity, maternal age, household income, health insurance, or marital status based on 2018 data.

The women's annual wellness visit provides an important opportunity to receive recommended clinical preventive services (including screening, counseling, immunization) which can lead to appropriate identification, treatment and prevention of disease to optimize the health of women.

The annual well woman visit is endorsed by the American College of Obstetricians and Gynecologists (ACOG). ACOG is leading the *Women's Preventive Health Initiative*, a collaborative effort between several national organizations to develop and disseminate recommendations for women's healthcare across the life course.

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

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

- Promoting women's wellness visits through systems building;
- Promote pre- and interconception health care visits; and
- Promote reproductive life planning.

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

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

The two approaches were adopted from the MCH Bureau Infant Mortality Collaborative Innovation and Improvement Network (CoIIN).
Updates on the strategy activities for this NPM are discussed below.

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

This strategy is focused on creating statewide collaboration and coordination around the importance of women's

wellness. The topic is integrated into several state plans and policies that promote partnerships across systems of care. Women's health and wellness are reflected as priorities in four major state plans and collaboratives:

- The Hawaii Early Childhood State Plan,
- The Early Childhood Action Strategy Plans,
- The Department of Health (DOH) Strategic Plan, and
- The HMIHC Strategic Plan.

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

Early Childhood State Plan, 2019-2024 (https://earlylearning.hawaii.gov/wp-content/uploads/2019/01/Hawaii-Early-Childhood-State-Plan-Comprehensive.pdf)

The Executive Office on Early Learning (EOEL) spearheaded the development of an early childhood state plan focusing on programs and services in state departments and public agencies. The comprehensive plan reflects the state's commitment to the children and families of Hawaii with specific measures to monitor progress. The plan focuses on five Building Blocks to support early childhood:

1. Child and Family Health, Safety, and Well-being;
2. Family Partnerships and Support;
3. Foundations for Early Learning;
4. A Well-Prepared, Well-Supported Workforce; and
5. Coordination of the Early Childhood System.

Originally, maternal and infant health was a separate building block but was combined with Child and Family Health, Safety, and Well-being in recognition that the overall foundations for early learning begin with access to quality healthcare, starting with prenatal care and women's health. Women's health activities include promoting preventive screenings for risk factors and assuring access to a medical home.

Early Childhood Action Strategy (ECAS)

The ECAS was originally launched in the EOEL and has become an independent non-profit that continues to focus on early childhood, pre-kindergarten and child development programs. The initiative is a research-based, public-private collaborative comprised of over 100 professionals supporting child health, safety, development and learning in settings where young children are located such as child care settings (home-based, center-based, family child care) and family child interaction learning programs. There are six cross-disciplinary focus areas:

- Healthy and Welcomed Births
- Safe and Nurturing Families
- On-Track Health and Development
- Equitable Access to Programs and Services
- High-Quality Early Learning Programs
- School Readiness for Successful Transitions

HMIHC leads the ECAS Healthy and Welcomed Births focus area.

Department of Health Strategic Plan: *Investing in Healthy Babies & Families,* (https://health.hawaii.gov/opppd/files/2013/04/Hawaii-Department-of-Health-Strategic-Plan-2015-2018-081616.pdf)

One of the three pillars of the current DOH Strategic Plan focuses on "Investing in Healthy Babies and Families." Women's reproductive health planning and health status during pregnancy are integral components of the plan. The evidenced-based strategies used to optimize women's health and assure healthy birth outcomes include using OKQ to promote planned pregnancies and screenings.

Hawaii Maternal and Infant Health Collaborative (HMIHC)
The HMIHC is a multidisciplinary collaborative focused on improving birth outcomes, reducing infant mortality, and promoting intended pregnancies. HMIHC was established through a 2013 National Governors Association Learning Network technical assistance (TA) award to improve birth outcomes. The TA application was submitted by Title V and the Hawaii March of Dimes (MOD) supported a series of planning sessions with stakeholders including the ECAS on "Healthy and Welcomed Births."

The HMIHC developed a strategic plan, "The First 1,000 Days," focused on reducing preterm births by 8% and infant mortality by 4%. The plan recognizes women's health as an important factor in reducing infant mortality, improving birth outcomes, and sustaining healthy families. Over 120 members across Hawaii participate in HMIHC including physicians, clinicians, public health professionals, community service providers, health plan representatives and health care administrators.

Strategy 2: Promote pre/interconception health care visits

This strategy focuses on the efforts of the HMIHC Pre- and Interconception Work Group and the implementation of OKQ and LARC.

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

The Title V agency and State Medicaid office provide leadership for the Work Group that includes representatives from the MOD; the Hawaii ACOG; the University of Hawaii John A. Burns School of Medicine (JABSOM) Department of Obstetrics, Gynecology and Women's Health; the Queen's Physicians Network; the Hawaii Healthy Mothers Healthy Babies (HMHB); Planned Parenthood; and the federally qualified health centers (FQHC). The involvement of Medicaid and FQHCs assures services are prioritized toward low-income, high-risk women of reproductive age. The DOH Preventive Health and Health Services Block Grant (PHHSBG), administered through the DOH Office of Planning, Policy and Program Development (OPPPD), is a key partner. The grant provides funding for staffing and project initiatives.

The Work Group meets monthly to develop, plan and implement strategies to improve systems building efforts to expand use of OKQ and LARC. An annual HMIHC meeting is used to provide updates and secure statewide input from agency/program stakeholders for the year's action plans.

One Key Question® (OKQ)
OKQ is a simple tool to engage women in a discussion about pregnancy intention by asking: "*Would you like to become pregnant in the next year?*" Depending on the women's response, follow up is tailored appropriately based on a women's yes/no response or ambivalence about pregnancy following standard protocols. Developed by the Oregon Foundation for Reproductive Health (OFRH), OKQ is now managed by the group *Power to Decide,* which is expanding the practice nationally. OKQ trainers are currently required to be certified. Hawaii is exempt from the Power to Decide certification process since the state was certified by OFRH.

HMIHC launched the OKQ initiative in 2016 at its annual statewide meeting with keynote speaker Michele Stranger Hunter, OFRH Executive Director. She conducted OKQ training sessions with varied service providers working with women of reproductive age statewide. The simple OKQ service algorithm was well-received due to the ease of

integrating OKQ into existing workflows. Three Title V programs participated in the pilot: WIC, Family Planning Program (FPP), and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV).

OKQ focuses on a women's *intent* rather than planning because the concept of pregnancy planning may not always resonate with all ages and cultures. OKQ is meant to be used in every client healthcare entry point because pregnancy goals and desires change over time. Regardless of the reason for a women's service visit, the use of OKQ creates a conversation that can lead to thoughtful planning and follow-up for reproductive and preventive health needs.

Policy

Based on recommendations from the HMIHC, the State Medicaid program issued Policy Memo QI-1613 in 2016 to support the use of OKQ and expand contraceptive coverage. The policy promoted the OKQ screening process and eliminated prior authorization for contraceptive procedures, methods or devices and allowed reimbursement for a 12-month supply of oral contraceptives.

The policy memo also clarified Medicaid reimbursement of inpatient LARC, 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 developed in partnership with the HMIHC and was disseminated to all Hawaii Medicaid health plans, hospitals, pharmacies, and health care providers in addition to posting on the Hawaii ACOG website.

The 2017 legislature passed Act 67 which also increase access to contraception. The Act authorizes pharmacists to prescribe and dispense self-administered hormonal contraceptive supplies to patients, regardless of a previous prescription. The law requires pharmacists to refer patients to their primary care provider upon prescribing and dispensing contraceptive supplies. If the patient does not have a primary care provider, the pharmacist shall advise the patient to consult with a licensed physician, advanced practice registered nurse, or other primary care provider of the patient's choice. In 2018, the University of Hawaii at Hilo College of Pharmacy offered comprehensive contraceptive education and certification for pharmacists to fulfill the requirements of HRS 461-11.6. As of September 2019, 18 pharmacists were certified to prescribe and administer FDA approved contraceptives. Enrollment in the program recently declined, possibly because there is no reimbursement for these services.

Promotion

Several opportunities to promote reproductive health and women's wellness were conducted in FY 2019.

In May 2019, the MCHB convened a statewide Hawaii Fatality Summit attended by over 200 multidisciplinary participants. The 2-day Summit was the first in the U.S. to bring together the efforts of the Child Death Review, Maternal Mortality Review and the Domestic Violence Fatality Review. National and local experts presented on prevention approaches and resources to build stronger communities with a unique focus on Hawaii's multi-cultural populations. The Summit provided an excellent opportunity to promote OKQ and the importance of women's wellness among the diverse partner agencies and participants. The WRHS disseminated OKQ and other educational materials to the participants. Stocks of materials were also distributed for participants to share with their clients. These materials covered topics such as general health care, adolescent care, reproductive life planning, and preventive health services.

The WRHS participated in several employee fairs (e.g. Matson shipping lines and Hyatt, Trump hotels) providing educational materials to increase awareness on personal health and well-being and to share information on community resources. Topics included reproductive life planning, spacing of children, family planning and OKQ as

well as adolescent wellness, suicide prevention, domestic violence, and men's health.

During FY 2019 over 1,350 OKQ brochures and related materials were distributed.

OKQ Trainings
The WRHS Family Planning Public Health Educator is an OKQ trainer and participates as a member of the HMIHC Pre- and Interconception Work Group. She continued to promote and conduct OKQ training to community providers.

In June 2019 an OKQ training assessment was prepared by HMHB. The study found the number of OKQ trained providers statewide increased to 850 providers (consisting of 411 clinical and 439 non-clinical providers) compared to 199 providers in 2018. In a unique partnership, DOH Public Health Nursing, working with the Girls Court Program, trains nursing students on OKQ under their preceptorship program.

OKQ trainings by HMIHC, Home Visiting, Early Childhood and Family Planning programs continue to expand the number of OKQ trained providers in the community. HMHB, through a MOD Hawaii Chapter grant, completed 8 statewide OKQ trainings for 10 community health centers and other community partners. OKQ information was also provided through other public health initiatives including provider trainings sponsored by Title V programs.

The Hawaii State Judiciary Family Circuit Court offered a new training venue for OKQ and other MCH health topics. The Court's strategic plan identified *addressing unintended pregnancy* as a priority. MCHB conducted two trainings for Court personnel during FY 2019. Topics included family planning, OKQ, adolescent wellness, preventive health services, perinatal support services, home visiting services as well as sexual and domestic violence. These sessions were attended by judges, parole officers, social workers and other court staff. Evaluation of these trainings indicated there was an increased awareness of adolescent health, reproductive health and knowledge about available community resources. Educational materials were distributed to share with at-risk youths, parents, foster parents, and guardians. MCHB continues this partnership with Family Court.

Evaluation of OKQ by the HMIHC Pre- and Interconception Work Group
Each agency using OKQ currently collects implementation data. However, there is no systematic repository to compile the information or a standard set of indicators that measure the effectiveness of OKQ to prevent unplanned pregnancies and improve reproductive health outcomes. The HMIHC Pre-and Interconception Work Group plans to obtain TA to develop an evaluation plan.

Messaging: SafeSex808
Social media is used to promote OKQ and help women—especially teens—to access reliable healthcare information and services. The JABSOM Department of Obstetrics, Gynecology, and Women's Health created Safe Sex 808 (https://safesex808.org/ or https://www.instagram.com/safesex808/), a Hawaii based, online resource to find sexual health resources and locate a reproductive health provider. The online resource is promoted by HMIHC and Title V programs, including the MCHB Adolescent Health program.

LARC
LARC was chosen as an evidenced-informed approach after other states showed its use could reduce rates of unintended pregnancy. A single visit or encounter is required for LARC placement and does not require additional medication or follow-up visits. Although LARC is considered a "highly-effective" form of contraception with the highest continuation rates among reversible family planning methods, practitioners are instructed to provide non-directive counseling and respect clients' selection decisions. Discussing reproductive health desires and goals immediately during the postpartum period (prior to discharge from the hospital) provides potential benefits for women who are at-risk for short-interval pregnancies or those not likely to return for post-partum care. Having this

discussion shortly after delivery helps eliminate additional office visits and Medicaid can cover costs for low income women.

The HMIHC Pre-Interconception Work Group activities focused on clarifying Medicaid policies for LARC insurance reimbursement for providers:

- Immediately postpartum prior to hospital discharge; and
- For outpatient visits for women of reproductive age.

In addition, denied Medicaid claims for LARC reimbursement were reviewed to address processing issues for various hospital and medical providers. A hospital billing toolkit is now available from the HMIHC and through provider partnerships such as Hawaii ACOG. This toolkit includes billing guidance related to inpatient stocking of LARC and a chart with reimbursement codes.

LARC Provider Training

The Title V Family Planning program in partnership with the JABSOM Department of Obstetrics, Gynecology and Women's Health conducts regular training for obstetricians/gynecologists and other practitioners on LARC insertion as well as counseling protocols to improve access to LARC for immediate postpartum initiation. All of the Title V Family Planning Program providers are trained in placement and removal of LARC.

Evaluation

Despite the Medicaid LARC policy, birthing hospitals have been slow to stock LARC devices. To support greater hospital use of LARC, HMIHC applied for a National Institute for Reproductive Health (NIRH) Grant to identify and address barriers and challenges. One of the issues identified was Medicaid's denial of reimbursements of hospital claims. HMIHC is working to secure Medicaid billing data for ordering and insertion of LARC to support system changes and correct billing processes.

In addition, HMIHC assisted several hospitals to establish in-patient pharmacy protocols to stock LARC. PHHSBG funding purchased devices to assist hospitals with the initial stock startup costs. The goal is for all 13 Hawaii birthing hospitals to stock and receive unbundled Medicaid reimbursements for LARC inpatient insertion. The NIRH grant will be used to generate similar LARC policy changes among private health insurers in Hawaii.

Strategy 3: Promote reproductive life planning

This strategy focuses on increasing access to reproductive life planning services and assuring provision of family planning services statewide.

Based on preliminary data for FY2019 (January-October 2019), the MCHB Title X Family Planning Services program, provided comprehensive statewide family planning services to 11,879 clients in 15,919 visits. The 1.3 visits per client ratio indicates that comprehensive family planning services must be provided during clients' first visit since most clients are not likely to return for follow-up. Family planning services are voluntary and includes client-centered/non-directive education and counseling, pregnancy testing, basic infertility services, preconception health, sexually transmitted disease/human immunodeficiency virus testing, and other related preventive health services including referrals as appropriate. Preventive health services include updating immunizations, blood pressure screening, weight management, and domestic violence and intimate partner violence screenings, tobacco cessation, cervical and breast cancer screening. Service highlights include:

- About 16% (1,783/11,445 clients) are pregnant or seeking pregnancy at time of visit.
- About 84% (9,662/11,445 clients) leave with their chosen contraceptive method. Of these, 86% (8,272/9,662

clients) leave with a “moderately” to “highly” effective method.

Family participation is encouraged for all clients served. All clients are encouraged to return for their annual well women exams to ensure health maintenance and other preventive health needs are addressed.

A 2019 Family Planning Program clinical services survey revealed all 12 community-based service providers (totaling 32 service locations) implemented OKQ. In addition, 4 of the 12 providers expanded OKQ in their other clinical settings such as primary care. During this time period, 14,466 reproductive life planning counseling visits were provided; resulting in 1.8 reproductive life plan counseling sessions per client.

Current Year Highlights for FY 2020 through April 2020

Here are some highlights of activities for FY 2020 including the impacts & changes from the early days of the COVID-19 pandemic in Hawaii.

- MCHB WHRS continued to provide ongoing Family Planning and Perinatal Support services. Systems work through the HMIHC Pre-Conception/Inter-Conception Workgroup continued to promote OKQ and address LARC issues.
- The Title V MCHB WHRS initiated a comprehensive review of contractual services for family planning and perinatal support to identify processes to increase the effective use of limited funds and provide a seamless continuum of care for clients transitioning between family planning and perinatal services.
- In November 2019, the MCHB WHRS convened a meeting of the Family Planning and Perinatal Support Service (PSS) contractors to discuss successes, challenges/barriers, and Medicaid policies and reimbursement. Integration of these services may provide a seamless continuum of care for both mother and baby resulting in improved health outcomes. Five of the eight PSS providers are also family planning providers and the meeting was also used to encourage greater coordination among the service providers. Information from the meeting will be used to enhance coordination of services and for the review of current service contracts.

With Stay at Home orders instituted in March 2020 several changes in service delivery were made.

- Most MCHB staff transitioned to teleworking.
- All MCHB Family Planning and PSS providers instituted or strengthened telehealth services to meet reproductive and other health care needs of clients.
- MCHB contracted service providers maintained clinic hours for family planning, perinatal support and other health services during the COVID-19 pandemic for both in-person and telehealth services. MCHB assured contractors followed recommended safety precautions to protect employees and clients.
- MCHB extended Family Planning and PSS contracts through June 30, 2021 to assure continued funding and services through the pandemic.
- After several months of deliberation with the Governor’s office, the Attorney General and DOH leadership, the Title X Family Planning program award ($2M) was returned to Office of Population Affairs. Hawaii did not submit a Title X non-competing continuation application and is no longer a Title X grantee participant effective April 1, 2020. DOH is exploring other funding opportunities to sustain program operations.

Review of the Action Plan

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

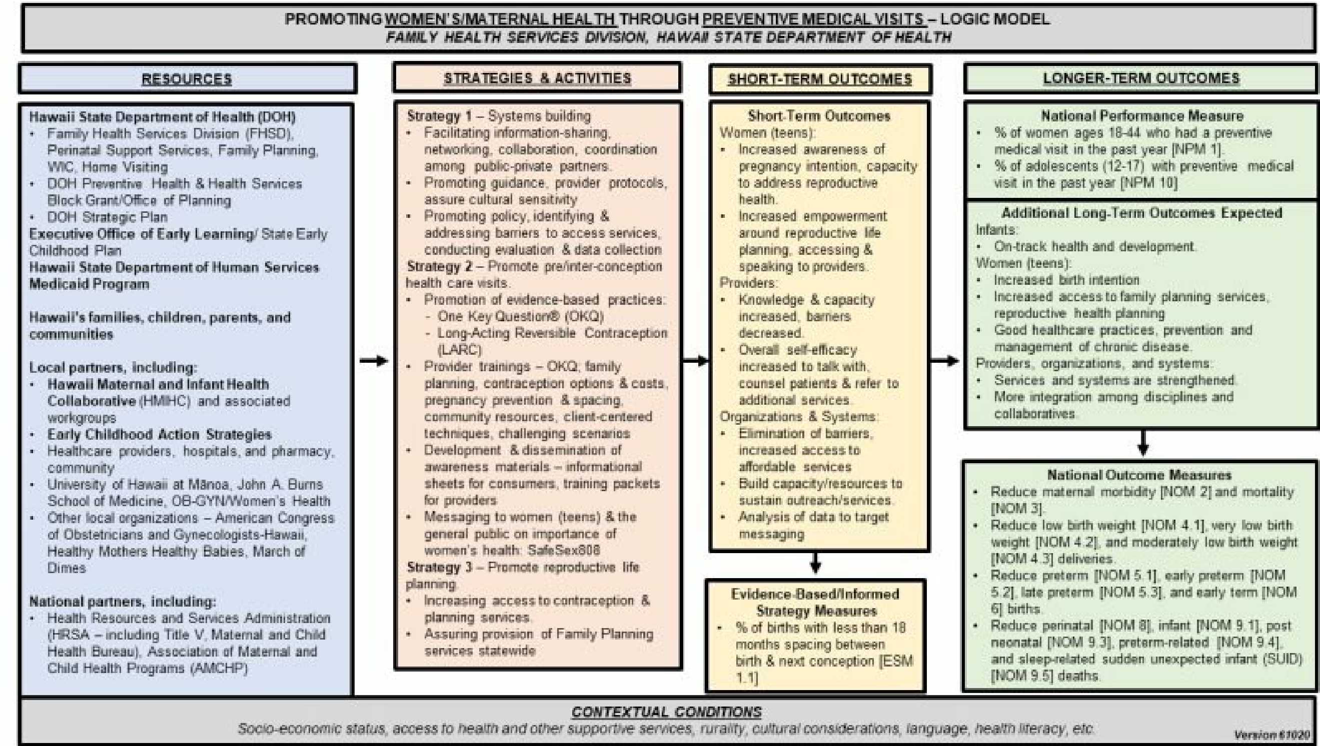
Teens and young adults continue to be one of the priority populations in need of reproductive health and other preventive services. Coordinated efforts addressing teen health needs and promoting adolescent wellness visits is described in NPM 10 and is included in the logic model.

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

The ESM on birth spacing is population based and does not directly measure the impact of the NPM strategies and activities. Hawaii will revise the ESM to a process measure next year to align with the HMIHC Pre- and Interconception Work Group evaluation measures that are under development.

Long-term outcomes include increased adolescent and women’s preventive medical care visits, increased birth intention, increased access to family planning services, and improved healthcare practices in prevention and management of chronic diseases. These long-term outcomes are expected to improve women’s health which subsequently, impacts on birth outcomes and infant health. Strengthening service delivery and health care systems by integration and collaboration of multidisciplinary teams and agencies ensures continuity of these efforts and improved long term impact.

Title V is also examining other women’s health measures for inclusion in the logic model. This data was reviewed in the 2020 Title V needs assessment on the health status of women. Data will come from measures in the BRFSS including self-reported assessments of general physical and mental health, obesity, smoking, alcohol use, dental visits, and contraceptive use.



Challenges, Barriers

Some of the ongoing challenges to implementing activities include:

- Lack of resources to provide oversight of a statewide comprehensive OKQ program including developing and implementing the OKQ work plan;
- Need to establish, coordinate and implement linkages in training needs; and ensure data management includes collecting accurate and valid data for OKQ and LARC benchmarks for program evaluation;
- How to address hospital barriers to LARC such as pharmacy stocking of LARC and private insurance coverage of the device;
- Lack of resources to develop a data management system to establish OKQ and LARC benchmarks, performance measures, and creating a systematic data collection processes;
- Lack of standardized health care plan coverage for medical supplies and services across private insurers; and,
- How to streamline complex administrative protocols for reimbursement and coverage of medical supplies and services.

Overall Impact

Systems building and partnership efforts were successful in advancing Title V activities to improve women's health that impact birth outcomes and reduce infant mortality. The establishment and ongoing work of the HMIHC is a key achievement. Integrating women's health into key state plans and collaborative health initiatives allows for the sharing of leadership, expertise and funding. These efforts include:

- Leveraging federal program TA including the 2013 NGA Birth Outcomes TA and the CoIIN;
- Securing support from both the Executive Office of Early Learning and Early Childhood Action Strategies and their funders (the Hawaii Community Foundation/Omidyar Foundation);
- Partnering with the State Medicaid program resulting in policy changes that promote and implement evidence-based strategies to enhance women's health;

- Partnering with the JABSOM Department of Obstetrics, Gynecology and Women's Health to acquire NIRH funding for LARC implementation;
- Funding and expertise from the DOH PHHSBG; and
- Willingness of Title V and other programs to integrate OKQ into service delivery for women.

The collaboration across the state system of care provided leadership, staffing, funding to sustain the HMIHC efforts over the past five years. These resources are crucial since the MCH Branch funds and staffing are limited.

Women/Maternal Health - Application Year

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
For the Women/Maternal Health domain, Hawaii selected NPM 1 Well-Women Visit as a continued priority based on the results of the 2020 5-year needs assessment. By July 2025, the state seeks to increase the number of women who have a preventive medical visit including pre- and interconception care to 87.0%. Plans to address this objective and NPM are discussed below.

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

System building efforts will focus around implementation activities for the key state plans. These collaborative efforts include:

- The Hawaii Early Childhood State Strategic Plan;
- Executive Office of Early Learning Action Strategy Plans focusing on pre-kindergarten and child development programs;
- DOH Strategic Plan "Investing in Healthy Babies & Families" component; and
- The HMIHC Pre- and Interconception Work Group.

Strategy 2: Promote pre/interconception health care visits

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

OKQ activities include:

- Continue OKQ training;
    - Conduct clinical and non-clinical OKQ implementation training focusing on private primary care providers;
    - Explore provision of OKQ trainings through online or virtual means such as webinars and Zoom;
    - Develop another high quality, interactive OKQ training video using adult learning concepts that capture lessons learned from the first two years of OKQ implementation including working with culturally diverse populations; and
    - Incorporate Power to Decide materials in OKQ packets.
- Develop methods to track, monitor and evaluate OKQ data across programs and agencies;
- Complete a study of OKQ use at a FQHC serving predominantly Native Hawaiian/Pacific Islanders to assure the OKQ approach does not conflict with multi-cultural views regarding pregnancy planning and spacing;
- Develop and implement a statewide OKQ work plan with a focus in expanding OKQ in new clinical settings statewide. Activities planned include:
    - Complete process mapping the OKQ screening in primary care settings (lead by State Medicaid);
    - Identify training needs for clinical and non-clinical providers; and
    - Identify and collaborate within the DOH and other state programs with common goals and objectives to integrate OKQ in their work plans/operations.
- Develop DOH OKQ work plan that aligns with the HMIHC Pre- and Inter-conception Work Group plan.

LARC activities include:

- Continue to assess and address barriers to implementation of the Medicaid LARC policy at Hawaii's 13 birthing hospitals including:

    - Stocking of LARC;
    - Insertion of LARC in conjunction with delivery;
    - Processing of reimbursement; and
    - Accessing Medicaid billing data.

  JABSOM Department of Obstetrics, Gynecology and Women's Health as part of the NIRH grant and in partnership with Medicaid will lead this activity.
- Continue to assess the need for provider training on changes to LARC coverage and codes, placement and removal of devices, and client counseling to increase provider competency.

Strategy 3: Promote reproductive life planning

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

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

Title V Women's Health Programs

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

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

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

Family Planning Services: assists individuals in determining the number and spacing of their children and promotes positive birth outcomes and healthy families. Education, counseling, medical services and referral as appropriate are available through state fund. The program provides leadership for the implementation of OKQ – "would you like to become pregnant in the next year?" OKQ supports reproductive life planning, increases planned pregnancies, and promotes healthy birth outcomes.

Adolescent Health Services: spans across the physical, mental and social emotional aspects including sexual health, positive youth development and transitioning into adulthood for adolescents and young adults ages 10-24 years of age. The WRHS Adolescent Health Services unit is a recipient of the Personal Responsibility Education

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

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

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

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

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

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

Perinatal/Infant Health

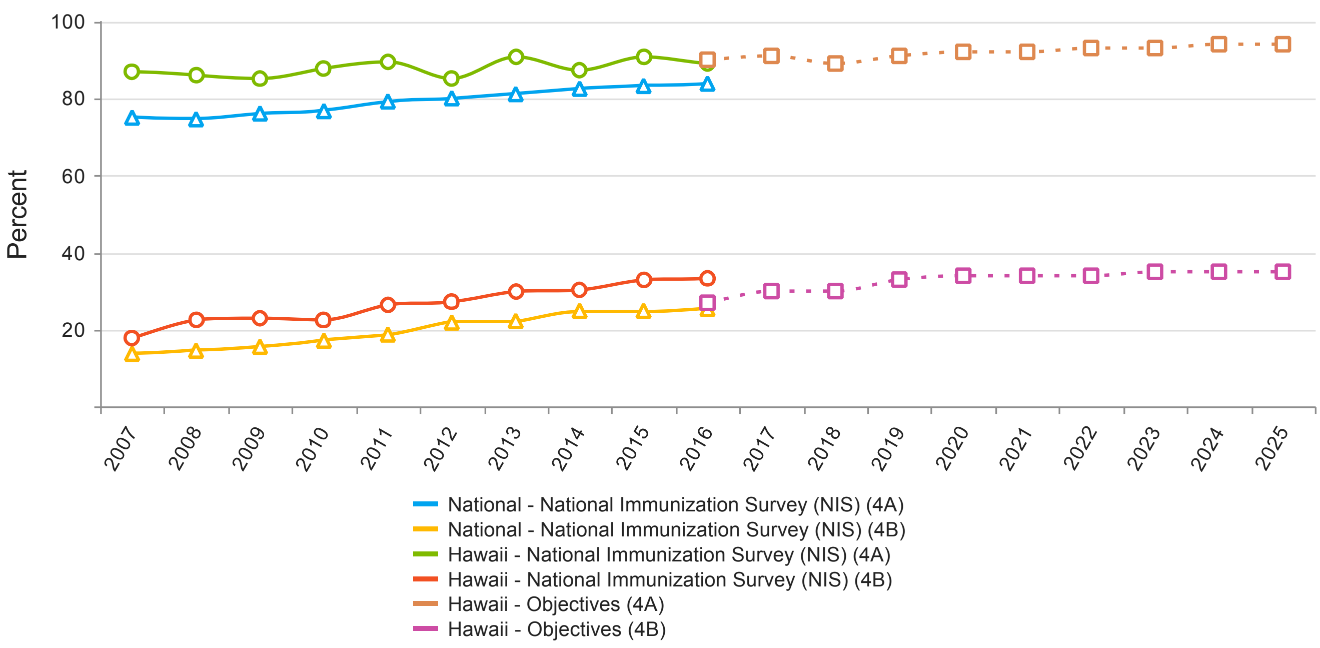
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	5.4	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.6	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	Data Not Available or Not Reportable	NPM 4 NPM 5

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	90	91	89	91
Annual Indicator	90.6	87.3	90.6	88.9
Numerator	15,214	15,007	15,313	15,129
Denominator	16,789	17,199	16,911	17,014
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	92.0	92.0	93.0	93.0	94.0	94.0

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

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	34.0	34.0	34.0	35.0	35.0	35.0

Evidence-Based or –Informed Strategy Measures

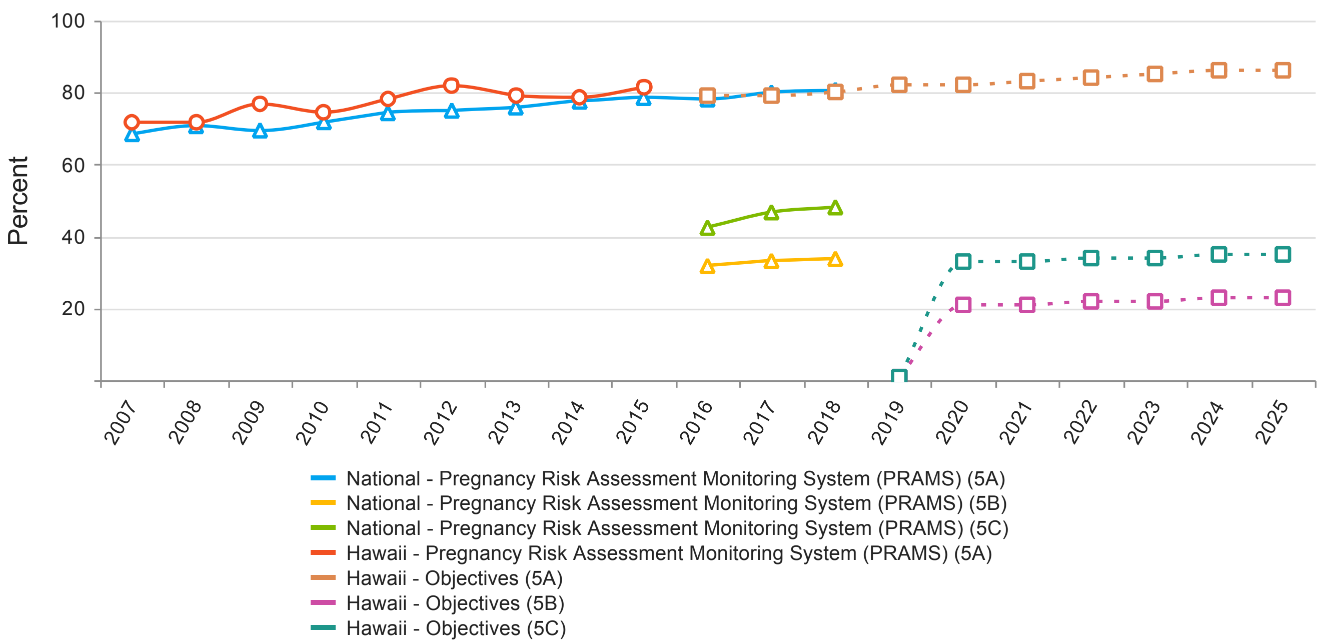
ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed

Measure Status:	Active

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	83.0	84.0	85.0	86.0	87.0	87.0

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



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

Federally Available Data

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

	2016	2017	2018	2019
Annual Objective	79	79	80	82
Annual Indicator	79.2	81.5	81.5	81.5
Numerator	14,243	14,376	14,376	14,376
Denominator	17,975	17,634	17,634	17,634
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2015	2015

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	82.0	83.0	84.0	85.0	86.0	86.0

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			1
Annual Indicator	100	100	20.3
Numerator	1	1	3,306
Denominator	1	1	16,296
Data Source	1	1	PRAMS
Data Source Year	1	1	2016
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	21.0	21.0	22.0	22.0	23.0	23.0

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			1
Annual Indicator	100	100	46.2
Numerator	1	1	5,186
Denominator	1	1	11,228
Data Source	1	1	PRAMS
Data Source Year	1	1	2016
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	33.0	33.0	34.0	34.0	35.0	35.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	11.0	11.0	11.0	11.0	11.0	11.0

State Action Plan Table

State Action Plan Table (Hawaii) - Perinatal/Infant Health - Entry 1

Priority Need

Increase the rate of breastfeeding

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

By July 2025, increase the percent of infants who are ever breastfed to 94%

By July 2025, increase the percent of infants breastfed exclusively through 6 months to 35%

Strategies

Strengthen programs that provide mother-to-mother support and peer counseling

Partner with community-based organizations to promote and support breastfeeding

Collaboration and networking

ESMs	Status
ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed	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 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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

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

Recruit, Support, Collaborate. Increase the membership of Safe Sleep Hawaii through recruitment and identify and engage in opportunities to support and collaborate on safe sleep efforts in our state.

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

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

NOMs

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

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

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NPM 4A - Percent of infants who are ever breastfed

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

Introduction: Breastfeeding

For the Perinatal/Infant Health domain, Hawaii selected NPM 4 (breastfeeding) based on the results of the 2015 Title V needs assessment. The first component of the 2020 Title V state breastfeeding objective is to increase the proportion of children who are ever breastfed to 92.0%. The 2019 indicator is from the 2016 National Immunization Survey (latest available data). The estimate for Hawaii (88.9%) failed to meet the annual objective of 91% but was higher than the national estimate of 83.8%. The current estimate for Hawaii has not changed significantly since 2011 (89.5%). There were also no significant differences among reported subgroups (birth order, educational attainment, household income, poverty level, marital status, maternal age, and race/ethnicity) based on the 2009-2011 aggregated data provided.

For the second component of the breastfeeding NPM, the 2020 Title V state objective is to increase the proportion of children who are breastfed exclusively through six months to 34.0%. In 2016 the estimate for Hawaii (33.2%) met the 2019 objective (33.0%), and was higher than the national estimate of 25.4%. The proportion of Hawaii children breastfed exclusively through six months increased since 2011 (from 26.4%). Higher risk groups were not assessed due to lack of federally available data.

Healthy People 2020 establishes breastfeeding initiation, duration, and degree of exclusivity as nationally recognized benchmarks for measuring success. Hawaii exceeds the 2020 objectives for both ‘ever’ breastfed and exclusively breastfed at 6 months.

Breastfeeding is a priority issue for Hawaii since the 2010 Title V needs assessment. Community stakeholders continue to recognize breastfeeding as a critical practice to improve birth outcomes, reduce infant mortality, and help the health and healing for mothers following childbirth. Hawaii’s efforts to improve breastfeeding rates are championed by two important state maternal and child health collaborative entities – the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the Early Childhood Action Strategy (ECAS). Hawaii’s Title V agency, Family Health Services Division (FHSD) is a key participant in both initiatives.

Within FHSD, the Women, Infants, and Children (WIC) Services Branch is the lead program for breastfeeding, but works collaboratively with other Title V perinatal/infant health programs and community partners. WIC is the largest public breastfeeding promotion program in the nation, providing mothers with education and support. In addition, WIC trains other service providers working with pregnant women and new mothers to promote breastfeeding. WIC also uses breastfeeding peer counselors (BFPCs) to support WIC enrollees at a limited number of clinic locations.

Over the years, WIC and breastfeeding advocates established supportive breastfeeding laws in Hawaii. The challenge now is systematic promotion, enforcement and monitoring of the laws and policies. The key breastfeeding laws and legislation in Hawaii are:

- Hawaii Rev. Stat. § 367-3 (1999) requires the Hawaii Civil Rights Commission to collect, assemble and publish data concerning instances of discrimination involving breastfeeding or expressing breast milk in the workplace. The law prohibits employers to forbid an employee from expressing breast milk during any meal period or other break period.
- Hawaii Rev. Stat. § 378-2 (2000, Act 227) provides that it is unlawful discriminatory practice for any employer or labor organization to refuse to hire or employ, bar or discharge from employment, withhold pay from, demote or penalize a lactating employee because an employee breastfeeds or expresses milk at the

workplace.

- Hawaii Rev. Stat. § 489.21 and § 489-22 provide that it is a discriminatory practice to deny, or attempt to deny, the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodation of a place of public accommodations to a woman because she is breastfeeding a child. The law allows a private cause of action for any person who is injured by a discriminatory practice under this act.
- Hawaii Sess. Laws. (2013, Act 249) requires specified employers to provide reasonable break time for an employee to express milk for a nursing child in a location, other than a bathroom, that is sanitary, shielded from view and free from intrusion. The law also requires employers to post notice of the application of this law in a conspicuous place accessible to employees.
- 2016 Session (Act 46) exempts from jury duty a woman who is breastfeeding or expressing breast milk for a period of two years from the birth of the child.

Although Hawaii's overall breastfeeding rates compare relatively well to national averages, studies show lower rates are associated with low-income households particularly for exclusivity. Strengthening WIC breastfeeding programs provides a key opportunity to assure a healthy start in life for infants and improved health outcomes for postpartum mothers.

The Hawaii Title V breastfeeding strategies were derived from the 2011 Surgeon General's *Call to Action to Support Breastfeeding* and are generally accepted by Hawaii breastfeeding stakeholders including Breastfeeding Hawaii, the ECAS, the HMIHC, the Perinatal Action Network, Healthy Mothers Healthy Babies, and the March of Dimes.

The Hawaii strategies include strengthening peer counseling programs, partnering with community-based organizations to bring WIC breastfeeding services to underserved populations, and collaborating/networking on statewide planning. A review of the AMCHP and MCH Evidence Center research supports Hawaii's strategies: the WIC Peer counseling program and activities such as workforce training of home visiting program staff to promote breastfeeding.

Strategies to address the objectives and NPMs are discussed below.

Strategy 1: Strengthen programs that provide mother-to-mother support and peer counseling.

One of WIC's core services is to provide breastfeeding education and support to participants. Breastfeeding services include: providing guidance, counseling, and breastfeeding educational materials to families before baby arrives; facilitating access to healthy and varied foods; direct engagement with mothers and families to ensure longer participation in the program; provision of breastfeeding aids such as breast pumps and breast pads; and availability of trained staff in varying roles.

WIC mothers are strongly encouraged to breastfeed their infants unless it is contraindicated for medical reasons. All WIC staff are trained to promote breastfeeding and provide the necessary support new breastfeeding mothers and infants need for success. Federal WIC program regulations require State WIC programs to create policies and procedures to ensure breastfeeding support and assistance is provided throughout the prenatal and postpartum period, particularly when the mother is most likely to need assistance.

WIC provides additional services through a Breastfeeding Peer Counseling (BFPC) Program, which conducts monthly group sessions for pregnant and breastfeeding WIC moms to address breastfeeding concerns and provide one-on-one support to those interested. Hawaii WIC uses the US Department of Agriculture's (USDA's) *Loving*

Support© model, an evidence-based curriculum, to assure the success of the program.

Feedback collected from WIC mothers indicates a high level of satisfaction with the program, particularly the camaraderie shared in the group meetings which is the primary aim of the program: to provide mothers with a trusted friend who has breastfed. Peer Counselors become part of a mother's "Circle of Care," providing basic breastfeeding information, monthly contacts during the pregnancy and postpartum period, and referrals to designated resources when issues fall beyond their scope of practice. The program is currently located at four WIC offices at community-based organizations, as well as three state-run WIC offices. A total of four peer counselors currently service all seven sites. The program is located only on Oahu.

Funding for the BFPC Program comes from USDA and is managed by the WIC Services Branch. Each local office recruits peer counselors and must follow the protocols as outlined in the *Loving Support*© model. Recruitment and retention of peer counselors can be challenging since the positions are part-time and applicants normally seek full-time employment.

The strength of the BFPC Program is in the support mothers receive from their peers. In 2019 seven 'baby showers' group events were completed by BFPCs. These events are meant to allow moms to learn and network with other mothers around breastfeeding as well as other aspects of family life. This support leads to increased breastfeeding duration and exclusivity.

To reinforce breastfeeding promotion (and other important health messages), WIC staff refer clients to the Healthy Mothers Healthy Babies "Text4Baby" service. The service sends enrollees free text messages on prenatal care, baby health, breastfeeding and parenting tips throughout pregnancy and baby's first year of life.

ESM 4.1 is the measure for this strategy: the percent of WIC infants ever breastfed. The numerator is calculated using the number of unduplicated WIC infants who were marked as currently breastfeeding (or if not currently breastfeeding, marked as having previously breastfed). The denominator is the sum of all unduplicated WIC infants. WIC anticipates reporting data for breastfeeding exclusively at 6 months in next year's report. Issues with the new data system are being addressed.

Strategy 2: Partner with community-based organizations to promote and support WIC breastfeeding services.

WIC partners with community-based organizations to promote and support breastfeeding. Over the past 15 years, WIC gradually transitioned its service provision from stand-alone state-operated clinics to contracting WIC services with community-based organizations like the Federal Qualified Health Centers. These organizations specialize in providing an array of services to low-income and underserved populations, hire staff that often reflect the diverse cultural groups found in these communities, and have access to language translation resources. Thus, WIC offices located in these organizations may be more effective in reaching WIC clients and providing services, including breastfeeding support.

WIC also works in conjunction with other Title V programs serving high-risk pregnant women by offering breastfeeding education and training to staff, service contractors, and community partners. These programs include the Maternal and Child Health Branch state-funded Perinatal Support Services program, the Hawaii Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, and the associated MIECHV Hawaii Home Visiting Network.

Strategy 3: Collaboration and networking.

Hawaii has an active state breastfeeding coalition, Breastfeeding Hawaii (BH), that works to promote, protect and support breastfeeding through collaboration of community efforts around outreach, legislation, policy enforcement, education, and advocacy. The state WIC breastfeeding coordinator is a board member of BH, and serves as a liaison to CDC's Division of Nutrition, Physical Activity and Obesity and the United States Breastfeeding Coalition.

As noted earlier, efforts to improve breastfeeding rates are championed by two important state maternal and child health entities: the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the Early Childhood Action Strategy (ECAS). Under the auspices of both organizations a state breastfeeding plan was developed in 2018 that identified project priorities.

ECAS continues to convene/staff monthly HMIHC workgroup meetings that focused on implementation of the breastfeeding priorities:

- Provide guidance regarding insurance reimbursement for lactation support workers who are not primary care providers,
- Create a breastfeeding toolkit for pediatricians and obstetricians and
- Develop and launch a campaign to communicate consistent messaging regarding breastfeeding aimed at the whole family.

Broad stakeholder involvement is a key factor of success for this effort. Other participants included: Breastfeeding Hawaii, Healthy Mothers Healthy Babies, March of Dimes, University of Hawaii Office of Public Health Studies, University of Hawaii School of Nursing and Dental Hygiene, University of Hawaii John A. Burns School of Medicine, American Academy of Pediatrics – Hawaii Chapter, Kona Community Hospital, Hawaii Public Health Institute, Early Head Start and Head Start, Family Support Hawaii, BAYADA Home Care, La Leche League, Hawaii Mothers Milk, Family Hui Hawaii, Federally Qualified Health Centers (FQHC), and Tripler Army Medical Center.

Despite Hawaii's excellent breastfeeding initiation rate, the CDC's Maternity Practices in Infant Nutrition and Care report shows that birthing facilities in Hawaii still have opportunities for improvement. The report is based on a survey of hospital practices conducted every two years. Areas for improvement include appropriate use of breastfeeding supplements, inclusion of model breastfeeding policy elements, provision of hospital discharge planning support, and adequate assessment of staff competency. Since the benefits of breastfeeding are dose-related, duration and degree of exclusivity need to be reviewed as well. The DOH Chronic Disease Prevention and Health Promotion Division leads the Baby-Friendly Hospital Initiative which is supported by the breastfeeding workgroup. Discussions continued with Hawaii's two largest labor and delivery hospitals to improve Baby-Friendly practices.

The Breastfeeding State Plan and its Logic Model focuses on four strategic areas: (1) leadership, (2) messaging & training, (3) laws & policies, and (4) support for families needed at critical junctures during the prenatal/postpartum period. Although there are no dedicated funds to implement the Plan, it serves as a guide to align existing breastfeeding efforts conducted by individual organizations and agencies. Without dedicated staffing, it is challenging to monitor and support plan progress.

Current Year Highlights for FY 2020 through April 2020

Here are some highlights of current breastfeeding activities for FY 2020 including the impacts & changes from the early days of the COVID pandemic in Hawaii.

WIC breastfeeding services continued through FY 2020 including BFPC services. The ECAS breastfeeding

workgroup continued meeting to implement project priorities.

WIC services are significantly impacted by COVID. With the March Stay at Home orders, most WIC staff at state clinics and local community organizations moved to telework. All WIC clinics were closed for in-person visits and services for WIC enrollees were provided remotely via phone. Fortunately, Hawaii WIC was in the process of implementing an eWIC (electronic benefits) program to replace the issuing of paper checks for food purchase, reducing the number of required in-person clinic visits.

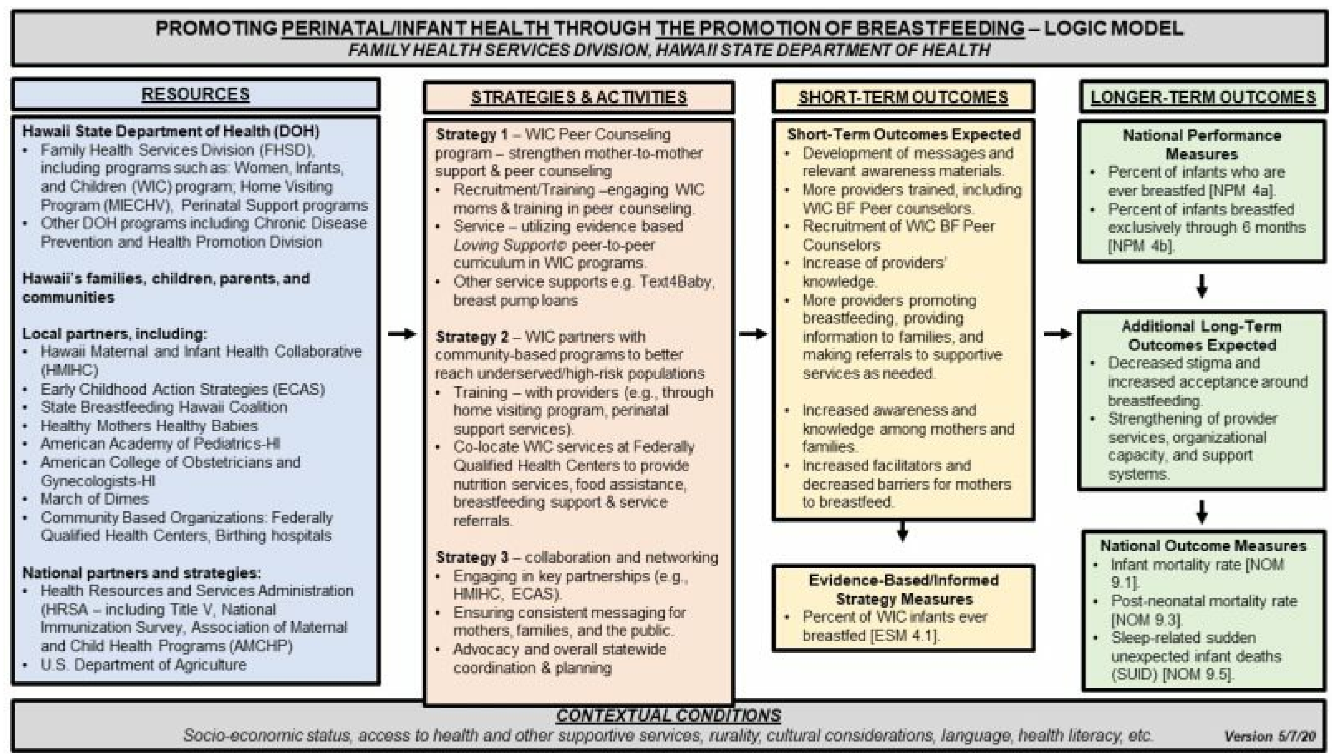
Due to the unprecedented closure of many Hawaii businesses and resulting increase in new unemployment filings, WIC saw an increase in new client enrollments for March/April. Prior to COVID, Hawaii WIC was following the national trend of decreasing WIC enrollment numbers.

WIC BFPC services are provided remotely via text and phone. Group events are suspended and staff are considering other methods to convene WIC moms to encourage networking.

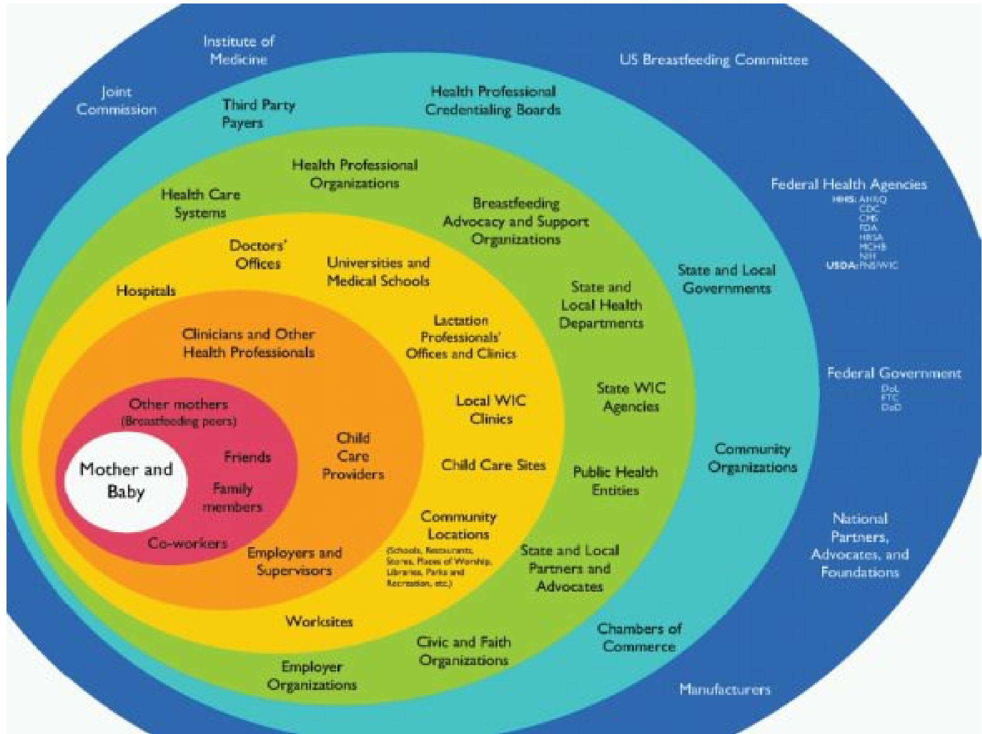
The ECAS BF Workgroup meet via Zoom. A list of BF resources and information specific to COVID-19 is being compiled.

Review of Action Plan

A logic model was developed for NPM 4 to review the alignment between the strategies, activities, measures and desired outcomes. By working on these strategies, the Hawaii Title V program plans to meet the breastfeeding objectives for ESM 4.1 and NPM 4 to increase the percentage of infants breastfed.



The strategies address several service levels toward promoting breastfeeding from enabling to population-based, system building efforts that impact a mother's 'circle-of-care' as illustrated in the graphic below from the USDA National Breastfeeding Campaign.



Challenges Encountered

While Hawaii has many dedicated breastfeeding advocates and partners, efforts to develop strategies and sustain their implementation in the community are difficult due to the lack of a Statewide Breastfeeding Coordinator to serve all families, including those not serviced by WIC.

Recruitment and retention of staff for the BFPC program also continues to be a challenge. Reasons for peer counselors leaving the program have varied, including returning to school, deciding to stay home with a new baby, need for higher salary/full-time work, and moving out-of-state.

Hawaii WIC data show the majority mothers stop breastfeeding between the first 2-4 weeks after hospital initiation. The primary reason mothers cite is not having enough milk. Additional data collection is needed to determine if moms' responses are due to true milk insufficiency or formula supplementation. Such information would greatly inform the breastfeeding support offered by the BFPC, which could be critical to ensuring mothers' continuation of the practice.

State policies that impact a mother's ability to increase her duration and degree of exclusivity also need to be implemented. Paid family leave is supported by the current state Administration, but legislation has not successfully passed.

Overall Impact

The FHSD WIC Services Branch breastfeeding promotion program can access a large high-risk population of pregnant women and young mothers to help promote and support breastfeeding in Hawaii. The Hawaii WIC program services nearly half the births in the state. Despite loss of staffing, WIC state offices and community contractors continue to promote breastfeeding to clients, as well as provide training/resources to WIC contractors and other community organizations serving pregnant women and new mothers.

The Affordable Care Act helped promote breastfeeding by requiring breast pump coverage through medical plans. This can assist mothers with lengthening the duration of exclusive breastmilk feeding, especially as new mothers return to work or school.

Additionally, Title V leveraged resources of key partners to provide leadership, staffing, and funding to sustain community-based activities beyond WIC. For example, the coordinator for the ECAS and HMIHC helped to convene breastfeeding stakeholders, coordinate statewide planning, and access national technical assistance resources. The Strategic Plan will be key in seeking resources for breastfeeding efforts such as reinstituting a State Breastfeeding Coordinator position.

Other Title V programs serving high-risk pregnant women also offer an opportunity to promote breastfeeding through education, workforce training, and support services. Partner programs include the MCH Branch Perinatal Support Services program and the Hawaii Home Visiting Network convened by the MIECHV program. In addition, the Title V Early Childhood Comprehensive Systems (ECCS) coordinator ensures breastfeeding is integrated into state systems planning and services where appropriate. For example, breastfeeding promotion is included in the Executive Office on Early Learning (EOEL) Early Childhood Strategic plan for the state.

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

Introduction: Safe Sleep

For the Perinatal/Infant Health domain, Hawaii selected NPM 5 based on the results of the 2015 Title V needs assessment. The 2020 Title V state objective is to increase the proportion of infants placed to sleep on their backs to 82.0%. The latest Pregnancy Risk Assessment Monitoring System (PRAMS) data from 2016 showed Hawaii below the 2019 state objective (77.9%), but similar to the national estimate of 78.4%. Hawaii did meet the Healthy People 2020 Objective for safe sleep (75.9%). Although the 2016 survey showed a slight decrease from the 2015 indicator, the difference is not statistically significant. State targets for this objective were updated through 2025 after reviewing trend data and consulting with program staff, reflecting an approximate 5% improvement over 5 years.

Looking at this objective over time, the proportion of infants placed to sleep on their backs increased significantly since 2007 (71.7%). Analysis of Hawaii PRAMS 2012-2016 aggregated data revealed Native Hawaiian mothers (72.9%) were less likely to place their infants on their back compared to Filipino (81.2%), White (85.3%), Chinese (86.3%), and Japanese (88.3%) mothers. Mothers that were under 20 years of age (69.4%) and 20-24 years of age (72.8%) were less likely to place their infants on their back to sleep, compared to mothers that were 25-34 (81.8%) and 35 years or older (83.6%). Mothers at or below 100% FPL (76.8%) and those between 101-185% FPL (76.7%) were less likely to place their infants on their back to sleep, compared to those at 301% and greater FPL (85.6%).

The Hawaii 2016 PRAMS survey provided first-time benchmark data for the two new Title V safe sleep national measures (NPM 5B and 5C) which assess whether infants are placed on an approved sleeping surface and placed with soft objects or loose bedding that may endanger infant safety. The 2016 data showed that only 20.3% of Hawaii infants were placed to sleep on a separate approved sleep surface, significantly lower than the 2016 national estimate of 31.8%. Approved surfaces would be a separate crib, bassinet, or pack and play, and not a mattress or bed, couch, sofa, armchair, swing or car seat. Also, only 31.6% of Hawaii infants were placed to sleep without soft objects or loose bedding, a significantly lower proportion than the national estimate of 42.4%. For this indicator, unsafe items include sleeping with a blanket, toys, cushions, pillows, or with crib bumper pads. Higher risk groups for

both measures are not able to be reported at this time, due to small numbers.

From a population standpoint, Hawaii child death numbers remain small (165 in 2018). Non-natural deaths due to external factors such as an accident or violence-related causes are even smaller (42 in 2018). Despite the small numbers, infant sleeping conditions continue to emerge as possible factors in several Child Death Review (CDR) cases each year. Hawaii CDR recommendations continue to promote safe sleep activities.

The 2015 Title V needs assessment confirmed the importance of providing safe sleep education and training to parents and childcare providers. The Hawaii Maternal and Infant Health Collaborative (HMIHC) and Early Childhood Action Strategy (ECAS) also identified the promotion of safe sleep practices as an important priority to improve birth outcomes and reduce infant mortality. Specifically, the HMIHC identified two priority strategies to achieve the objective of decreasing infant mortality in the first year of life: 1) Foster safe sleep practices for all who care for infants; and 2) Provide professional development and training opportunities for caregivers of infants.

Although safe sleep is part of the Title V Maternal and Child Health Branch (MCHB) program efforts, implementation of the strategies occurs through collaboration across the Family Health Services Division (FHSD). MCHB provides general support and leadership through its Parenting Support Programs (PSP) and Safe Sleep Hawaii (SSH), a statewide partnership that promotes life-saving safe sleep techniques, policies, and education for parents, health professionals, and other caregivers. The CSHN Branch nurse manager for the Newborn Metabolic Screening program also worked with the Perinatal Nurse Managers Task Force (PNMTF), which represents all birthing hospitals, to integrate safe sleep into hospital practice.

There is no dedicated funding source for Safe Sleep staffing or program activities. Title V-funded staff provide leadership and overall support for safe sleep program efforts. The supervisor for the Family Strengthening and Violence Prevention (FSVP) Unit under the MCHB serves as the Title V program lead for safe sleep. The FSVP supervisor oversees family violence prevention and parenting support programs. The position was vacated in 2018, and filled recently in March 2019.

Under this new leadership, Title V safe sleep strategies were updated to reflect the most up-to-date data and accomplishments. The strategy to have all Hawaii birthing hospitals formally adopt safe sleep was completed, so the strategy was deleted and the related strategy measure (ESM 5.1) was inactivated. The workforce development strategy which originally targeted birthing hospital staff was generalized, to expand training to a broader range of healthcare and service providers through the development of partnerships. A new strategy was added, with an accompanying ESM 5.2, focusing on outreach to non-English-speaking communities. The new strategy was added based on data findings and input from service providers that work with multi-cultural families.

A review of the AMCHP and MCH Evidence Center research indicates that targeting caregivers with education is supported by some evidence of effectiveness. Hawaii’s other two strategies are also recommended as best practices for Title V agencies.

The safe sleep strategies and activities are discussed below.

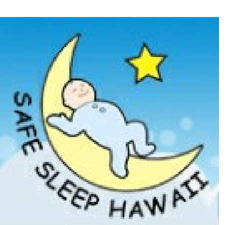
Strategy 1: Assure competent workforce through partnerships & training

Originally this strategy focused on identifying safe sleep competency training needs for birthing hospital professionals, but was broadened to support workforce training for providers that work with families of young children using evidence-based/informed information/trainings.

The PNMTF continues to focus on assuring a competent hospital workforce and keeping regular staff trained on the most recent safe sleep environment recommendations, and also recognizes the need to provide training opportunities for new nurses. Although none of Hawaii's birthing hospitals include safe sleep as a formal workforce competency, the topic is discussed with families at discharge and included on the hospital discharge checklists. Hospitals use various means to promote safe sleep education including creation of safe sleep committees and providing information at regular staff skills fairs. In addition, safe sleep remains a standing agenda topic at some hospital staff meetings to assure consistent messaging and encourage staff to access safe sleep trainings for nurses on the National Institute of Child Health and Human Development website. The CSHNB nurse on the PNMTF serves as the hospitals' safe sleep subject matter expert and provides technical assistance and training on safe sleep environment policy and protocol development, as well as guidance on related issues.

Safe Sleep Hawaii (SSH)

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



SSH has a diverse membership (see Table 1 below) with representation from government, non-profit, for-profit, and grass-roots organizations and sectors, as well as families who are committed to preventing infant mortality through safe sleep practices. In-person SSH meetings are held quarterly and ad-hoc teleconferences are scheduled as needed.

Table 1: Safe Sleep Hawaii Coalition Membership

ORGANIZATION	COUNTY
Adventist Health Castle	Honolulu
Child and Family Services	Statewide
Department of Health – Maternal Child Health	Statewide
Department of Health – FHSD	Statewide
Department of Health – Public Health Nursing	Statewide
Department of Human Services	Statewide
Hawaii AAP (American Academy of Pediatrics)	Statewide
Hawaii Primary Care Association	Statewide
Healthy Mothers Healthy Babies	Statewide
Kaiser Permanente	Statewide
Kapiolani Medical Center for Women and Children	Honolulu
Keiki Injury Prevention Coalition	Statewide
March of Dimes	Statewide
Military (Navy)	Statewide
PATCH (People Attentive to Children)	Statewide
Private Citizens	Honolulu
Queens Medical Center	Honolulu
Shriners Hospital for Children	Statewide
Waianae Coast Comprehensive Health Center	Honolulu
Wilcox Medical Center	Kauai

The Title V lead for safe sleep is responsible for managing the service contract for the SSH Facilitator, coordinating

the efforts relating to safe sleep within FHSD, and acting as the point-of-contact for all safe sleep related inquiries and activities.

The SSH Facilitator contract is state funded and the position is filled by a Registered Nurse whose responsibilities include:

- convening SSH quarterly meetings;
- identifying relevant safe sleep materials and opportunities;
- maintaining SSH membership and LISTSERV;
- convening the sub-committee on identifying AAP-approved on-line training courses for caregivers at childcare facilities;
- providing ad-hoc safe sleep advice; and
- coordinating a yearly Safe Sleep Summit.

The SSH Facilitator is also contracted by the DOH Injury Prevention and Control Section (non-Title V) to convene the State Keiki (*child*) Injury Prevention Coalition (KIPC), thus integrating safe sleep into overall statewide child injury prevention efforts.

Safe Sleep Policy for Licensed Child Care Facilities

The Department of Human Services (DHS) Child Care Program is a key agency partner in the promotion of safe sleep workforce training. The Child Care Program is responsible for the licensing of child care facilities statewide, and implements a policy requiring all child care facilities to have a written operational safe sleep policy, review these policies with staff, and undergo annual training on safe sleep practices. There is emerging evidence to support the effectiveness of mandatory child care provider education. SSH initially assisted DHS to develop training materials and continues to monitor implementation of the program.

Strategy 2: Inform, Educate, Empower. Develop appropriate and consistent parental education and general awareness safe sleep messages.

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

Data to Inform Program Planning/Policy

To encourage the use of data to inform program planning, an Infant Safe Sleep Fact Sheet was developed using data from PRAMS and the Child Death Review (CDR) program. This fact sheet provides general information on Sudden Unexpected Infant Deaths (SUID), Sudden Infant Death Syndrome (SIDS), and data trends, and highlights the importance of creating a safe sleep environment. This fact sheet is accessible via the HI-PRAMS website (http://health.hawaii.gov/fhsd/home/hawaii-pregnancy-risk-assessment-monitoring-system-prams/). This fact sheet was shared with PRAMS steering committee members, the SSH, the CDR program, and other key stakeholders. Plans are to update the fact sheets with 2016 data and conduct further data analysis include examining correlations between co-sleeping, substance use/abuse, and breastfeeding.

Partnering on Parent/Family Educational Tools

The safe sleep educational materials for families and providers were developed in partnership with the DHS Child Care program are now widely disseminated for general safe sleep promotion to many Hawaii programs and agencies serving families. The materials include:

- AAP-recommended guidelines regarding safe sleep environments;
- a letter from a family, "*Don't let a preventable infant death happen*…,"; and

- a poster that can be displayed in the infant's home, in pediatrician offices, or used as a training tool.

The goal was to provide families with helpful materials that could begin dialogues about safe sleep practices with everyone who cares for their children, whether family or not. To ensure the guide was "parent-friendly," the materials were tested with DHS First-To-Work (FTW) program families and revised based on input.

The guides have been used by the DHS Child Care program as well as by early childhood programs such as Women, Infants and Children (WIC), Child Abuse and Neglect Prevention programs, Home Visiting Programs, and birthing hospitals throughout the state. The guides were also used with crib distribution programs sponsored by the Title V's MCHB. MCHB's Parenting Support Programs help to store and provide ongoing distribution of the Safe Sleep Guide for Parents statewide.

Promotion of Safe Sleep Environments

Nurse educators who conduct childbirth classes at birthing hospitals provide education to parents about safe sleep environments. Two hospitals use the safe sleep posters in their birthing rooms to stress the importance of providing a safe sleep environment for infants. Nurses report that the poster is a valuable teaching tool when educating family members about safe sleep.

Another valuable educational tool is the Safe Sleep Hawaii video. The video includes personal family stories about the importance of adhering to safe sleep recommendations, and supports the educational information presented on safe sleep practices and environments. A copy of the Safe Sleep Hawaii video is available for birthing hospitals to play on their internal video sites (http://www.safesleephawaii.org/). The largest maternity hospital in the state requires parents to view the video prior to discharge.

Pack 'n Play Distribution

There are several small program efforts to promote safe sleep environments for families with minimal financial resources. Hawaii's Healthy Mothers, Healthy Babies has a "Cribs for Kids®" program targeting low-income families through referrals from community agencies. Parents without a safe sleep environment for their child, and who are willing to participate in a one-hour educational session, can receive safe sleep information and a free Pack 'n Play (PNP) portable crib. Some of the birthing hospitals also have their own PNP distribution programs for low-income, at-risk families.

DOH sponsored an effort to distribute play yards called "Play yards for Keiki." This initiative provided a safe sleeping environment to families that did not have a safe sleeping environment for their infant child. Participants of this program must meet eligibility criteria and complete safe sleep educational trainings.

In May of 2019, the DOH funded a new crib distribution initiative administered by the Keiki Injury Prevention Coalition (KIPC) called "KIPC Crib Distribution." This program sought to build on the "Play yards for Keiki" initiative and assure those families most in need received a play yard. Eligibility criteria focused on supporting low-income families that were unemployed or receiving government assistance such as Temporary Assistance for Needy Families (TANF). The "KIPC Crib Distribution" program implemented agreements with its distribution sites (e.g., Kauai District Health Office, YWCA, Parents and Children Together, etc.) to improve efficiency.

Strategy 3: Expand outreach to non-English-speaking families and caregivers through translation of educational materials and safe sleep messages.

Hawaii is a state with a high immigrant and diverse ethnic population, including many English as a second language (ESL) speakers. These populations also bring diverse traditional and cultural practices for infant sleep, sometimes

including co-sleeping. To expand outreach to these groups, Title V MCHB partnered with the Department of Human Services (DHS) and the Office of Language Access (OLA) to translate the Safe Sleep Guide for Parents into the most common second languages spoken in Hawaii households.

A workplan and budget was developed for the project. Ongoing activities include identifying the languages for translation, coordinating with translators, selecting a design and printing company to complete the project, and distribution of the final products. A new ESM 5.2 was developed to assure completion of this project: The number of languages Hawaii safe sleep educational materials are currently available for the community.

Current Year Highlights for FY 2020 through April 2020

In October of 2019, Safe Sleep Hawaii held its annual Safe Sleep Hawaii Summit. The Summit was funded by the MCHB. The plenary speaker was Dr. Rachel Moon, an internationally recognized expert in SIDS and post-neonatal infant mortality. Dr. Moon currently serves as Division Head of General Pediatrics at the University of Virginia. Her presentation focused on the causes of sleep-related infant deaths and methods to prevent these types of deaths, including interventions and skillsets needed to promote behavior change with families and caregivers to create safe sleep environments for infants. The Summit also featured a panel discussion compromised of professionals who provide infant safe sleep education, describing the common issues and challenges they encounter. Breakout sessions focused on practical skills to address difficulties working with families through realistic scenarios. The 2020 Summit Planning Group is rethinking plans for an in-person conference, given the gathering and travel restrictions brought about by COVID-19.

The DOH, DHS, and OLA began implementation on the joint venture to translate the Safe Sleep Guide for Parents. This workgroup reviewed several sources of data including Census data, requests for language interpretation services by DHS entitlements programs, and PRAMS data, to help identify cultural groups/languages that appear to have an increased risk for sleep-related infant mortality. Through this process, eleven languages were selected for translation: Chuukese, Ilocano, Japanese, Korean, Marshallese, Samoan, Spanish, Simplified Chinese, Tagalog, Traditional Chinese, and Vietnamese.

The Safe Sleep Guide was translated into the identified languages using OLA resources, and the workgroup selected a graphic designer to format the documents. The translated text and design layouts were reviewed by focus groups of native speakers to ensure the translations were correct, and information and graphics were appropriately displayed in a readable and understandable manner. Next steps include printing the translated materials and finishing the distribution plan that includes website development and social media.

Review of the Action Plan

A logic model was developed for NPM 5 to review alignment among the strategies, activities, measures, and desired outcomes. The strategies were revised to reflect:

- all birthing hospitals successfully adopting and implementing safe sleep policies;
- expansion of workforce training to providers beyond the hospital; and
- translating safe sleep education materials into languages other than English.

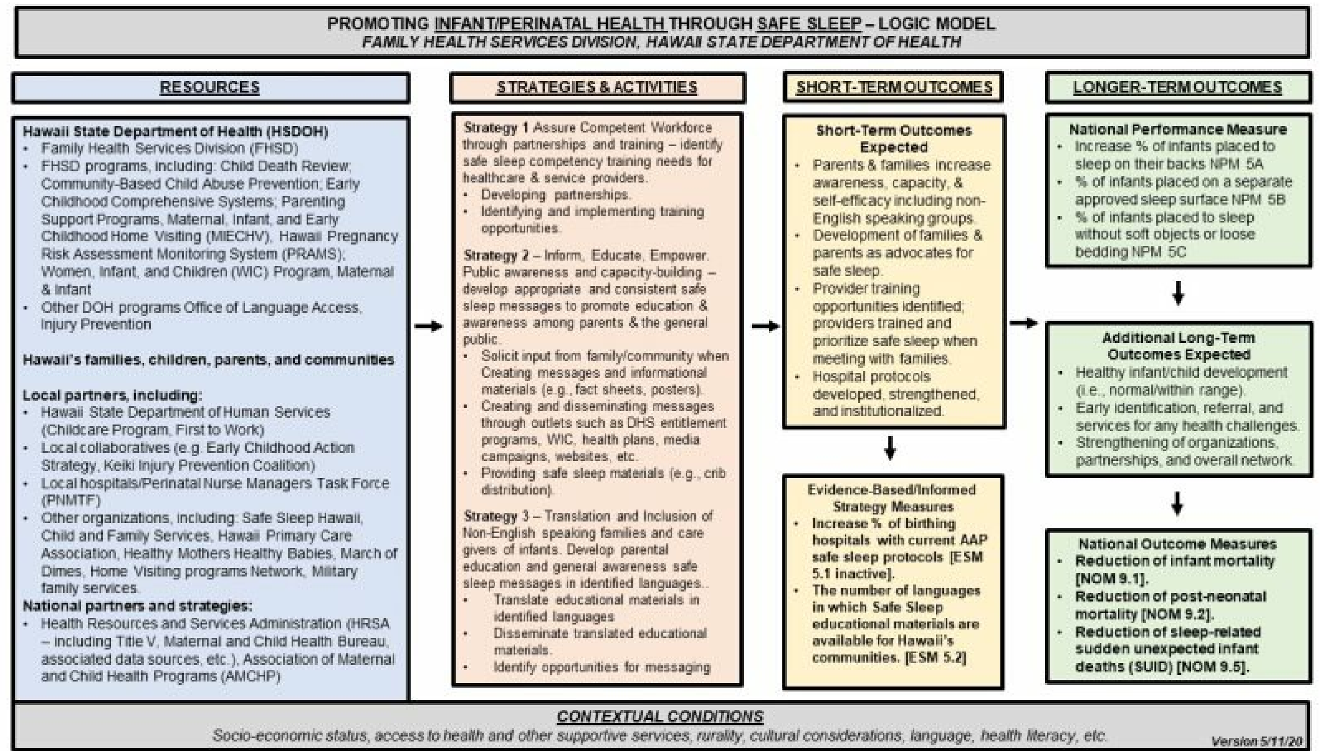
By working on the three strategy areas, Hawaii plans to increase the percentage of infants placed safely to sleep. The activities associated with each of the three strategies directly correlate with short-term outcomes and will impact longer-term outcomes (NPM 5 and NOMs 9.1, 9.2, 9.5). Short term outcomes include:

- Parents and families increase awareness, capacity, and self-efficacy specific to safe infant sleep, including non-English speaking groups.
- Development of families and parents as advocates for safe sleep.
- Provider training opportunities are identified; providers are trained and prioritize safe sleep when meeting

with families.

- Hospital protocols are developed, strengthened, and institutionalized.

ESM 5.1 was inactivated since it was completed in FFY 2018 with all birthing hospitals becoming compliant with AAP protocols. A new ESM 5.2 was created to assure completion of the new strategy to expand availability of safe sleep educational materials through language translation for Hawaii's diverse ethnic populations.



Challenges Encountered

COVID-19

Due to social distancing recommendations discouraging face-to-face meetings, Safe Sleep Hawaii is arranging for remote meetings only. Providers of Safe Sleep education are challenged to rethink service delivery, given the new restrictions. For example, the KIPC crib distribution program funded by DOH requires parents to complete an in-person class or meeting with an educator on safe sleep. New options are being explored for virtual learning.

Addressing Co-Sleeping

Co-sleeping is a common practice in Hawaii. Initiatives such as 'Pack and Play' distribution and education through the Cribs for Kids Program have proven effective nationally with high risk populations. However, addressing local/cultural beliefs and a general acceptance of co-sleeping is challenging. The practice may be attributed to the State's ethnic/cultural diversity, as well as economic constraints related to the State's high cost of housing which contributes to the sharing of small dwellings and/or multi-family living arrangements. Data indicate certain ethnic groups, young mothers, and low-income families are particularly at risk. Targeted outreach to diverse cultural populations is a key strategy for future prevention education activities.

Education Dissemination

FHSD will continue to engage with other Title V programs (e.g., WIC and Home Visiting), birthing hospitals, FQHCs, DHS benefit programs, as well as other "non-traditional" partners such as pre-schools and churches, to expand educational efforts to a broader audience. With translated safe sleep materials, SSH will also expand community

partnerships to reach broader multi-cultural populations.

Overall Impact

By working with key stakeholders to address this issue, parents, families, caregivers, and the medical community have increased knowledge and understanding of creating a safe sleep environment for infants. Program activities successfully addressed safe sleep through a multi-pronged approach consisting of advocacy, policy development, workforce training, education, supporting safe sleep champions, and grass roots programs/initiatives. These activities, combined with input from parents and families, and the leadership provided by the PNMTF, SSH, and Title V were successful in mobilizing Safe Sleep efforts. PRAMS data shows stable safe sleep rates comparable to the U.S. for infant positioning. However, 2016 PRAMS data show Hawaii below national estimates for the two Title V safe sleep measures regarding approved sleep surfaces and the dangers of soft bedding. More effort is needed to increase awareness about these topics.

Crib distribution programs that are paired with education help families provide the necessary physical environment to create safe conditions as specified by AAP guidelines. These efforts are targeted toward vulnerable families in need.

Perinatal/Infant Health - Application Year

NPM 4A - Percent of infants who are ever breastfed
NPM 4B - Percent of infants breastfed exclusively through 6 months

For the Perinatal/Infant Health domain, Hawaii selected NPM 4 (breastfeeding) as a continuing priority based on the results of the 2020 Title V needs assessment. The 2025 Title V state objectives are to increase the proportion of children who are ever breastfed to 92.0%, and to increase the proportion of children who are breastfed exclusively through six months to 35.0%. Work on the three breastfeeding strategies will continue.

Strategy 1: Strengthen programs that provide mother-to-mother support and peer counseling.

With installation of a new WIC data system largely complete, analysis of WIC breastfeeding data will be conducted to inform program planning and report on ESM 4.1. Data should also be available on 6-month breastfeeding exclusivity for WIC mothers.

WIC will continue to explore ways to expand BFPC to neighbor island clinics.

Strategy 2: Partner with community-based organizations to promote and support WIC breastfeeding services.

Some of the major activities under this strategy include developing breastfeeding trainings on reimbursements and insurance, pilot test a breastfeeding toolkit for providers with the FQHC staff, and coordinating education activities for home visitors, pediatricians, and other service providers.

Strategy 3: Collaboration and networking.

The breastfeeding state plan implementation activities will continue in FFY 2021 supported by the ECAS and HMIHC. The breastfeeding workgroup refined its breastfeeding logic model to focus on four strategic areas: (1) leadership, (2) messaging & training, (3) laws & policies, and (4) support for families. Other activities will include:

- Continue breastfeeding trainings for service providers who can assist mothers in overcoming common breastfeeding challenges.
- Referring all pregnant moms served by FHSD programs to the Healthy Mothers Healthy Babies “Text4Baby” service.
- Continue collaborating with the DOH Chronic Disease Prevention and Health Promotion Division on the Baby-Friendly Hospital Initiative.

An update on progress will be provided in next year’s Title V report, as well as any needed adjustments to the 5-Year Plan.

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

For the Perinatal/Infant Health domain, Hawaii selected NPM 5 Safe Sleep based on the results of the 2020 Title V needs assessment. The 2025 Title V state objective is to increase the proportion of infants placed to sleep on their backs to 86.0%. Objectives were set for NPMs 5B and 5C. SSH will provide ongoing technical support, using the findings and recommendations from child death reviews and the Pregnancy Risk Assessment Monitoring System (PRAMS), to inform safe sleep messages and materials targeting parents and others who care for infants. Plans include updating the safe sleep fact sheet with new data and findings.

The Title V program and Safe Sleep Hawaii (SSH) will continue to focus on activities mentioned in the FY 2019 report. With new leadership and direction for Safe Sleep Hawaii (SSH), the strategies were revised with a focus on building the public-private coalition. The strategies on workforce training and messaging were deleted. However, these activities will be incorporated into a new strategy to build the capacity of SSH to lead and support statewide safe sleep efforts. The new strategy is: "Recruit, Support, Collaborate to increase the membership of Safe Sleep Hawaii through recruitment, and identify and engage in opportunities to support safe sleep efforts in the state," and is supported by evidence presented by the Child Safety Network during an MCH Evidence Center sponsored webinar. Cross-cutting strategies to establish and leverage partnerships to support implementation of evidence-based/informed programs and practices are effective when addressing injury related topics. Title V agencies can help lead, manage, and broaden partnerships to:

- use a systems approach,
- conduct an environmental scan,
- conduct a stakeholder analysis,
- align partner priorities through planning, and
- apply a quality improvement approach to assure results.

The strategy to translate safe sleep educational and general awareness messages to languages for non-English speaking populations remains.

Workplan highlights for the two strategies are listed below.

Strategy 1: Recruit, Support, Collaborate. Increase the membership of Safe Sleep Hawaii through recruitment and identify and engage in opportunities to support and collaborate on safe sleep efforts in our state.

The implementation activities for this new strategy include:

- Recruit safe sleep educators and programs that provide safe sleep education throughout the state to Safe Sleep Hawaii.
- Identify and engage in efforts to support training and delivery of safe sleep education.
- Support and collaborate on adapting safe sleep programs and services with respect to social distancing and other effects of COVID-19.
- Support the development of trainings, with technical assistance through the SSH Clinical review team. The SSH Clinical review team consists a group of licensed professionals familiar with AAP guidelines, who will review trainings developed by programs providing Safe Sleep education to assure quality and maintain standards.
- In collaboration with existing programs (i.e., Cribs for Kids), identify opportunities and secure funding to expand Pack 'n Play distribution/education efforts to meet the continuing need in the community, especially among existing high-risk populations (e.g., homeless) and new families with minimal access to transportation and limited financial means.
- Engage and collaborate other programs (i.e., WIC and Home Visiting), birthing hospitals, FQHCs, DHS benefit programs, and other "non-traditional" partners such as pre-schools and churches, to assist in providing parents and families with information and education on safe sleep environments.
- Develop an inventory of safe sleep educational materials and support the creation a network to share information updates, guidance and resources among programs and educators.

Strategy 2: Expand outreach to Non-English-speaking families and caregivers through translation of

educational materials and safe sleep messages.

The implementation activities for this strategy include:

- Work with OLA and DHS in the finalization of digital and printed materials for distribution.
- Identify and work with a distributor for the translated materials as a central source for the state of Hawaii. The distributor will also track data on which languages are being requested, by whom, and quantities, to inform future language access efforts and printing of materials.
- Work with SSH on a distribution plan to ensure that programs and educators in need of translated materials have access.
- Work with SSH, OLA, and DHS to identify/develop opportunities for messaging that will reach the identified communities. Messaging outlets may include, but are not limited to, social media, internet, radio, TV, websites, and printed materials.
- Report data for ESM 5.2 to measure progress on this strategy: The number of languages Hawaii safe sleep educational materials are currently available for the community.

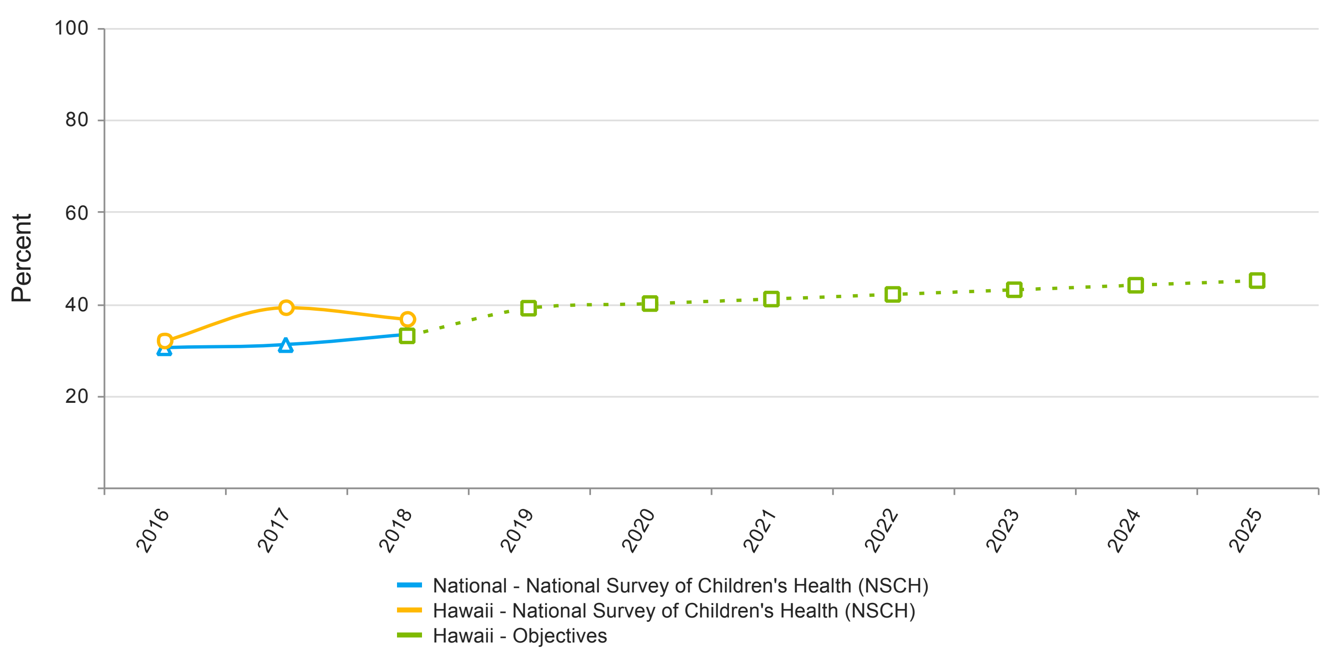
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	8.6 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	92.4 %	NPM 6 NPM 13.2

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			33	39
Annual Indicator		32.0	39.1	36.5
Numerator		12,946	14,121	13,201
Denominator		40,486	36,113	36,145
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	40.0	41.0	42.0	43.0	44.0	45.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			12
Annual Indicator			
Numerator	9	19	23
Denominator	30	30	30
Data Source	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	18.0	24.0	27.0	30.0	30.0	30.0

State Performance Measures

SPM 1 - Rate of confirmed child abuse and neglect reports per 1,000 for children ages 0 to 5 years.

Measure Status:	Active		
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			5.9
Annual Indicator		5.9	5.5
Numerator		635	584
Denominator		108,119	105,815
Data Source		DHS CAN annual report	DHS CAN annual report
Data Source Year		2017	2018
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	5.5	5.4	5.4	5.3	5.3	5.2

State Action Plan Table

State Action Plan Table (Hawaii) - Child Health - Entry 1

Priority Need

Improve the percentage of children screened early and continuously ages 0-5 years for developmental delay

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

By July 2025, increase the percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year to 45.0%

Strategies

Systems Development

Family Engagement and Public Awareness

Data Collection and Integration

Social Determinants of Health and Vulnerable Populations

Policy and Public Health Coordination

ESMs	Status
ESM 6.1 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Hawaii) - Child Health - Entry 2

Priority Need

Reduce the rate of confirmed child abuse and neglect cases per 1,000 with special attention to children ages 0-5 years.

SPM

SPM 1 - Rate of confirmed child abuse and neglect reports per 1,000 for children ages 0 to 5 years.

Objectives

By July 2025, reduce the rate of confirmed child abuse and neglect cases per 1,000 for children to 5.2 per 1,000

Strategies

Collaborate on and integrate child wellness and family strengthening activities across programs.

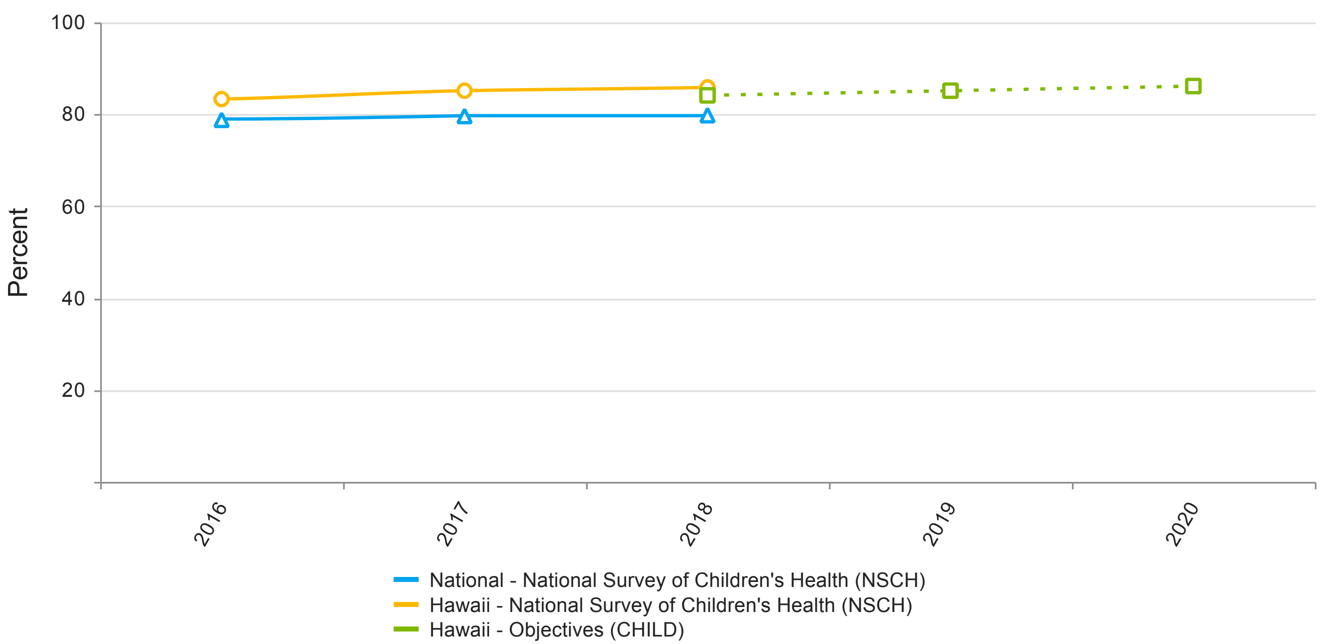
Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

Provide community-based training and technical assistance promoting safe, healthy, and respectful relationships to prevent child abuse and neglect.

Collaborate with the Hawaii Department of Human Services Family First Prevention Services Act primary prevention initiatives.

2016-2020: National Performance Measures

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year Indicators and Annual Objectives



2016-2020: NPM 13.2 - Child Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			84	85
Annual Indicator		83.1	84.9	85.6
Numerator		243,681	242,790	234,467
Denominator		293,312	285,950	273,914
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 13.2.3 - The number of organizations and individuals participating in State Oral Health Coalition meetings and activities

Measure Status:		**Active**
State Provided Data		
	2018	**2019**
Annual Objective		
Annual Indicator	48	64
Numerator		
Denominator		
Data Source	Hawaii Oral Health Coalition	Hawaii Oral Health Coalition
Data Source Year	2018	2019
Provisional or Final ?	Provisional	Provisional

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

Introduction: Developmental Screening

For the Child Health domain, Hawaii selected NPM 6 Developmental Screening as a priority based on the 2015 five-year needs assessment. By July 2020 the state seeks to increase the proportion of children ages 9 through 35 months, receiving a developmental screening, to 40.0%. Aggregated data from 2017 to 2018 show the estimate for Hawaii (36.5%) did not meet the 2019 state objective (39.0%) but was not significantly different from the national estimate of 33.5%. The differences between the 2017-2019 annual indicators were not statistically significant; thus, developmental screening rates remained relatively stable. Based on 2017-2018 data, there were no significant differences among reported subgroups; that is, by health insurance, household income poverty level, nativity, race/ethnicity, sex, and household structure. After reviewing baseline data and consulting with program staff, state objectives for 2020 to 2025 were updated to reflect an annual increase of one percentage point.

Developmental screening is a continuing priority from the 2010 needs assessment for Hawaii's Title V agency, the Department of Health (DOH) Family Health Services Division (FHSD) which coordinates federal, state, and local efforts on screening, referrals, and services. The DOH Strategic Plan also identifies developmental screening and service referral as a priority area. The developmental screening leads for FHSD are the Children and Youth with Special Health Needs Program (CSHNP) Early Childhood Coordinator and the Early Childhood Comprehensive Systems Impact (ECCS Impact) Grant Coordinator. Title V convenes internal partners through a Developmental Screening Workgroup with representatives from FHSD early childhood programs. Members include representatives from:

- Hi`ilei Hawaii Developmental Screening Program – offers on-line or paper copies of the Ages and Stages Questionnaire:3 (ASQ:3) for families of children birth through five years.
- Home Visiting Services Unit – receives funding from the Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant. Its home visitors work with parents to complete the ASQ.
- Newborn Hearing Screening Program – oversees the Early Hearing Detection and Intervention data system for hearing screening of children birth through age 3.
- Early Intervention Section (Hawaii's IDEA Part C agency) – provides services and supports for children birth to age three who have a developmental concern.
- Early Childhood Comprehensive Systems Impact (ECCS Impact) Grant – focuses on developmental screening of children birth through five years for Maui County.
- FHSD Programs within the District Health Offices from Hawaii Island, Maui, and Kauai.

There is also broad collaboration with agencies and stakeholders beyond FHSD, working towards the goal of creating a statewide systematic approach to developmental screening. Hawaii works with medical partners, early childhood providers, and community-based non-profits who conduct developmental screening and ensure children are connected to services or supports if a concern is identified. Also, the Executive Office on Early Learning's Early Childhood State Plan for 2019-2024 identifies screening as a priority in the area of Family Health, Safety, and Wellbeing. Hawaii received a federal Preschool Development Grant Birth through Five (PDG B-5) and developmental screening is included as a strategy in the PDG B-5 Strategic Plan. It is also a priority strategy for the Early Childhood Action Strategy (ECAS), a non-profit public-private partnership, focusing on children's issues prenatal through age eight.

Nationally, developmental screening is promoted through various grants and guidance documents. HRSA emphasizes partnership with healthcare and early childhood care/education providers through the ECCS Impact Grant, since these two communities promote developmental screening of children for optimal development and

school readiness. Guidance from the national American Academy of Pediatrics (AAP) policy statement recommends that children are screened using a validated screening tool at 9, 18, 24 or 30 months. Screening should also be part of the well-child visit per the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines for the Medicaid program. In Hawaii, Medicaid is administered by the State Department of Human Services (DHS) Med-QUEST Division (MQD).

Hawaii's five developmental screening strategies focus on systems-level approaches, and follow guidance from three sources:

- the federal ECCS Impact Grant,
- HRSA's Title V "State Technical Assistance Meeting" in March 2016, and
- 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, and
- assess policy and public health coordination.

The last strategy is assessed via a Policy and Public Health Coordination Scale (PPHC) designed to monitor implementation of the systems-level approaches and is used as the NPM 6 strategy measure (ESM 6.2).

The HRSA ECCS Impact best practices promote working with early childhood providers to ensure that screenings are done as part of their assessment of children's development. This approach is also reflected in the National Association for the Education of Young Children (NAEYC) Accreditation Standards, as well as the Head Start Performance Standards for childcare providers. The National Institute of Early Education Research also includes "Screenings, Referrals and Support Services" as one of their quality benchmarks for early education programs. Hawaii works with all programs to ensure strongest evidence and implementation of its strategies.

Research provided by AMCHP and the MCH Evidence Center were reviewed to identify additional evidence for Hawaii's strategies. Findings indicate support for training of health care providers on developmental screening, and screening through home visiting programs, although further evidence is needed. Following these promising practices, Hawaii provides community-based trainings on the ASQ:3 to both healthcare and early childhood providers. Although quality improvements in both healthcare settings and systems-level approaches were found, Hawaii's Title V agency does not have direct control over healthcare settings and therefore chose a systems approach to continue quality improvement practices.

FHSD, as the state Title V program, serves as a convener and coordinator for strategy implementation. Title V does not directly fund program supports for the development screening strategies. The activities and efforts are largely funded by the federal ECCS Impact grant which provides an ECCS Impact Coordinator who oversees developmental screening activities in Maui County and provides funding for Maui County and statewide screening activities. Title V-funded staff provide overall management, data and epidemiological support, and administrative support for the NPM. Updates on the five strategies are provided below.

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

The activities for this strategy focus on developing guidelines and a toolkit to standardize organizational practices for screening and referral for those needing services. The strategy also includes working with partners to develop

infrastructure for training and technical assistance for service providers. Hawaii has strong partnerships with a variety of early childhood and healthcare providers. While DOH does not have direct control over the healthcare system, childcare and early childhood partners can implement strategies and training directly without having to work through insurance companies for reimbursement. Hawaii continues to work with both the healthcare and early childhood community since both are necessary for optimal health and development of children.

Guidelines on Screening and Referral

In 2018, the Hawaii Title V agency worked with partners to complete the "Hawaii Developmental Screening and Referral Guidelines for Early Childhood and Community Based Providers." The guidelines continue to be used statewide to promote screening efforts. The purpose of the guidelines is to provide basic information for those conducting developmental screening of children ages birth through five years of age. They are based on the following national resources:

- AAP Policy Statement of Developmental Surveillance and Screening Guidelines;
- The Centers for Disease Control and Prevention (CDC) Act Early Campaign;
- Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents;
- Caring for Our Children national standards for early care and education settings developed by the National Resource Center for Health and Safety in Child Care and Early Education (NRC);
- Head Start Performance Standards; and
- NAEYC standards.

The guidelines also include local best practices and were vetted with early childhood and medical providers and other key stakeholders. The Maui ECCS Impact Community team, which serves as advisors to the grant, used these guidelines to ensure screening and referrals are provided to children and families in Maui County. This document can be found on the Department of Health website: https://health.hawaii.gov/cshcn/hiileihawaii/

Workforce Training: Conduct Community-Based Training on Developmental Screening

The ECCS Impact grant supported five family service providers to receive a training-of-trainers on the use and implementation of the ASQ:3 and Ages and Stages Social Emotional Questionnaire 2 (ASQ-SE2). The team subsequently provided training to over 200 Maui providers on the screening tools and general child development concepts. In addition, seven Maui programs have established or updated their developmental screening practices. Because these trainers belong to long-standing community agencies, they serve as a stable training resource for the entire county. One of the trainers also works for the state's largest childcare resource and referral agency that trains home visitors and childcare providers statewide; therefore, training will be available on all islands. Title V also works with Hawaii's CDC Act Early Ambassador who is providing training on developmental screening to healthcare providers. In September 2019, he conducted a training for family and childcare providers statewide on developmental screening and child development. Title V continues this collaboration and other partnerships to promote training to both healthcare and early childhood providers.

Strategy 2: Family Engagement & Public Awareness

The activities for this strategy focus on engagement with families to promote understanding of the importance of developmental screening and child development.

Work with Family Partner Organizations

Hawaii's CSHNB Early Childhood Coordinator works closely with the Family Hui Hawaii who conducts parent support groups. The Hui regularly conducts developmental screening with families both in their program and at community events. The Hui has been instrumental in assisting with the development of family-friendly messages to promote the importance of developmental screening. On Maui, the ECCS Impact Coordinator worked with the

Family Hui to create Child Activity Kits that encourage family engagement to promote children's development. These kits include activities that complement ASQ screenings and promote children's development along five domains: gross motor, fine motor, communication, personal-social, and problem solving. The kits are intended to be distributed through partner programs represented on the Maui ECCS Impact Community team to use and evaluate with their families.

Website to House Screening Documents
Hawaii works with the Early Childhood Action Strategy (ECAS) which is a public-private collaborative that works across sectors to increase the number of young children in Hawaii who are born healthy, develop on track, are ready for school when they enter kindergarten, and are proficient learners by third grade. 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 access to all seeking information about child development (https://hawaiiactionstrategy.org/). Additionally the DOH CSHNB website houses information about developmental screening on its website that is accessible to the public: https://health.hawaii.gov/cshcn/aboutus/.

Strategy 3: Data Collection and Integration

The activities for this strategy focus on analyzing and reviewing data to identify high-risk populations and communities.

Reviewing/Developing Data Sources
Finding population-based data sources that effectively track developmental screening rates is challenging. Many available sources focus on screenings conducted by healthcare providers. Yet, healthcare providers do not always conduct the screenings during short office visits, nor do all children have medical homes. Thus, it is important to collaborate with all of Hawaii's early childhood service providers to assure a comprehensive system for development screening.

Hawaii's Title V works with the DHS MQD to access screening data extracted from EPSDT Claims forms. MQD also reports these data to the Centers for Medicare and Medicaid Services annually, via its "Form CMS-416: Annual EPSDT Participation Report." The database tracks the number of individuals eligible for EPSDT, the expected number of screenings, the total screens conducted, and the number receiving services or treatment as a result of screening. Unfortunately, the EPSDT dataset has a major limitation in that the data track healthcare visits and use that indicator as a proxy for actual screenings.

Similar limitations exist with the National Survey on Children's Health (NSCH) data used for NPM 6 which asks parents about screenings which occur in a healthcare provider office. As discussed above, developmental screens also occur in other service settings which are not reflected in the NPM data. Thus, Title V focuses on collecting additional data from its programs such as FHSD early childhood services and the ECCS Impact grant in Maui County.

Develop Internal Family Health Services Division (FHSD) Tracking System
A data system was created among four of FHSD's early childhood service programs: MIECHV, Early Childhood Comprehensive System Impact Grant focusing on Maui County, Hi'ilei, and Early Intervention. Data from the MIECHV Home Visiting program for 2018 showed that of the 767 children enrolled in the program, 79% of children were screened for developmental delay. Hawaii's home visiting program screens at 9, 18, 24 and/or 30 months, following guidance from the national AAP.

Hawaii's Hi'ilei Developmental Screening Program provides parents and caregivers an option of completing an

online screening or completing a paper copy of the developmental screener that is mailed to them. Hiʻilei data from 10/1/2018 through 9/30/2019 show that 27 children birth through five years were screened. Most of the families who use Hiʻilei are from Oahu, where the majority of the state population is located and where most outreach efforts are conducted.

Hawaii's ECCS Impact grant collects developmental screening data from two major childcare providers serving Maui County. Over the past year, roughly 118 three-year-old children have been screened by two primary agencies (an Early Head Start program and a Family Child Interaction Learning Program). The ECCS Impact Coordinator hosts bi-monthly community meetings to discuss the data from the ECCS project including the number of children screened from within the referral range, and number referred and connected to services. The statewide team meets annually to discuss ECCS and Medicaid EPSDT data. The Title V Workgroup will be convened to share these data and discuss enhancements and community supports that can promote developmental screening and referrals in the community.

Referrals to Early Intervention (EI) come from various sources, and FFY 2018 data (7/1/2018 – 6/30/2019) show that 3,416 children were referred, with 57% of referrals coming from Primary Care Providers, 20% from parents, 10% from other healthcare providers, 2% from social services, and 2% from child welfare. Of the 2,622 children evaluated, 2,220 (85%) were found eligible for EI services.

Develop Process for Communicating Data Story

Developing a data system for FHSD and the state around screenings and referrals was hindered by the different time frames in which data are collected, and the different ages at which children are screened. While the NPM focuses on capturing data on developmental screening only, the Hawaii team feels it is more important to follow what happens to the children who are identified with a developmental concern so that children receive necessary supports and services to promote their optimal development.

Strategy 4: Social Determinants of Health

The activities for this strategy focus on working with partners to identify vulnerable populations who would most benefit from developmental screening.

Develop Process for Identifying Vulnerable Populations

As part of the work with the Preschool Development Grant Birth through Five, Hawaii underwent a process for identifying vulnerable populations throughout the state. The strategic planning process included a needs assessment that identified communities where access to health care and information about child development was most needed. According to the assessment, rural communities statewide and neighbor islands faced the greatest needs, since medical and specialty services are concentrated in urban Honolulu. FHSD Neighbor Island Coordinators also share information on emerging needs in their communities at the CSHNB Children and Youth with Special Health Needs Program Staff meeting. Substantial information on vulnerable populations are shared through this venue.

Work with Stakeholders to Address Supports for Vulnerable Populations

Hawaii has a growing homeless problem and recognizes that children who are living in homelessness may be more susceptible to developmental delays. One of the state's largest emergency shelters, the Institute for Human Services (IHS), provides short-term stabilization through shelters that lead to permanent housing. The CSHNB Early Childhood Coordinator works with the IHS Program Director to address the challenges faced by children and families whose main concerns are finding stable housing, adequate employment income, and other concrete needs. The CSHNB EC Coordinator, as part of the Early Childhood Action Strategy, is working with IHS to track the developmental

screening of children and referrals to services.

Strategy 5: Policy and Public Health Coordination

The purpose of this strategy is to track infrastructure development within Family Health Services Division's efforts to improve developmental screening rates of children.

ESM 6.2 Policy and Public Health Coordination Scale
To track and monitor progress on Title V efforts to improve developmental screening rates of children, Hawaii developed and uses a Policy and Public Health Coordination Scale (PPHC, see below). The scale reflects the activities in the NPM 6 logic model and workplan and includes Systems Development, Family Engagement and Messaging, Data Collection/Integration, Addressing Social Determinants, and Policy & Public Health Coordination. The scale ensures there is a mechanism to monitor and track activities in the first four strategy areas. Since ESM 6.1 was largely completed, the PPHC scale was adopted as a new ESM 6.2 in last year's report. Completion of the scale is self-reported by the EC Coordinator who oversees all the activities.

The total possible points for the scale are 30. The FY 2019 indicator was 23 and met the annual objective set at 12. Progress was made in systems development, family engagement, and addressing vulnerable populations. The rating scale is used by the EC Coordinator to track progress on the NPM 6 strategies even prior to its formal adoption as an ESM last year. Scores show steady improvement since FY 2017 when the score was 9.

Element	0 Not Met	1 Partially Met	2 Mostly Met	3 Completely Met
Systems Development				
1. Develop guidelines and toolkit for screening, referral, and services.				x
2. Work with partners to develop infrastructure for ongoing training, technical assistance, and support for providers conducting developmental screening activities.			x	
Family Engagement and Public Awareness				
3. Work with families and parent organizations to develop family-friendly material explaining importance of developmental screening and how to access services.			x	
4. Develop website to house materials, information, and resources on developmental screening.			x	
Data Collection and Integration				
5. Develop data system for internal tracking and monitoring of screening, referral, and services data.			x	
6. Develop process for on-going communication to review data findings and adjust for better outcomes for children and families.			x	
Social Determinants of Health and Vulnerable Populations				
7. Develop process for identifying vulnerable populations.			x	
8. Work with stakeholders to address supports and targeted interventions for vulnerable populations.			x	
Policy and Public Health Coordination				
9. Develop Policy and Public Health Coordination Rating Scale.				x
10. Conduct process for annual assessment of rating scale.				x
Total Score	**23 out of 30**			

The Evidence Center partnered with the MCH Workforce Center to conduct a remote training for the Title V Leadership Team on Results-Based Accountability to help strengthen Hawaii's ESMs. Targeted technical assistance was provided by both organizations on NPM 6 and its new ESM. The Title V agency continues work to strengthen its ESMs by shifting from process to outcome impacts/measurements when possible. Hawaii acknowledges that the PPHC rating scale is subjective and may be difficult to implement elsewhere, given each state's unique strategies and activities. However, the scale addresses all the components of Hawaii's system approach and serves as a useful quality improvement measure, a practice which is cited as having moderate evidence by the MCH Evidence Center.

Current Year Highlights for FY 2020 through April 2020

This section provides highlights of current developmental screening activities for FY 2020, including initial impacts and changes from the early days of the COVID-19 pandemic in Hawaii.

Hawaii continued to work with the ECCS Impact grant and other partners, with meetings conducted virtually. Access to online developmental screening through Hi'ilei has become even more vital. With telemedicine services becoming the new normal for doctors' visits, there is concern that parents will not be taking their young children to the doctor for the immunizations and developmental screening normally conducted during well-child visits. For children younger than two, it is critical that they receive their immunizations as well as the 18- or 24-month screens per the AAP and CDC COVID guidance. Hawaii will find avenues to assess this challenge given the extended period of the COVID-

19 pandemic and as a result, the Governor's Stay-at-Home Orders.

Plans for FY 2020 started positive, with the new ECCS Impact Coordinator fully prepared to expand grant activities having been in the position for a year. Connecting Maui pediatricians to the CDC Act Early Ambassador started in FY 2019, and there were plans for more concerted efforts and joint opportunities to occur in the spring.

Title V's CSHNB met with the Hawaii Project Extension for Community Healthcare Outcomes (ECHO) which is a medical education/mentoring model using telehealth that builds primary care capacity while improving access to specialty health care in rural communities. The Title V Rural Health program coordinator serves on the ECHO steering committee. Early in FY 2020, the Title V CSHNB worked with Project ECHO to plan a training series on newborn metabolic screening, developmental screening, and Early Intervention Services. A survey was sent to medical providers and these topics generated the most interest. The CDC Act Early Ambassador was scheduled to conduct the developmental screening webinar, with information about referral sources provided by the CSHNB EC Coordinator. The second webinar was going to focus on the Title V Early Intervention program which provides services to children identified by the screening. Because of the COVID-19 outbreak, however, the CSHNB series was postponed and replaced by more timely topics on telemedicine, trauma-informed care, and self-care. Hawaii will conduct the originally planned trainings starting in June.

Before the COVID pandemic, the ECCS Impact Coordinator began working with the Maui WIC office to conduct developmental screenings using the ASQ in WIC waiting rooms. This pilot effort utilized Public Health Nurses, highlighting Maui's collaborative strengths. Because the pilot program was interrupted by the COVID closure of WIC offices, only preliminary data were collected: 55 children were screened, and four children were identified as needing monitoring and connected to services.

The EC Action Strategy Team focusing on children's health planned to work with IHS homeless families and children to track and monitor developmental screening and referrals. Because of COVID-19 prevention and control practices, the project has been postponed. Head Start Programs that provide learning opportunities and developmental screening to children in the homeless shelter have also closed. The Team is reassessing how to support virtual developmental screening for families in the shelter.

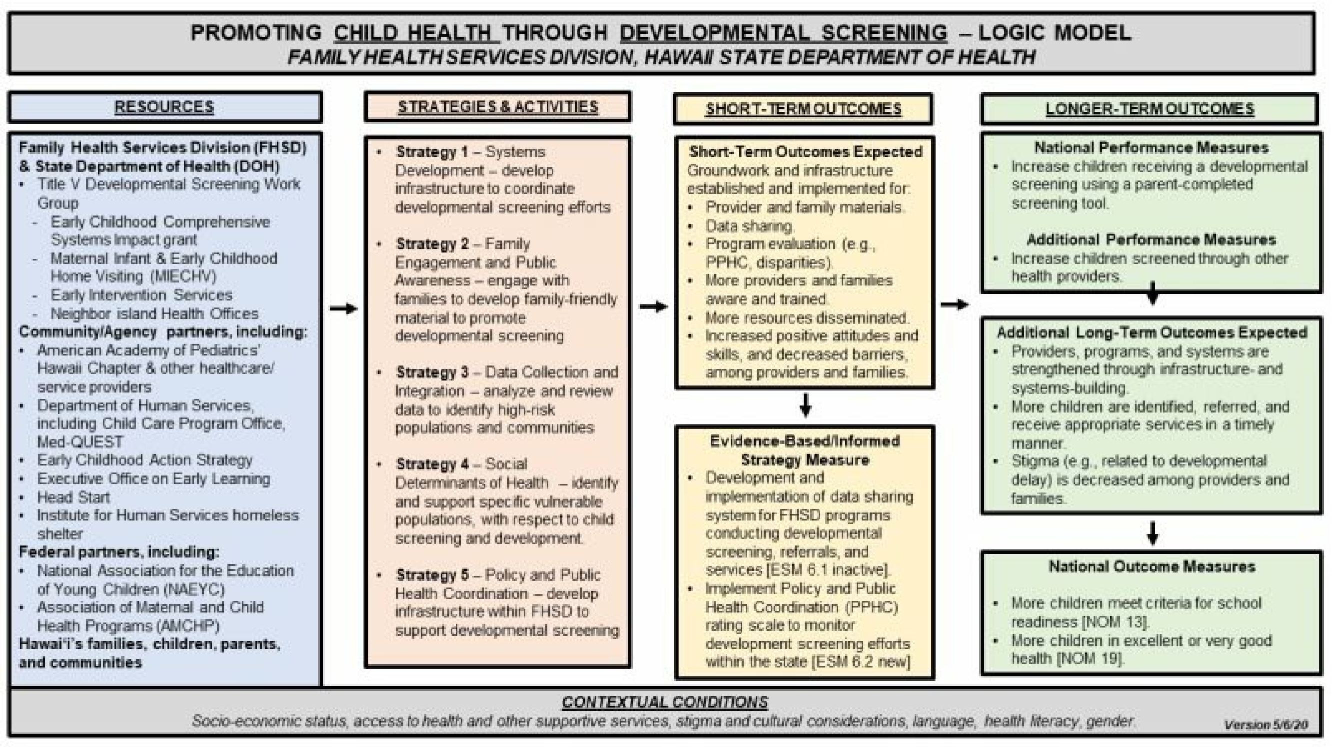
Hawaii had also begun discussing the use of the Survey of Well-being of Young Children (SWYC) as a developmental screening tool with healthcare and early childhood providers, since it was recently added to the national AAP validated screening tools list. The CSHNB Chief and EC Coordinator reached out to AAP Hawaii and the State Med-QUEST Medical Director to discuss use of the tool. Training on the tool would need to be developed, and referral sources would have to be compiled, for this tool to become effective as an option. Because the SWYC is a free tool and covers behavioral and family wellbeing (social determinants of health), in addition to developmental screening, referrals may be broader than IDEA Part C (EI services) and B programs (Department of Education services). Hawaii will continue to work with partners to see if this is a viable tool, especially with the severe economic impacts on families due to COVID-19 that may create greater stresses on a family's ability to afford food, housing, healthcare, and childcare.

Because of the mandatory restrictions on physical distancing, many programs which conduct home visits suspended in-person visits, including the Early Intervention Section (EIS). While referrals are still accepted, EIS cannot conduct in-person visits for multi-disciplinary evaluations. EIS modified eligibility guidelines to temporarily include "presumed eligibility" so a child may receive EI services until eligibility can be determined. EIS evaluators will use information submitted with referrals, including any developmental screening results or developmental information, in determining whether a child is "presumed eligible." When ASQ screening results submitted with referrals fall in the "referral

range," the child will be presumed eligible for EI services. Children who are not "presumed eligible" will be referred to the Hiʻilei Developmental Screening Program.

Review of Action Plan

A logic model for Title V NPM 6 was modified based on the ECCS Impact Grant to include Title V measures (NPM, ESM, NOM). Strategies were developed with consideration of community, statewide, and national efforts. Strategies included input from partners and additional feedback from families and providers solicited at conferences and community events. The major strategies for the work plan revolve around the areas of Systems Development, Family Engagement and Public Awareness, Data Collection and Integration, Social Determinants of Health, and Policy and Public Health Coordination.



By working on these five strategies, Hawaii plans to meet its NPM of increasing the number of children receiving a developmental screening using a parent-completed screening tool by addressing systemic challenges, working with families to promote understanding of the importance of completing the screening tool, using data to address areas of concern, and working on policy and public health coordination. By addressing all areas of the logic model and rating scale, there will be consistent information and guidance to providers. Hawaii will also address social determinants of health to focus efforts on communities of greatest need. Hawaii continues to use this logic model to guide its work on strategies and activities.

Challenges Encountered

Challenges remain in the areas of data, policy, and messaging.

Data: There is no unified data collection system on developmental screenings to monitor children who are screened, referred, and receiving service in the state. Other states have similar challenges because no one data system collects developmental screening and referral efforts. Because of this, efforts to target communities and populations of greatest need are hampered. Medicaid CMS-416 Claims Data provide basic information on participation and

service utilization for the Medicaid child health program for low income families. Approximately 40% of Hawaii's children are insured through Medicaid. Generating screening data for this population would be invaluable to develop effective strategies. Currently, EPSDT data use is limited because the data track healthcare visits, and not actual screenings. Hawaii will collaborate with Med-QUEST (Medicaid agency) and the state Medicaid Ombudsperson to explore other data sources, as well as other quality assurance measures such as Pay for Performance, so Medicaid and other insurance plans can acquire better screening data.

Policy Implementation: There are national policies on developmental screening from both the medical and early childhood community. As part of the Bright Futures Guidelines, developmental screening should be part of the well-child visit. The AAP recommends developmental screening at 9, 18, 24, or 30 months, as well as annual screenings after age 3. The pediatrician or primary care physician's office is where most children younger than age five are seen on a regular and consistent basis and should be the place where developmental and behavioral problems are identified. However, not all providers follow the national recommendations. Also, parents expect their pediatricians to give them guidance on developmental issues but may turn to other community systems (childcare providers, home visitors, community non-profits, family members) if the pediatrician does not fill this role. Lack of appropriate guidance and referrals may result in delays in diagnosis and appropriate intervention. Over-screening by different community systems may also lead to confusion if one provider says a child may have a delay, and another provider says the child is fine. Oftentimes, providers use a "wait-and-see" approach if a child misses a major milestone, while others will rescreen if there is a concern. Otherwise, a child will be screened at the next interval if they are in an early childhood program or at the next doctors visit. Both parents and providers need to understand the importance of recognizing delays early, since early intervention may improve outcomes for children.

Public Awareness and Messaging on Importance of Developmental Screening: There is still a general lack of awareness about the importance of developmental screening. Messaging around developmental screening emphasizes the need to identify children who have a developmental delay. However, consumers need more information to understand what screening involves, the purpose, and how it helps support child development. Hawaii continues to work with family groups to address this issue. Because of COVID-19, many screening opportunities are not currently available (i.e. early learning environments, in-person home visits and early intervention services). It is even more imperative that families have their children screened to ensure there is progress toward meeting developmental milestones and identifying concerns as soon as possible.

Overall Impact

Hawaii has many engaged partners willing to promote developmental screening and who recognize the importance of timely access to services and supports if a delay is identified. Both the DOH Strategic Plan and the Executive Office on Early Learning's Early Childhood State Plan and Strategic Plan identified developmental screening as a key priority. By working together to address this issue, providers and partners are now more aware of the importance of developmental screening using a validated screening tool, ensuring needed referrals are timely, and communication with the medical home. More work can be done to promote a more seamless system of screening and referral.

More effort is also needed to reduce the stigma that may prevent families from seeking follow-up services for their child. Normalizing the conversation and making screenings part of a well-child visit or a routine early childhood practice helps to ensure screenings and follow-up occur. Partnerships with the AAP-Hawaii Chapter and Medicaid also help to share consistent information about screenings and referrals, including the availability of the online ASQ through the Hi`ilei program. These partnerships help make a greater impact in Hawaii. With more promotion of accessible tools for families, an increase in the number of children receiving a standardized screening is anticipated.

Hawaii still shows a relatively high rate of developmental screening, with 39.1% of parents reporting completion of a

developmental screening tool, as compared to the national rate of 31.1%. Efforts by programs like MIECHV and many other early childhood programs who conduct developmental screenings help contribute to this high percentage. However, this still leaves most of Hawaii's children who are not receiving developmental screenings, and better outreach could be done to promote its importance. Working with early childhood providers, efforts will continue to promote developmental screening and sharing of information with the medical home.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Introduction: Child Oral Health

For the Child Health domain, Hawaii selected NPM 13.2 (children's oral health), based on the 2015 five-year needs assessment. Aggregated data from 2017-2018 show that the estimate for Hawaii (85.6%) met the 2019 state objective (85.0%), and was higher than the national estimate of 79.7% for preventive dental visits among children. With this baseline data, the state objectives through 2025 reflect an approximate 5% improvement over 5 years. Children 1-5 years of age had a lower visit estimate (72.3%) compared to children 6-11 years of age (92.0%) and 12-17 years of age (91.8%). There were no other significant differences in reported subgroups by household income, poverty level, language spoken at home, nativity, race/ethnicity, sex, and household structure based on the 2017-2018 data provided.

The related Healthy People 2020 for this measure is: increase the proportion of children, adolescents, and adults who used the oral health care system in the past year to 49%. Hawaii far exceeds this target for children.

Although data from national surveys indicate Hawaii's rates of oral health status and service utilization are similar or better than the rest of the U.S., clinical data reveal a very different story. A 2015 oral health Basic Screening Survey (BSS) revealed Hawaii's third graders have the highest rate of caries in the U.S. and some of the highest rates of urgent care needs. Within this group key disparities exist. Children who are low-income, have Medicaid coverage, and/or are Native Hawaiian or Pacific Islander suffered disproportionately throughout the state. A BSS of children enrolled in the Hawaii Head Start program reveals similar findings for young children from low income families.

A major contributor to the problem of dental disease is the lack of community water fluoridation. In the U.S., Hawaii has the lowest proportion of residents with access to fluoridated drinking water, at 11.3% according to the Centers for Disease Control and Prevention (CDC). In Hawaii, only federal military installations have fluoridated water sources. Fluoridation efforts continue to generate substantial community opposition. In addition, all the county water supply agencies strongly oppose fluoridation due to the additional operational costs and burden.

Workforce issues also contribute to Hawaii's poor dental rates. Despite Hawaii's favorable ratio of dentists to residents, most of the State's primary and specialty care providers are located on the island of Oahu (Honolulu County). Like many states, Hawaii also has a shortage of providers willing to treat Medicaid clients. The situation is particularly acute on the neighbor islands and in low income areas of Oahu. Moreover, Hawaii does not have a school of dentistry. Only programs for dental hygienists and dental assistants are available in state.

The critical nature of Hawaii's oral health is reflected in the five consecutive "F" grades received by the Pew Charitable Trusts' state report cards for children's oral health. While not funded, the Hawaii State Department of Health (DOH) does have statutory responsibility for assessing dental needs and resources, planning and providing services, conducting education and training, and applying for federal funding for oral health infrastructure/services.

In 2013, the DOH received a five-year CDC oral health infrastructure-building grant which ended in August 2018. Hawaii submitted a new application for CDC funding in 2018. Although the application was approved, the grant was not awarded due to insufficient funds. Family Health Services Division (FHSD), the Title V agency, is the DOH lead for oral health population-based activities and administered the CDC grant. With the end of the CDC grant, staffing was lost and population-based services largely ended.

When needed, Title V partners with the DOH Developmental Disabilities Division (DDD) dental staff which operates several dental clinics on Oahu serving primarily adults with disabilities and other special needs.

Due to the loss of program staff and funding, strategies were revised to reflect Title V's reduced resources and activities.

Strategy 1: Program Development Explore & pursue options to staff State Oral Health Program

The importance of dental program leadership and staffing is critical to sustain any program activity. With no local health departments or dental school, the State Oral Health Program (SOHP) is key in providing statewide leadership

for public health surveillance, evaluation, and planning functions. In addition, given the state's unique diversity in ethnicity, language and cultural practices, many best practices may not translate to Hawaii. The SOHP plays an important role to promote and adapt evidence-based oral health practices in both public and private settings by supporting workforce training, policy guidance, and research.

With the end of the five-year CDC oral health infrastructure grant in August 2018, FHSD lost SOHP staff including a half-time Dental Director and Office Assistant and a full-time Program Manager. The FHSD Division Chief now serves as the state dental contact but program activities have largely ceased.

In 2019 a budget funding request to support the SOHP staffing and operations was not included in the Governor's budget proposal. Title V continued to explore other funding options to support oral health activities.

Strategy 2: Surveillance-Maintain oral health surveillance activities

Following the state oral health surveillance plan, DOH continues to collect oral health data through surveillance surveys including PRAMS and YRBS. The oral health data is available on the DOH data warehouse website, Hawaii Health Matters. Data activities were limited in 2019 with vacancies in FHSD's two epidemiologists positions.

Partnering with the DOH Office of Planning, Policy and Program Development (OPPPD) epidemiologist, FHSD analyzed and distributed state hospital and emergency department data for dental-related utilization. The information was shared with the Hawaii Oral Health Coalition.

The Title V Office of Primary Care and Rural Health continued to monitor workforce shortages and establish federal designations for health professional shortage areas (HPSA) for dental services. In 2019, dental HPSAs existed on all islands except for Kauai. The entire islands of Hawaii, Maui, Molokai, and Lanai are dental shortage areas (see HPSA maps in Supporting Documents).

An MCH Bureau Graduate Epidemiology intern published an article in the Hawaii Journal of Health that analyzed YRBS dental visits data. Disparities in dental care utilization were confirmed among Hawaii public high and middle school students based on age, race/ethnicity and number of risk behaviors:

- students older than 14 years of age were less likely to visit the dentist compared to students who were 14 years of age or younger,
- Pacific Islander, Native Hawaiian, Hispanic/Latino, Filipino students and those who did not identify as a single race/ethnicity were more likely than whites to visit the dentist,
- Students having four or ≥ five risk behaviors were associated with lower likelihood of dentist visits compared to those with no risk behaviors.

Strategy 3: Partnership/Coalition-Building-Support ongoing partnerships and coalition-building activities

The CDC oral health grant required the SOHP to build partnerships throughout all its project work and focus on coalition building. Partnerships allowed Hawaii to leverage limited resources to support public health activities.

Title V continued to contract with sixteen community-based health service programs including the Federally Qualified Health Centers (FQHC) to provide primary care services for the uninsured and under-insured, including dental treatment services. In 2019, 13,861 adults and children received dental services through this program with service provider reimbursements totaling $1.3M. After consulting with the Hawaii Primary Care Association, the reimbursement schedule was modified in July 2019 to include telehealth visits (including dental visits) and for silver diamine fluoride application.

Substantial progress was made in 2019 to establish a formal organizational structure for the Hawaii Oral Health Coalition (HOHC) with by-laws, elected officers and defined membership categories. Previously, the coalition operated as an informal network of dedicated stakeholders. Coalition activities included:

- Oral health community leaders met to formally adopt the HOHC mission, vision, values, and operating structure/guidelines. The HOHC is organized around seven standing committees that continued to work on establishing priorities.
- Officers was elected and interim leadership for each committee was confirmed.
- Advocacy priorities for 2020 were approved and a statewide collaborative communication network established.
- A website established at www.hawaiioralhealthcoalition.org.

- The Hawaii Public Health Institute (HPHI) and the Hawaii Children's Action Network (HCAN) received grants to support/staff the HOHC. Funders included the DentaQuest Foundation, the Hawaii Community Foundation, AlohaCare (Hawaii Medicaid health insurer) and the DOH Family Health Services Division. HPHI was confirmed as the HOHC fiscal agent.
- The HOHC oral health network extended to over 300 individuals statewide. Development of an online membership management system was explored by the HOHC membership committee.

A new ESM was created for FY 2020 focusing on the state coalition work. ESM 13.2.3 is the number of organizations and individuals participating in State Oral Health Coalition meetings and activities. Although the formal membership enrollment registration system was not established in FY 2019 there were 64 participants in the meetings that helped establish the HOHC organizational structure a slight increase over the previous year's meeting participants.

Other partnership activities included the pilot teledentistry programs on Hawaii island and Maui. The DOH dental director for the Developmental Disabilities Division is providing technical assistance for the project. The site at the West Hawaii Community Health Center is in its fourth year providing services to young children at Head Start, WIC, a traveling preschool and a homeless transitional housing complex. The pilot has seen over 1,000 children and is now in discussions with the Department of Education to expand the program to public elementary schools in their service area.

A second teledentistry pilot project on Maui is partnering with the Native Hawaiian Health Center to serve young children at Head Start and WIC as well as a senior assisted living facility. The project also includes an oral health professional educational component in collaboration with the Maui Community College Dental Hygiene School. The VDH project is a promising practice in the AMCHP Innovation station.

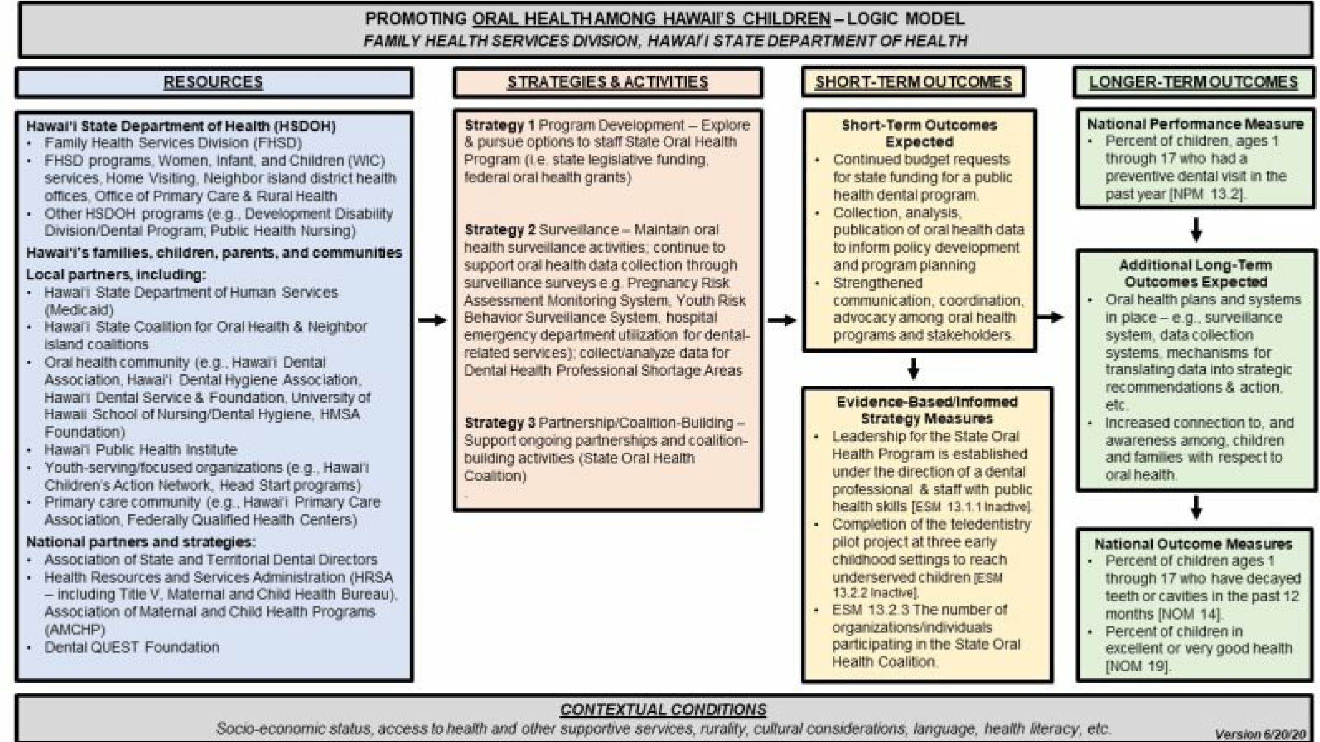
Current Year Highlights for FY 2020 through April 2020

Here are some highlights of current oral health activities for FY 2020 including early impacts & changes from the COVID pandemic in Hawaii.

- In FY 2020, FQHCs continued to provide dental services and provide reimbursement for telehealth dental visits and application of silver diamine fluoride.
- Hawaii Title V continued its support of the HOHC, providing funding to HIPHI.
- During the 2020 legislative session the HOHC advocated for the reinstatement of Hawaii adult Medicaid dental benefits. Passage appeared promising based on cost estimates from the state Medicaid program. Unfortunately, with the COVID-19 pandemic, the Legislative session was suspended and the legislation died.
- The HOHC established a membership management system which was rolled out as just before the start of the COVID-19 pandemic. The Coalition plans to actively campaign for official enrollment for network members later in the year.
- HOHC leadership have routinely met to respond to COVID-19 concerns in the dental community during this crisis including sharing safety/infection control guidelines initially for emergency and, as of June, regular dental visits. The Coalition identified sources to secure personal protective equipment and encouraged purchasing partnerships among dental professionals.
- The 2020 Title V needs assessment did not select oral health for children as a continuing Title V priority due to the lack of available funding and resources.

Review of Action Plan

The logic model was updated, reducing the number of strategies to reflect decreased public health activity since Hawaii Title V no longer has staffing or funds for program operations. However, the logic model resources were expanded to reflect the partners in the State Oral Health Coalition activities. Oral health data sources critical for ongoing surveillance efforts were also detailed to reflect the infrastructure services supported by Hawaii Title V.



Overall Impact

The CDC oral health grant supported program activities to rebuild the SOHP infrastructure capacity lost in the 2009 recession including: leadership, data surveillance, partnership and coalition-building as well as assessment and planning. The grant's accomplishments helped elevate dental disease as an important public health issue and build community capacity to support ongoing oral health work through the state Coalition. The Coalition will continue to convene and coordinate the state's dedicated oral health stakeholders, community-based programs, and strong advocacy agenda.

Challenges, Barriers

The primary barrier to progress will again be securing sustainable funding for SOHP staffing and operations. While FHSD continues to explore funding options to help support ongoing public health functions little program activity is possible without resources.

SPM 4: Rate of confirmed child abuse and neglect cases per 1,000 children aged 0 to 5 years.

Introduction: Child Abuse and Neglect in Hawaii

The 2015 needs assessment confirmed that Child Abuse and Neglect (CAN) prevention should continue as a priority under the Child Domain. Child maltreatment stands as a foremost concern in the state. Community needs span the spectrum from primary prevention services to support families as well as improvements to the Child Welfare Service system to prevent children entering foster care.

Originally, Hawaii aligned this 2015 priority with NPM 7, which addresses hospital-related injuries. However, the benchmark was too broad to measure progress for CAN prevention. In 2018 under the current Title V grant guidance, Hawaii elected to establish CAN prevention as a SPM using confirmed cases as the measure.

The objective for SPM 4 was set: by July 2020 the state seeks to reduce the rate of confirmed CAN cases per 1,000 children aged 0 to 5 years to 5.8. The FY 2019 indicator is 5.5 and met the 2019 objective of 5.8. Objectives for 2020-2025 were updated. Objectives are set at 5% improvement over 5 years.

While death due to the abuse of a child is an infrequent event, there were still 1,296 unique confirmed child abuse victims in 2018 in Hawaii (latest available data). By maltreatment type:

- 54% of victims experienced neglect or medical neglect,
- 10% suffered psychological abuse,
- 31% were threatened with harm,
- 19% experienced physical, and
- 34% were sexually abused.
- 30% sex trafficking

(Hawaii Department of Human Services, Child Abuse and Neglect in Hawaii, 2018, https://humanservices.hawaii.gov/wp-content/uploads/2018/06/2017-CAN-report-print.pdf).

Note: A child may have more than one maltreatment type and may have been reported more than once during the one-year period, but the same maltreatment is counted only once. Sex trafficking was added in 2018.

Confirmed abuse or neglect was essentially the same for males (637) and females (639).

The Title V Child Abuse and Neglect Program (CANP) is administratively located in the Maternal and Child Health Branch (MCHB) Family Support and Violence Prevention Section (FSVPS). This Section is made up of the sexual violence, domestic violence prevention, parenting support programs, as well as the Maternal Infant and Early Childhood Home Visiting (MIECHV) program. The CANP is funded by the Administration for Children and Families (ACF), under a Community-Based Child Abuse Prevention (CBCAP) grant. While Title V does not directly fund CAN prevention activities, it does fund key staff related to the program including the FSVPS Section supervisor and other MCH Branch support staff such as the Branch research statistician.

Child abuse and neglect are complex problems rooted in unhealthy relationships and environments. Preventing CAN requires addressing factors at the individual, relational, community, and societal levels. Hawaii's four CAN prevention strategies reflect a broader public health systems approach, specifically to:

- Collaborate on and integrate child wellness and family strengthening activities across programs.
- Develop a child abuse and neglect surveillance system.
- Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.
- Provide community-based training and technical assistance promoting safe, healthy, and respectful relationships to prevent child abuse and neglect.

While CAN Prevention is not a Title V NPM, research presented by the MCH Evidence Center from the Child Safety Network supports Hawaii's cross-cutting strategies that leverage partnerships to support evidence based/informed programs and practices.

Strategies and activities to address the SPM 4 objectives are discussed below.

Strategy 1: Collaborate on and integrate child wellness and family strengthening activities among programs.

The complexity of risk factors relevant to prevent and reduce CAN requires collaboration with diverse private and public organizations in the community, including those that directly engage in CAN work, as well as agencies addressing broader community concerns (e.g., housing, employment, safe neighborhoods, substance use, etc.). Key collaborations are described below.

Under the guidance of the ACF Children's Bureau, the CANP Coordinator, Hawaii Family Court judges, Judiciary and DHS staff came together to serve as the State Team to develop the 2020-2024 Child and Family Service Plan (CFSP). The CFSP is a five-year strategic plan that sets the State's vision and goals to strengthen the child welfare system. It outlines initiatives and activities to administer and integrate programs and services that promote the safety, permanency, and well-being of children and families. The State Team completed a revised vision and year one goals for collaboration. The Plan is a requirement for Hawaii Department of Human Services (DHS) to receive federal Title IV-B child welfare services funding for the State.

The Family Strengthening and Violence Prevention Section (FSVPS) programs collaborate to address similar preventive factors and shared systems resources. The FSVPS programs often share funding, resources and data, and coordinate training and technical assistance (TA) opportunities. These prevention programs help to create a foundation for healthy relationships among parents and future young adults.

The Sexual Violence Prevention Program's primary prevention included: sexual violence-related trainings, TA, and outreach targeting middle and high school-aged students, statewide community action teams; University staff and students; public and private agencies. Trainings on health/respectful relationships for high school football coaches was conducted to help mentor young athletes.

The Domestic Violence Prevention Program activities included: support for the Domestic Violence Fatality Review (DVFR) statewide team to develop findings/recommendation to prevent family/inter-personal violence; conduct DV trainings and outreach and implement systems changes in partnership with public and private agencies. Educational topics include teen dating violence, connecting the dots of violence, and promoting healthy relationships.

Home visiting supports pregnant moms and new parents to promote infant and child health, foster educational development and school readiness, and help prevent CAN. Federal MIECHV funds are used to support the Hawaii Home Visiting Program (HHVP) providing voluntary, evidence-based home visiting services to at-risk pregnant women and parents with young children. Home visiting services are provided statewide using the evidence-based programs – Healthy Families America, Parents as Teachers, and Home Instruction for Parents of Preschool Youngsters. In fiscal year 2018-2019, the seven home visiting programs in Hawaii provided direct preventive services to 718 parents and 692 children including 71 families who had at least one child with a disability. MIECHV also partners with Title V early childhood and perinatal programs to promote family/child wellness.

The MCHB Parenting Support Program (PSP) administers family strengthening contracts for parenting and child development services statewide. Services include The Parent Line (http://www.theparentline.org/), a telephone warm-line for parents, information dissemination on child development and community resources; short term in-home parenting support, and parent-child interactive education groups for homeless families. The contracts provide access to CANP resources and services to families. The PSP also supports activities conducted by the Keiki Injury Prevention Coalition (KIPC) and Safe Sleep Hawaii (SSH). KIPC is a collaboration of over 150 organizations and agencies committed to preventing injuries. SSH provides statewide leadership in preventing infant deaths by providing education on Safe Sleep Practices following American Academy of Pediatrics (AAP) guidelines.

Title V programs collaborated with community partners to sponsor a Toxic Stress/Resilience and Trauma Informed Care Conference. The purpose of the conference was to increase knowledge about the neurobiology of toxic stress, Adverse Childhood Experiences (ACES), and transgenerational/historical trauma impacting Native Hawaiians. The conference also expanded collaboration across service delivery sectors. The sponsors included the FSVPS programs, the Children with Special Health Needs (CSHN) Branch, the Executive Office of Early Learning (EOEL), Early Childhood Action Strategy (ECAS), and the Hawaii Preschool Development Grant.

To support CAN prevention statewide, the FSVPS programs collaborated with the District Health Offices (DHO) in Maui, Kauai, and Hawaii counties to provide violence prevention trainings and TA for community-based programs working on CAN prevention/family strengthening. These efforts helped reach the state's largely rural communities. The DHO staff serve on the CWS Citizen's Review Panel and are actively engaged in CAN prevention program planning and policy development activities.

The Early Childhood Action Strategy (ECAS) Initiative continues to support collaboration across service sectors through its work groups:

- Safe and nurturing families
- Equitable access to services
- On-track health and development, and
- Healthy and welcomed births.

This statewide public-private collaborative brings together government and non-government organizations to align priorities for children prenatal to age eight, and to strengthen and integrate the early childhood system by streamlining services, maximizing resources, and improving programs to support the state's youngest children. The Title V CANP and Sexual Violence Prevention Coordinators serve on the Safe and Nurturing Families team. The team developed short and long-term Action Plan outcome measures and completed the evaluation methodology for a messaging campaign.

A Steering Committee was formed to support the creation of Hawaii's first CAN Prevention Plan. The plan will be a framework to guide community activities to prevent of all forms of CAN and other ACEs. Committee members includes the CANP Coordinator, Hawaii Children's Trust Fund Advisory Committee members, DHS, Liliuokalani Trust, ECAS, and several community-based agencies.

CBCAP programs are required to address child maltreatment prevention for special populations, such as adults and children with disabilities, youth at risk for homelessness, and members of underserved or underrepresented groups. The CANP program is focusing on adults and children with a disability, specifically individuals affected by prenatal exposure to alcohol that fall under the general descriptor of Fetal Alcohol Spectrum Disorder (FASD). The CANP Coordinator served as a core member of the FASD Action Team for over 12 years. In 2019, the CANP program provided funding and participated in the planning of a statewide FASD conference on creating an environment to transform FASD from a single focus condition to a systems concern. Local and national speakers presented current practice models to over 200 parents, probation officers, medical professionals, mental health and substance abuse professionals, attorneys, judges and other community members.

Other key partners in CAN prevention include the Domestic Violence Action Center, Hawaii Children's Trust Fund, and Healthy Mothers Healthy Babies.

Strategy 2: Develop a Child Abuse and Neglect (CAN) surveillance system.

Surveillance is vital to provide health information to guide planning, implementing, and evaluating public health practice, policy, and programming. Without consistent, reliable data it is difficult to accurately assess the magnitude of child maltreatment in relation to other public health problems, and limits the ability to identify groups at highest risk, monitor the effectiveness of ongoing prevention and intervention activities, and measure changes in the incidence and prevalence of CAN over time. Developing a centralized repository for public and private CAN data enables a clearer and accurate picture of CAN in the islands.

The University of Hawaii Public Health program was contracted to create an inventory of existing secondary CAN

data sources. The scope included agency, survey, and program data related to risk and protective factors. Data is available at a sufficient granular level to allow analysis by island, county, zip code, census tract, race/ethnicity, age, and gender. The data analysis also produced mapping of high-risk indicators for each island.

Data sources included:

- Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) data on substance use before, during and after pregnancy, domestic violence and maternal depression
- Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavioral Surveillance System (YRBS) data on domestic and sexual violence and high-risk behaviors
- Hawaii Child Death Review data on intervention strategies;
- Home Visiting performance measure data
- DHS Child Abuse and Foster Care reports
- National Survey of Children's Health data on ACES and resilience measures

Further analysis is needed to address the challenges of working with such diverse datasets to develop findings that inform CAN prevention programs and policies. Title V will work with stakeholders to continue these efforts.

Strategy 3: Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

The FSVPS programs sponsored events and initiatives focusing on building awareness and knowledge of strategies to prevent family violence. The events focused on families, caregivers, service providers, and the community at-large. Activities included 'Wear Blue Day' and family activity days conducted in partnership with the state libraries where more than 1,600 children and parents/caregivers participated in hands-on fun activities to learn about positive parenting, family engagement, and child development. Child development professionals were available to share information about child behavior, nurturing the emotional, physical, intellectual, and social development of children, and offer referral information.

Another activity was the screening of the documentary *Resilience* followed by a facilitated discussion. Feedback included the need to support policy change, funding more programs to address toxic stress, and the need to focus on prevention and treatment. More than 350 adults participated in this activity.

The documentary was also screened by Oahu's west side with discussions led by the community leader of houseless encampment. Conversations focused on investing in the community and the importance of having a stable adult in a child's life. Participants reported feeling motivated to advocate for better programs to combat child adversity and toxic stress. Statewide media coverage on local TV and radio shows promoting the events provided brief introductions about toxic stress and resilience to a larger audience.

The April Sexual Assault Awareness Month sponsored events and activities highlighting sexual assault as a public health, human rights, and social justice issue, and reinforcing the need for prevention efforts. The Department of the Attorney General, DOH, and the Hawaii Coalition Against Sexual Assault partnered to recognize 14 community members and organizations who made a difference in the islands by encouraging healthy relationships, teaching youth about consent, and how power dynamics impact consent.

Keiki TALK, a Ted Talk-like event, hosted a presentation on toxic stress and the impact on a child's developing brain. The event was attended by business, policymakers, community, and philanthropic leaders. This was an opportunity for non-public health leaders to understand the role their organizations play in preventing child maltreatment. Attendees discussed ideas on building resilience and mitigating the causes of toxic stress in local communities.

Maui County has two CAN prevention collaboratives: 1) the Ho`oikaika Partnership - a coalition of more than 60 Maui County agencies - that raises awareness about CAN, educates parents and providers about available resources, educates parents, professionals, and the public about the risk and protective factors associated with CAN, and provides training to businesses, social services agencies, partners; and 2) Islands of Hope (IOH) - a collaborative effort of Maui Child Welfare Services, Casey Family Programs, and Ho`oikaika Partnership - that supports a County-wide public-private safety net to protect and nurture children, strengthen and support families, and improve opportunities for vulnerable children, youth and parents. The signature initiative of IOH is a One-Stop Shop resource center located inside one of Maui's largest shopping centers staffed by volunteers from public and private organizations.

In May 2019 the MCHB, in partnership with the MOD Hawaii Chapter, Healthy Mothers/Healthy Babies Coalition, the Maternal and Child Health Leadership Education in Neurodevelopmental Disabilities (MCH LEND) program, sponsored the Hawaii Fatality Summit. The Summit provided information on the role and work of three fatality review initiatives - the Child Death, Domestic Violence Fatality, and Maternal Mortality Fatality. In addition, two violence tracks addressing childhood adversity and domestic violence were offered. The Summit provided the opportunity to identify areas for collaboration particularly for CAN and domestic violence prevention.

The ECAS work conducted by the Safe and Nurturing Families Team focused on building a violence prevention communication framework designed to increase awareness of all forms of family violence—including CAN and intimate partner violence. The effort will 'reframe' how this public health issue is presented and addressed across disciplines. Draft messages and visual graphics were tested across all ECAS Teams and a 5-7-year communication sustainability plan was created.

Strategy 4: Provide community-based training and technical assistance promoting safe, healthy, and respectful relationships to prevent child abuse and neglect.

Research suggests that in 30-60 percent of the families where either domestic violence or child maltreatment is identified, both forms of abuse co-exist. Children can suffer from a range of behavioral problems when witnessing or being exposed to violence in the home, even if they are not the direct victim. FSVPS programs continued to collaborate on training and TA focusing on topics such as the impacts of children exposed to violence, ACEs, protective factors, resilience, and promoting safe, healthy, and respectful relationships.

The Sexual Violence Prevention program continued to fund training on the Futures Without Violence *Coaching Boys into Men* (CBIM) program and curriculum. The Centers for Disease Control and Prevention recognizes CBIM as an effective and promising prevention program. The curriculum provides high school athletic coaches the resources to promote respectful behavior among players and helps prevent relationship abuse, harassment, and sexual assault. By learning about healthy relationships at a young age, these boys will carry forward the learned skills and behaviors into their own families and communities.

The HHVP offered ongoing training and TA to their contractors promoting child development, encouraging positive parenting, and working with caregiver participants to set attainable goals for the future to prevent CAN.

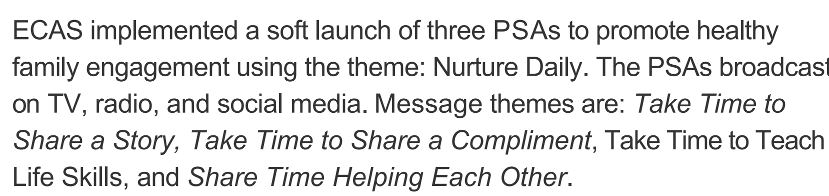
Current Year Highlights for FY 2020 through April 2020

Below are some highlights of current CAN prevention activities for FY2020, including the impacts and changes from the early days of COVID pandemic in Hawaii.

CBCAP entered into a new collaboration with the Hawaii State Department of Education (DOE) to participate in the planning and implementation of a 5-year trauma recovery project called *Ho`oikaika* (striving toward strength). The overall purpose of the project is to build the capacity of trauma sensitive schools by improving the current system of support. The project focuses on students from low-income families who have experienced trauma resulting in a negative impact on their educational experience.
The CBCAP Program will initiate corresponding prevention efforts in the school communities selected to be part of the pilot. This new collaboration intersects with ongoing public/private efforts to improve workforce competencies and systems to adopt trauma-informed responsive approaches. Aligned with the DOE project, the CBCAP Coordinator participates as a member of the Hawaii Core Implementation team in a Learning Community training under the National Council of Behavioral Health. The training is providing tools and skills to support bringing a trauma-informed, resilience-oriented approach to the behavioral health and community service organizations participating in the DOE project. It is a mechanism to strengthen collaborations across system including DOE, DHS, community mental health providers, and DOH. Initial conversations were held with a leader from the faith community to collaborate on strategies to support and promote resilience to a west side Oahu community. The community has long-standing social and health problems such as youth and parent incarceration, generations of fatherlessness, involvement with the child welfare system, and the highest number of confirmed child maltreatment for the state.

The CANP continued work with DHS on the CFSP and FFSPA. The 2020-2024 CFS plan was submitted in June. The State Team is currently developing strategy details for the first CFSP goal on collaboration.

Fact sheets addressing CAN prevention, intimate partner violence prevention, sexual violence prevention, ACEs, and resilience were drafted and are being finalized for distribution.



ECAS implemented a soft launch of three PSAs to promote healthy family engagement using the theme: Nurture Daily. The PSAs broadcast on TV, radio, and social media. Message themes are: *Take Time to Share a Story, Take Time to Share a Compliment*, Take Time to Teach Life Skills, and *Share Time Helping Each Other*.

COVID-19 stay at home orders instituted in March alarmed many social service agencies concerned about the increased potential for family violence including CAN. The closure of workplaces, businesses, public amenities, and shelter-at-home orders; created greater social isolation and stress for families. Also, the furlough and layoff of thousands of workers imposed further economic anxieties on families that could increase the risk of family violence.

Many Hawaii health and social service agencies responded with social media, TV, and radio messaging campaigns, creating new remote resources for family support, and providing information on family violence and mental health resources. MCHB developed several public service announcements (PSA) focusing on safe and nurturing families, healthy relationships, and promoting the state Parent Line resources. The PSAs were broadcast statewide on major local media platforms. MCHB also secured three time slots on a local television station with tips on staying connected, keeping children busy and happy at home, and managing stress. ECAS and Hawaii Children's Action Network are serving as information/service hubs for parents, service providers regarding COVID resources.

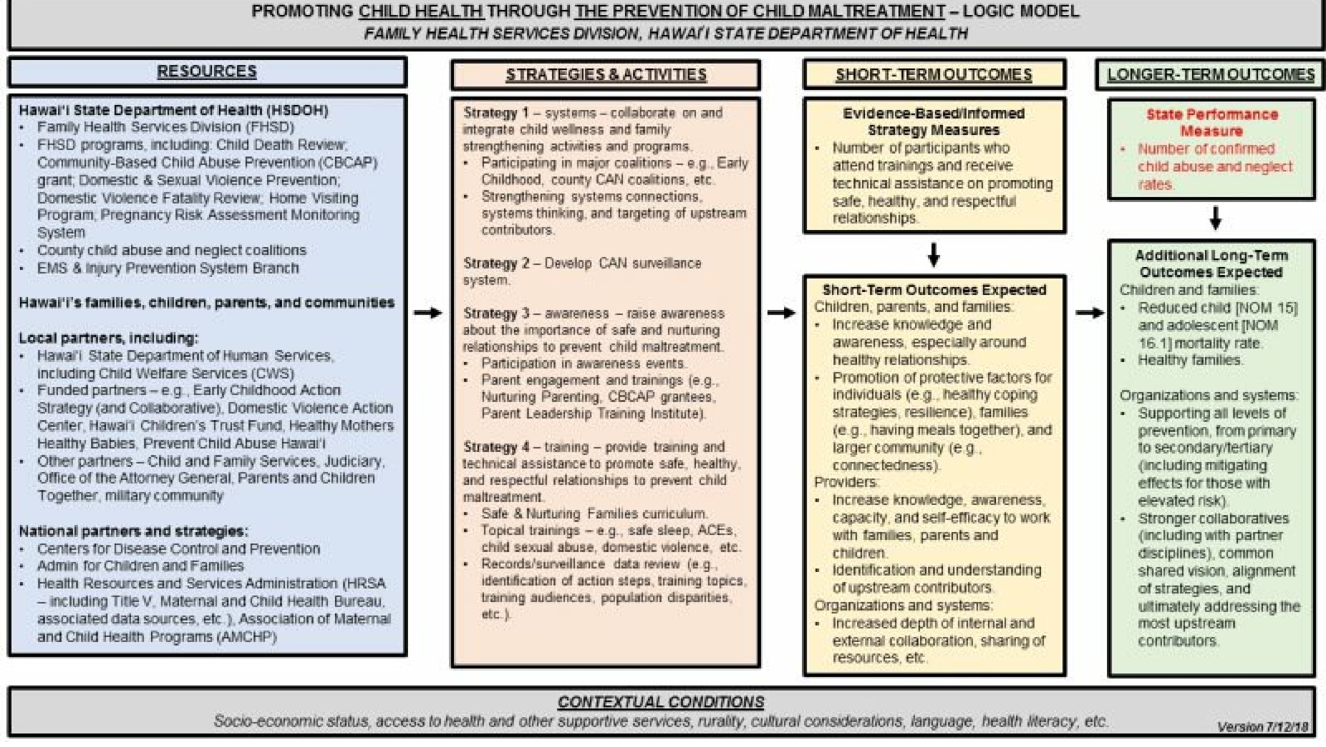
MIECHV program staff worked with their contractors to successfully transform in-person home visiting contacts to virtual format home visiting platform with their families.

The decision was made to pause the work on the child abuse and neglect (CAN) surveillance system. Because of

COVID, there is an urgent need to refocus on developing new and expanding existing services and resources for families, service providers, state and county offices, and the general public.

Review of Action Plan

The CAN logic model below describes an overview of current activities. Preventing child abuse and neglect cannot be addressed as a stand-alone public health concern. The logic model confirms the importance of acknowledging and addressing contextual conditions that impact and influence CAN negatively or positively, in tandem with programs that specifically target violence prevention. The logic model also captures the broad array of service partners/resources to address CAN in Hawaii: Title V and DOH programs, State Executive Departments, namely the DHS/CWS, Judiciary, and Office of the Attorney General. Other critical local partners include funded programs such as Healthy Mothers Healthy Babies, Hawaii Children's Action Network, Na Leo Kane, Domestic Violence Action Center, and the Sex Abuse Treatment Center. CAN prevention is supported through national resources including but not limited to FRIENDS, the National Center for Community-Based Child Abuse Prevention (CBCAP), CDC, SAMHSA, Prevent Child Abuse America, and the Children's Trust Alliance that provides training and technical assistance, and the California Evidence-Based Clearinghouse for Child Welfare.



The logic model will be revised next year with the removal of Strategy 2 - develop a CAN surveillance system - because the work will be integrated into larger state planning efforts including the creation of a Hawaii CAN prevention plan. It will be replaced with the new strategy - build and expand the primary prevention collaboration work under the Hawaii Family First Prevention Services (FFPSA) Act. This Act is requiring complex, systems changes regarding the infrastructure and financing of the child welfare system. One of the major changes is the ability to use federal Title IV-E foster care funding to support programs that prevent the placement of children and youth into the foster care system. The CBCAP grant is identified in the Act as an instrumental partner because of its focus on the primary prevention of CAN.

Challenges and Barriers

With the new federal FFPSA legislation, child welfare systems face the enormous challenge to prevent CAN and reduce the number of children being placed into foster care. The goal of FFPSA is to ensure children are safely reunified with family or find a permanent home. A more comprehensive, systems building approach is required to achieve and sustain change that both addresses systemic issues, as well as implementation of service innovations. The challenge will be to create a well-functioning system of care that is coordinated with shared principles, processes, and practices across social service agencies and community partners.
Some of the challenges include:

- Coordinating different funding requirements, time frames and budget periods, differing performance measures and data collection methods
- Limited staffing resources and vacancies
- The complexity of preventing child maltreatment and the broad scope of services and disciplines engaged in this effort

Given the complexity and scale of system improvements required, time and flexibility are needed to address the barriers that are encountered. Discussions continue with partners and stakeholders to use innovative/evidence-based strategies to address these challenges and sustain progress.

Overall Impact

Hawaii FFPSA work resulted in strengthening partnerships across state agencies – DOH, DHS, Judiciary, and the DOE. Each agency adopted the state vision and outlined their agency's role in the partnership to move this federal legation forward.

Important systems changes resulted as private and public programs began to integrate Trauma Informed Care (TIC) into client services. Agencies adopting TIC include the DHS Child Welfare Section and their contractors, the Hawaii Community Foundation, Early Childhood Action Strategy (ECAS), DOH, FSVPS, and Partners in Development. Potential benefits associated with TIC are:

- creating safer physical and emotional environments for clients, families, and staff
- reducing the possibility of re-traumatization
- creating environments that care for and support staff
- increasing the quality of services, reducing unnecessary interventions, reducing costs
- creating a resiliency and strengths-based focus
- increasing client and family satisfaction
- increasing success and job satisfaction among staff

Access to federal TA resources, specifically, MIECHV, CBCAP, CDC Rape Prevention and Education, and the CDC Preventive Health and Health Services Block Grants were instrumental in creating greater state capacity to address the prevention of CAN.

Child Health - Application Year

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

For the Child Health domain, Hawaii selected NPM-6 Developmental Screening as a continuing priority based on the 2020 five-year needs assessment. By July 2025, the state seeks to increase the percentage of children ages 9 through 35 months, receiving a developmental screening, to 45.0%. Plans to address this objective and NPM are discussed below.

Based on findings from the 2020 Title V Needs Assessment, Hawaii's Developmental Screening Workgroup will reconvene to assess the activities under the strategies of the Policy and Public Health Coordination Scale. While most providers and families still believe developmental screening is a critical priority that the state needs to address, some of the activities may need to be reevaluated to assure Hawaii is achieving measurable impacts to assure healthy child development. Also, because of the COVID-19 pandemic, Hawaii will need to reassess developmental screening strategies and activities in context of other critical needs of children and families.

Strategy 1: Systems Development

Hawaii will to continue work with partners to implement the statewide system for developmental screening, referral, and services. These efforts are part of the strategic plan for the federal Preschool Development Grant Birth through Five (PDG B-5). Hawaii will consider social determinants of health to assure service accessibility to the most vulnerable populations, based on lessons learned from the pilot initiative at the IHS homeless shelter. Community level initiatives, such as the ECCS Impact grant focused on Maui County, will be used to refine statewide policies, procedures, and guidelines.

Strategy 2: Family Engagement & Public Awareness

Hawaii will continue to work with the Family Hui to refine the child development kits to be shared with families to support their children's development, using evaluation findings from the prototype. Hawaii would like to connect the kits to a messaging campaign. If parents sign up for alerts about child development and remember to complete the screens, then kits may be distributed to them. Based on findings from the 2020 needs assessment, the community and professionals both endorsed developmental screening as a priority. Most of the input collected on strategies and activities validated the current approaches. The issue may be that service providers and families are unaware of developmental screening resources, and so more communication/messaging is needed.

Strategy 3: Data Collection and Integration

Hawaii will continue to work within FHSD to analyze available data to better target outreach efforts among various communities. New data sources, possibly from individual health plans, may be explored.

Strategy 4: Social Determinants of Health and Vulnerable Populations

Based on feedback from the IHS Homeless Shelter pilot, Hawaii may reach out to other vulnerable communities where children's development may be at risk due to lack of access to basic concrete supports including housing, food security, health care, childcare and school, and living wages. The SWYC may be used as a tool to help screen children and families not just around healthy development, but also with respect to social determinants of health.

Strategy 5: Policy and Public Health Coordination

Hawaii will continue to implement the Public Health and Policy Rating Scale to track Title V-led activities around developmental screening. By working in all five areas, a better system of developmental screening will emerge, and more children and families will be supported. The FY 2021 objective is set for 27.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

There are no plans for NPM 13.2 since the priority was not selected by the 2020 Hawaii needs assessment for continuation due to the lack of program resources.

SPM 4: Rate of confirmed child abuse and neglect cases per 1,000 children aged 0 to 5 years.

For the Child Health domain, Hawaii selected Child Abuse and Neglect (CAN) prevention as a continuing state priority based on the 2020 5-year needs assessment. By July 2025 the state seeks to reduce the rate of confirmed child abuse and neglect cases per 1,000 children aged 0 to 5 years to 5.2. Plans to address this objective and SPM are discussed below.

Based on findings from the 2020 Title V Needs Assessment, the Title V CAN Program (CANP) will continue to focus on activities reported in the FY 2019 report. The strategies for FY 2021 were revised. The development of a CAN surveillance system will be deferred until the State CAN prevention plan is completed. A new strategy was created to reflect the collaborative work on the federal Family First Prevention Services Act (FFPSA).

Strategy 1: Collaborate on and integrate child wellness and family strengthening activities across programs.

Preventing CAN will continue to be addressed through established collaborations with external organizations including the Early Childhood Action Strategy (ECAS), the Hawaii Community Foundation, Hawaii Children's Trust Fund (HCTF), and the Hawaii Children's Action Network (HCAN). New collaborations will be sought out with the Hawaii Primary Care Association, Federally Qualified Health Centers, Rural Health Association/Rural Health Clinics. Early discussions were held with several of these groups with encouraging preliminary outcomes.

CANP supports the implementation of a promising practice - Strong Communities for Children (SCS) on west side of Oahu Island. The project is in partnership with faith-based leadership using CBCAP funding. SCS is a community level strategy that organizes voluntary assistance between neighbors especially for families of young children. Outreach workers facilitate community engagement and leadership development to enable the community to develop a sense of responsibility for its parent support and child safety needs. The program facilitates planning and implementation of a community level vision, goals and strategies for wellbeing.

Strategy 2: Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

Statewide community-level events and activities will be employed to increase awareness and knowledge of safe and healthy relationships and to promote family strengthening and community resiliency. Events will take place at public sites, i.e., shopping malls, libraries to maximize public reach. Resource materials covering child development, appropriate discipline by age, parenting tips and materials will be distributed. Events may be staffed with resource experts on child development, parenting, and other topics of interest. In-person events may need to be redesigned in lieu of COVID restrictions. April CANP activities will continue to be supported.

The Title V MCHB Parenting Support Programs will continue to provide statewide outreach to parents, caregivers, the professional community, and community at-large. Services include a telephone warm-line, information on child development, and available community resources. Similarly, the Home Visiting (HV) Program will maintain its home-based visiting services to at-risk pregnant women and parents with young children. HV services will continue to use three evidence-based programs – Parents As Teachers (PAT), Healthy Families American (HFA), and Home Instruction for Parents of Preschool Youngers. PAT and HFA are listed as well-supported models on the FFPSA Clearinghouse.

CBCAP funding will be used to support awareness, knowledge and skill-building on the neighbor islands working with the District Health Office FHSD nurses and the CANP coalitions. Pinwheel gardens, Mayoral proclamations, social media, and family activities will again be employed to reach rural communities. Coalitions will also be supported to design their own CANP activities.

Strategy 3: Provide community-based training and technical assistance promoting safe, healthy, and respectful relationships to prevent child abuse and neglect.

Strategy 3 efforts will focus on sponsoring training activities, expanding awareness, and providing tools to support prevention designed to reach specific at-risk populations or settings such as home, school and other community sites. Trainings and technical assistance (TA) events will be evaluated to determine whether the events are reaching the targeted populations and making an impact. To plan for future training and TA needs, attendees will be queried regarding unmet or new training needs.

ACEs, Resilience and Trauma-informed/Responsive care are major topics for workforce development for many state and private organizations that provide family services. The CANP program is exploring the possibility of developing virtual learning sessions for early childcare providers, community professionals and the general public. Topics will include “Building Community Resilience/Pair of ACES” and “the Development of Resilience - Positive Outcomes of Children and Families facing Adversity”.

Future trainings related to child maltreatment including safe sleep, safe and effective discipline, and domestic violence will be made available to a range of private and public agencies, organizations and offices. The Hawaii Home Visiting Program will continue to provide quarterly trainings to their contracted statewide service providers.

Strategy 4: Collaborate with the Hawaii Department of Human Services Family First Prevention Services Act primary prevention initiatives.

The CANP Coordinator will continue to participate in FFPSA initiatives. Hawaii’s FFPSA vision is children and families are thriving with access to a range of effective child welfare prevention services that strengthen families, support parents and keep children safe at home. Specific initiatives and activities will be determined by the DHS/CWS.

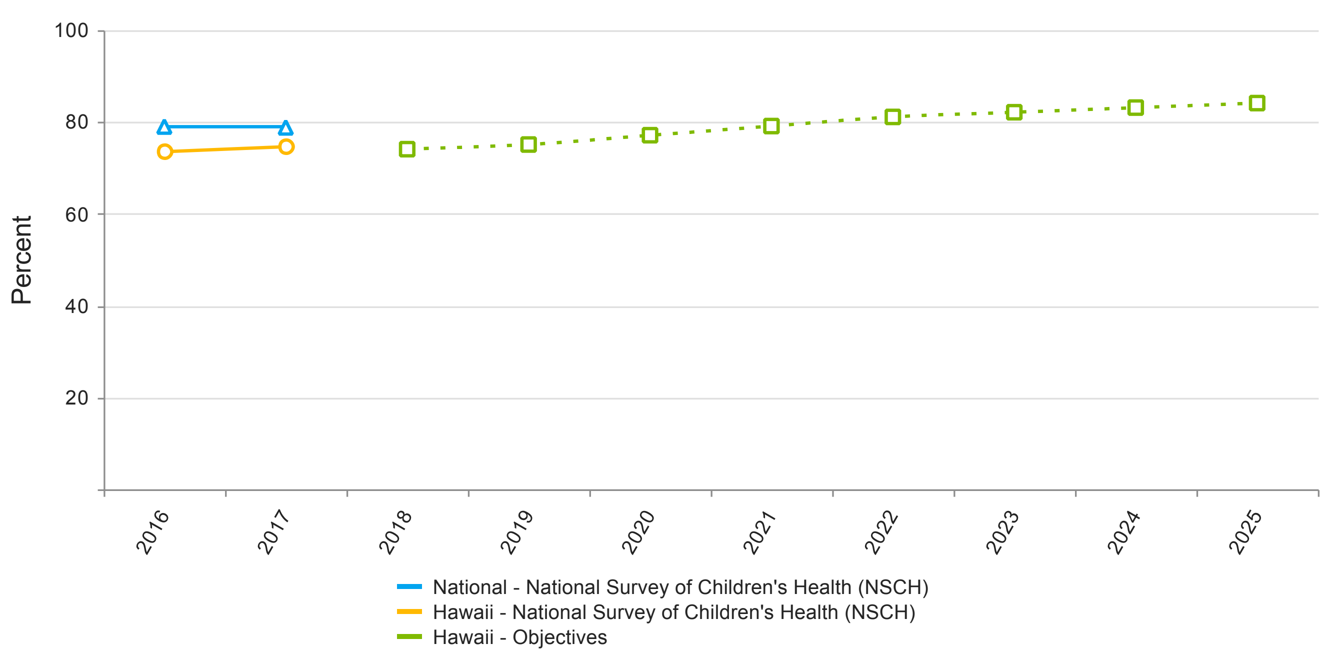
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	25.1	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	8.6	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	9.9	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	54.4 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	92.4 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2017_2018	11.5 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2016	9.6 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2017	14.2 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2018_2019	61.8 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2018	76.7 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2018	85.8 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2018	83.6 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	17.2	NPM 10

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	2017	2018	2019
Annual Objective			74	75
Annual Indicator		73.5	74.6	74.6
Numerator		67,325	74,226	74,226
Denominator		91,592	99,470	99,470
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	77.0	79.0	81.0	82.0	83.0	84.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2018	2019
Annual Objective		
Annual Indicator		
Numerator	9	13
Denominator	30	30
Data Source	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	18.0	23.0	25.0	28.0	30.0	30.0

State Action Plan Table

State Action Plan Table (Hawaii) - Adolescent Health - Entry 1

Priority Need

Improve the healthy development, health, safety, and well-being of adolescents

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By July 2025, increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 84%

Strategies

Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits.

Engagement. Work with adolescents and youth service providers to develop and disseminate informational resources to promote access to adolescent preventive services.

Workforce Development. Provide resources, training, and learning opportunities for adolescent caregivers, community health workers, and other service providers to promote teen-centered, annual wellness visits.

ESMs	Status
ESM 10.1 - Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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

2016-2020: National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Introduction: Adolescent Wellness Visits (AWVs)

For the Adolescent Health domain, Hawaii selected NPM 10 (preventive medical visits) based on the results of the 2015 five-year needs assessment. New data from the National Survey on Child Health (NSCH) for FY 2019 is unavailable due to a change in the survey question. Aggregated data from the previous year's survey (2016-2017) show the estimate for Hawaii (74.6%) was similar to the national average of 78.7% and the annual FY 2019 objective (75%) was nearly met.

Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they are expected to assume individual responsibility for health habits. In particular, adolescents with chronic health problems take on a greater role in managing those conditions. Adolescence is a critical time to empower, educate, and engage teens to establish health behaviors that will lay the foundation for their health into adulthood.

Nationally, Adolescent Wellness Visits (AWV) are recognized as an important standard of care. The American Academy of Pediatrics' (AAP) *Bright Futures* guidelines recommend that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations.

Disparities related to access to preventive health care exist among Hawaii's adolescents. NSCH data show that parents who graduated from college were more likely to have their adolescents seen for a preventive visit (83.5%), compared to those with some college (69.6%) or with only a high school education (66.4%). Data for parents with less than a high school education were not reported, due to small numbers. Similarly, adolescents who lived in households with higher income (>=400% of the federal poverty level [FPL]) were more likely to have a preventive visit (86.1%), compared to those at 200-399% of the FPL (74.2%), those at 100-199% of the FPL (59.4%), and those below 100% of the FPL (65.5%). Finally, adolescents living in a household where a non-English language was spoken had lower estimates (51.1%) of preventive medical visits, compared to those where English was the primary language spoken (77.0%).

The 2017 Hawaii Youth Risk Behavior Survey (YRBS) showed somewhat lower estimates of preventive visits: 47.9% of middle school-aged adolescents and 65.9% of high school teens reported seeing a doctor for a check-up or preventive physical exam. Since 2015, this is a 2% increase for middle schoolers, and a 4% increase for high school teens. These numbers may be overstated if adolescents defined sports physicals as a wellness visit. Neighbor island disparities remain. Kauai County middle and high school youth reported the lowest percentages of adolescent wellness visits, followed by Maui County and Hawaii County.

The Title V Adolescent Health Unit (AHU) in the Maternal and Child Health Branch (MCHB) is the lead for the AWV measure. The AHU also administers the federal Personal Responsibility Education Program (PREP) grant and assists with management of state-funded Perinatal Support Services (PSS) contracts. The AHU coordinator is Title V-funded.

The strategies for this measure are based on guidelines from the national Office of Adolescent Health's Think, Act, Grow (TAG) Call to Action designed to promote adolescent health through a comprehensive approach working with varied stakeholders. The strategies are:

- Collaboration. Develop partnerships with community health and youth service providers to promote

adolescent 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 adolescent caregivers, community health workers, and other service providers to promote adolescent health and wellness visits.

Research provided by AMCHP and the MCH Evidence Center were reviewed to identify additional evidence for Hawaii's strategies. The AHU is using several strategies recommended by the National Adolescent and Young Adult Health Information Center and cited in the evidence-based literature. These include building collaborative networks, providing training to youth-serving professionals, and using innovative outreach techniques developed with input from youth.

Coordination with NPM 12: Transition to Adult Health Care

Hawaii elected to continue work on the state priority to improve the percentage of youth with and without special health care needs (YSHCN), ages 14-21 years, who make a successful transition to adult care. Since the national performance measure for transition services addresses youth with and without special needs, the AHU is coordinating efforts with the CSHN program to address performance measures of both programs.

Strategies to address the NPM for adolescent preventive visits are discussed below.

Strategy 1: Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits.

The Title V Adolescent Health Unit (AHU) continues to build partnerships with community health and youth service providers to promote adolescent health and wellness visits. AHU strategically leveraged the partnerships with community-based service providers to work with youth directly, and expand provider outreach to youth in the community. These providers are funded through the federal Personal Responsibility and Education Program (PREP) teen pregnancy prevention program and the state-funded Perinatal Support Services (PSS) program. Through these programs, AHU received valuable input from youth to develop effective messaging and provide workforce training and resources to youth service providers.

Since 2017, the Hawaii National Guard Youth Challenge Academy (YCA) is the state's primary PREP provider. YCA staff use the evidence-based Teen Outreach Program® (TOP®) curriculum in their Hawaii Island and Oahu Island residential facilities. YCA targets youth who are at high risk for substance abuse, teen pregnancy, delinquency, and criminal activity. The teens voluntarily enroll in the alternative, quasi-military school. Each calendar year, 94% of their 250 participants,16 to 18 years of age, complete the positive youth development and teen pregnancy prevention TOP® curriculum.

Among many other beneficial outcomes of this partnership, YCA participants provided valuable baseline information on their knowledge and awareness of AWV. Youth also identified health topics of greatest interest and preferred methods of receiving health information. AHU used the input to develop a framework for an Adolescent Resource Toolkit (ART) intended for teens, their families, and providers. Generally, youth had little understanding of AWV so information on AWV was integrated into the TOP® curriculum. Program evaluation surveys now include questions to measure youth knowledge and skills to schedule a wellcare visit with a medical home.

The AHU also used partnerships established with providers of its state-funded PSS program to expand outreach efforts to high-risk youth. Most of the providers are Federally Qualified Health Centers (FQHCs) and several are

located on the neighbor islands where teens have the lowest rates of AWV. Community health workers (CHWs) at the FQHCs are ideal partners to provide prevention education and link youth to medical services as part of their outreach activities in underserved communities. Healthcare staff within the clinics are also encouraged to integrate adolescent preventive care into athletic evaluations or chronic disease management (e.g. screening for risk behaviors and disease, assessing reproductive health concerns, updating of immunizations, and offering health guidance).

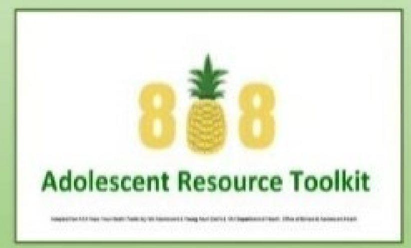
The AHU continued to partner with the CSHN Branch to coordinate efforts to improve successful transition to adult healthcare. The PREP grant coordinator was part of a 5-person state team participating in a National MCH Workforce Development Center (WDC) technical assistance cohort to advance Hawaii's Title V work on transition. The WDC TA assisted with the integration of transition information and planning tools into the AHU adolescent health trainings, including the TOP® curriculum.

AHU also collaborated with the Title V Family Planning program to integrate reproductive health planning information into AHU trainings and the TOP® program.

The AHU routinely partnered with many of the state's youth-serving organizations to promote adolescent health and wellness visits, including the Hawaii Youth Services Network, Office of Youth Services, the Coalition for a Drug-Free Hawaii, the Hawaii Partnership to Prevent Underage Drinking, the Youth Tobacco prevention coalition, the DOH Chronic Disease School Healthy program, the Prevent Suicide Hawaii Taskforce, and Mental Health America of Hawaii. The AHU maintained a contact listserv to disseminate information shared from national and local resources.

The AHU participates in the Hawaii Health Survey committee which consists of representatives from the Department of Education, the University of Hawaii, Office of Hawaiian Affairs, and the DOH Chronic Disease School Health program. The Committee provides oversight for the YRBS which is administered in odd-numbered years. The most recent Middle and High School YRBS data are from the 2017 survey. The 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?*" is an important AWV measure. Although the survey is self-reported from youth, the sample is much larger than the NSCH and provides greater stratified data. Recent efforts to increase the study's sample size will allow for more detailed analysis of risk/protective behaviors.

Strategy 2: Engagement. Work with adolescents and youth service providers to develop and disseminate informational resources to promote access to adolescent preventive health services.



The Adolescent Resource Toolkit (ART) remains AHU's primary vehicle for information dissemination to the community. The ART focuses on building adolescent knowledge, behavior, and skills to access health care and community resources. By meeting youth where they are in their transition to adulthood, health educators and outreach staff will be able share at least one local resource and/or connect them to a website or health center.

Information specific to AWVs was integrated into the ART to provide teens and their families with critical health information needed to access annual healthcare services including:

- the benefits of an AWV;
- identifying a medical home;
- how to schedule an appointment;
- age-of-consent; and

- their rights to privacy and access to care (e.g., confidentiality of medical appointments and records, and accessing mental health, family planning and emergency contraception services for those 14 years and older).

The ART's original physical format evolved into a mix of printed cards, pamphlets, and materials that are geared for the adolescent audience. Currently, the ART is distributed through a "warm hand-out" strategy deemed most effective to deliver the materials and empower youth to make informed decisions about their health and well-being. This approach, where information is delivered during a two-way in-person interaction (as opposed to passive or one-way dissemination), also builds relationships between the adolescent and an adult/organization. Printed versions of the ART were used by FQHC outreach CHWs to encourage teens to visit their physicians annually.

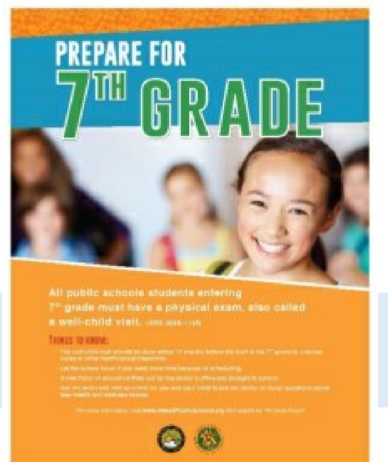
The AHU continued to refine the ART with adolescents in mind, using input from teens as well as youth service providers. The AHU worked with the PREP YCA provider to collect input from youth on health topics of interest and ideas to effectively communicate information (e.g., common language used and engaging designs). The YCA's 250 teens were surveyed for input.

Through the partnership with the Title V CSHN program's Transition Workgroup, the ART now includes information adapted from that group to increase adolescents' confidence to access health care services and strengthen independent life skills.

safe
sex
808
.org

The AHU forged partnerships with allied agencies and collaboratives to expand the ART's content and disseminate a broader array of health information. Through the Hawaii Maternal and Infant Health Collaborative (HMIHC), the AHU learned about the *SafeSex808* online resources aimed at teens and young adults to reduce the cases of sexually transmitted disease and unintended pregnancies. Spearheaded by the University of Hawaii John A. Burns School of Medicine (JABSOM), *safesex808.org* is an interactive reproductive health website, complete with an on-line "talk to a nurse" feature. JABSOM noted that queries on the website clearly indicate a need for medically accurate information for this age group. The website was incorporated into the ART.

The AHU continues to partner with the DOH's Chronic Disease and Health Promotion Division (CDHPD) to implement legislation passed in 2016 which requires all public school youth entering the 7th grade to have a physical examination. CDHPD helped lead the effort to pass the legislation and currently convenes a diverse group of stakeholders to promote AWV through a public messaging campaign. Information on the law is included in the ART.



The CDHPD messaging campaign to youth and families continued in partnership with the Department of Education (DOE), in the form of public service announcements played through various media channels. The CDHPD reported that of the 13,150 public school teens who entered the 7th grade in the 2018-19 school year, 6,477 (49.3%) received physical exams. This was a 2% increase from the previous year (47.8%). The AHU will work with FQHCs and other partners to increase these numbers in the coming year.

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.

The AHU provides training and technical assistance (TA) on adolescent health and positive youth development for youth and other service providers. The AHU continues training on positive youth

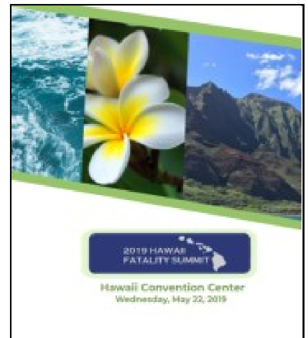
development and protective factors as part of the PREP program, using the evidence-based TOP® facilitator certification training. AHU continues to provide staff development webinars and on-line training opportunities, in addition to TA to both YCA sites.

All PREP youth participants complete pre- and post-program surveys. Questions inserted into the TOP® survey ask about AWV knowledge and ability to schedule an appointment. Survey information is also used to assess barriers to accessing AWV.

The AHU provided three adolescent health presentations for workers at the youth detention center (DC) on Oahu. The trainings included the importance and benefits of AWV. The training series was discontinued, however, as the facility could not accommodate the scheduling requests. The AHU continues to look for opportunities to collaborate with workers who serve high risk youth.

The AHU is also working with the Title V family planning program to train adolescent service providers and parents to use a modified One Key Question® approach to start a preventive health conversation with youth. Participants are trained to ask the question, "*Would you like to become a parent in the next year*?" Regardless of the answer, the recommendation is to encourage the teen to schedule an AWV if they did not have one in the last twelve months.

In 2019 the AHU attended a national teen pregnancy prevention and adolescent health conference in Louisiana, and sponsored attendance for adolescent outreach staff at the Lanai and Molokai PSS provider sites. This was a great learning opportunity for the FQHC staff to increase awareness about adolescent health programs, services, and issues.



The DOH held a two-day Fatality Summit which attracted more than 200 clinicians, first responders, epidemiologists, agency providers, and DOH staff to hear and learn from domestic violence, maternal mortality, and child death review experts in the field. The AHU helped plan presentations on teen suicide prevention and adolescent mental health issues which were well-attended. Resources on adolescent health were also disseminated to participants.

Evidence-Based/Informed Strategy Measure

The Evidence-Based/Informed Strategy Measure (ESM) selected for adolescent wellness is ESM 10.2 Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits. The measure uses a scale to track progress on the development and dissemination of the ART. Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 30. Scoring is completed by Title V AHU staff with input from key stakeholders. Baseline data for FY 2018 is 9 out of 30 points (or 30%). There was a slight increase in FY 2019 to 13 out of 30 points (or 43%). Objectives have been set through 2025. The most current data collection form is below.

Element	0 Not met	1 Partially met	2 Mostly met	3 Completely met
Strategy 1: Collaboration				
1. Utilize partnerships with youth servicing programs to promote AWV and adolescent health including AHU service contractors, other Title V and DOH programs, community coalitions and organizations.			X	
2. Introduce CSHN's "Footsteps to Transition" to contractors and outreach staff to utilize the infograph to show participants where they are in their transition to adulthood and to direct the warm handout conversation to the topic area needed.		X		
3. Update the listserv of adolescent health stakeholders and if available, collect adolescent developed handouts for incorporation into the ART.		X		
4. Develop a local base of speakers on issues affecting adolescent behaviors.		X		
Strategy 2: Engagement: Adolescent Resource Toolkit (ART)				
5. Test the Footsteps to Transition and ART materials with teen informants and outreach workers/educators as well as the "warm hand-out" dissemination approach.			X	
6. Conduct assessments to determine adolescent awareness of the AWV and the perceived barriers to accessing an AWV.		X		
7. Assess service provider and informant information to assure the ART will provide useful health and resource information that will meet the needs of adolescents.		X		
Strategy 3: Workforce Development Training for Community Stakeholders				
8. Maximize opportunities to inform internal direct service providers and community stakeholders regarding AWV visits, the warm hand-out strategy, and the ART.		X		
9. Utilize the listserv to inform the work of lead adolescent health advocates regarding webinars, in-person training opportunities and other adolescent resources to include: positive youth development, teen pregnancy prevention, mental health first aid, gender orientation and the benefits of AWVs.			X	
10. Assess stakeholders for increased knowledge and comfort level post training.		X		
Total Points	13			

Current Year Highlights for FY 2020 through April 2020

Here are some highlights of current adolescent health activities for FY 2020, including the impacts and changes from the early days of the COVID pandemic in Hawaii.

In January 2020, AHU contracted with a second PREP provider, the Hawaii Youth Correctional Facility, now known as the Kawailoa Youth and Family Wellness Center (KYFWC). KYFWC is administratively attached to the state Department of Human Services, Office of Youth Services (OYS). The program is a residential facility of "last resort" for more than 30 court-involved youth 16 to 18 years of age from across the state. KYFWC is now implementing the evidence-based, positive youth development TOP® curriculum.

KYFWC youth correction officers (YCO) were trained by AHU to deliver TOP® interactive lessons, lead discussions, and design a community service learning project that ends the program cycle for the teens. KYFWC facilitators used the "Footsteps to Transition" infographic developed by the CSHN Branch to begin the conversation with teens about information needed to schedule a doctor's appointment and the benefits of having an AWV annually. While many teens noted having health insurance, most did not know the carrier, did not carry a copy of their insurance card, and had never made their own doctor appointments.

KYFWC administration reported a significant change in the relationships between the residents and YCOs as a result of the TOP® program. TOP® follows a new 'restorative justice' approach used by KYFWC to reform discipline and problem-solving practices with the adolescents in their care. The AHU continues to provide technical assistance to the YCOs as system reforms progresses.

In February 2020, FQHC Perinatal Support Services (PSS) outreach workers on the neighbor islands (Lanai, Molokai, Maui and Kona on Hawaii Island) were trained on adolescent health and promotion of wellness visits. The training included engagement techniques using a "warm hand-out" method to begin a conversation with youth around their healthcare provider. FQHC outreach workers also received training in the evidence-based middle school teen pregnancy prevention curriculum, Pono Choices. The Pono Choices program received an AMCHP best practice award in 2019.

The COVID-19 experience challenged the AHU to broaden strategies to update and disseminate the ART, while continuing to incorporate input and prototypes developed by teens. The Title V AHU continued efforts to partner with youth-serving organizations to further refine the ART. In 2020, AHU contracted with the Coalition for a Drug Free Hawaii (CDFH), a statewide organization working to prevent drug use since 1987. Many of their programs are directed toward youth. TeenLink Hawaii (TLH) is the CDFH youth empowerment, outreach, and education program that provides information and referral services for teens in Hawaii through a TLH website, social media activities, and youth leadership development groups on each island. Other youth service groups also use TeenLink to disseminate information to adolescents in the state.

AHU contracted with CDFH to work with their youth leadership groups to revamp and revise the ART. The current format was not deemed accessible based on input from the youth. CDFH youth groups began a broad-based survey of their peers across the state to validate the importance of health/wellness issues and identify the specific topics of greatest interest to include in the ART. A report on the survey results is expected later this year.

The CFDFH youth leadership groups will also develop outreach methods and tools to disseminate the information to peers, families, and youth-serving programs. Information will include promotion of annual wellness visits. The information will be included on CDFH's TLH website.

Implementation of COVID-19 stay-at-home orders and subsequent school closures statewide required substantial pivots for the AHU, given that many of its usual activities involve direct engagement with youth. A few activities provided include:

- MCHB's Family Support and Violence Prevention Section and the AHU worked on public service announcements aimed at adolescents and their families regarding staying connected with family, keeping kids busy/family activities, and tips for healthy relationships.
- The AHU is working with the Coalition for Drug Free Hawaii to provide adolescents and their families with additional information on programs and resources via the TeenLink Hawaii (TLH) program, complete with social media accounts and an interactive website.
- AHU provided information on webinars and adolescent-centered training opportunities to its youth service provider listserv. In response to families delaying healthcare visits, the DOH issued a press release encouraging parents to schedule back-to-school vaccination and physical examination appointments as services started to reopen in June.

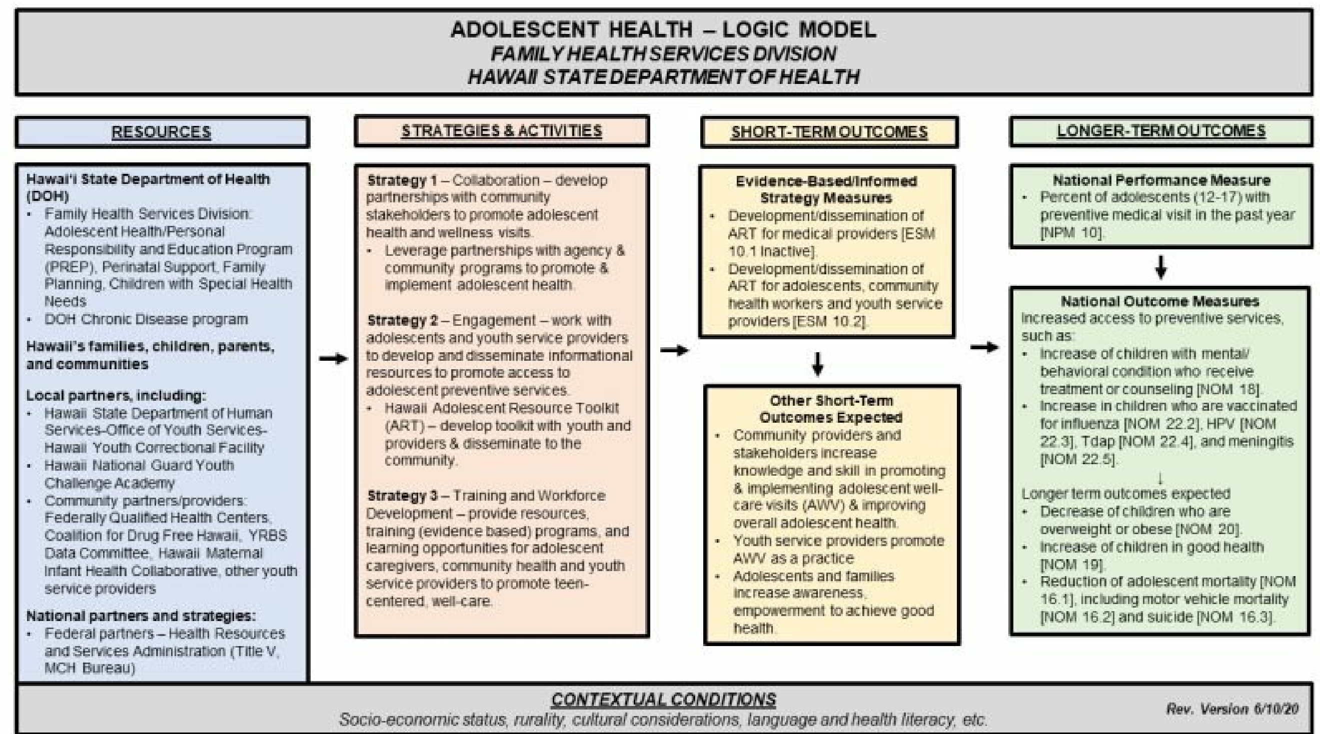
Review of the Action Plan

A logic model was developed for NPM 10 to review alignment among strategies, activities, measures, and desired

outcomes. By working on the three strategy areas, Hawaii will increase the percentage of adolescents with a preventive medical visit. The strategies are derived from guidelines from the national Office of Adolescent Health's Think, Act, Grow (TAG) Call to Action and other evidence-based strategies designed to promote adolescent health through a comprehensive approach with varied stakeholders including parents, professionals, businesses, policymakers, and adolescents themselves. The strategies are supported through research provided by the MCH Evidence Center.

Short-term outcomes for the strategies include:

- Increased knowledge and skill among community youth service providers to promote and assist with scheduling adolescent well-care visits and support overall adolescent health.
- Increased awareness and empowerment among adolescents and their families in achieving good health.



Challenges, Barriers

The AHU's ART aims to promote positive health behaviors including lifestyle factors (e.g. physical activity), encourage youth to take greater responsibility for their health decisions, provide teens with information they need to connect with their personal physicians, develop the ability to schedule well-visits, and link youth to health services (e.g., AWVs) and resources.

Despite ongoing promotion of AWVs throughout the state, certain challenges and barriers persist. Many adolescents only access care for illness or to secure clearance for athletic program participation. Adolescents and their family members may equate a sports physical to an AWV. Hawaii's shortage of primary care providers, particularly on the neighbor islands and parts of rural Oahu, may also impact access to wellness care for adolescents. New players in the health care market like 'minute clinics' and urgent care centers also pose new challenges to AWVs. Busy families use these convenient community-based options as a primary source of care which can undermine the benefits of the more comprehensive AWV provided by a medical home.

Federal healthcare reform proposals, prior to COVID-19, created uncertainty for health plans and health care

providers to continue prioritizing preventive services as a major cornerstone for positive health.

The COVID-19 pandemic presents new challenges to the in-person comprehensive wellness office visit because of social distancing guidelines and the loss of health insurance for families affected by the increasing unemployment crisis. Many families may elect to postpone preventive health visits and vaccinations or opt for less comprehensive telemedicine options.

Overall Impact

The AHU effectively leveraged partnerships with community-based, youth service providers funded through its PREP and PSS programs. The three PREP sites serve some of the state's most at-risk youth populations, using evidence-based programs to promote adolescent health and wellness visits.

Because the current PREP program sites are both residential, the TOP® 'social club model' was readily accepted by the teens and staff and easily implemented as a mandatory extra-curricular activity since youth are housed for more than six months at a time. Program directors were receptive to new approaches/curriculum since their internal program resources were so limited. Partnering with programs administered by state agencies also simplified contracting.

With the integration of AWV into the evidence-based TOP® curriculum, pre-post surveys from 648 program participants showed a nearly 50% increase in participant knowledge about their medical home provider and health insurance coverage.

AHU partnerships with FQHC-based PSS programs substantially expanded outreach efforts to at-risk youth in schools and underserved communities. FQHC outreach CHWs shared adolescent health information and linked youth directly to medical services as part of their activities.

Partnerships have also helped to strengthen the content of the ART as well as increase training opportunities to promote AWV. Partnering with the CDFH youth groups has allowed the ART to become a youth-driven resource.

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 5-year needs assessment. By July 2025 the state seeks to increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 84%. Plans to address this objective are discussed below.

Moving forward, the Adolescent Health Unit (AHU) strategies will continue as:

- Collaboration. Develop partnerships youth service providers to promote adolescent health and annual wellness visits (AWV).
- Engagement. Work with adolescents and youth service providers to develop and distribute information 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.

Strategy 1: Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits.

The Title V Adolescent Health Unit (AHU) continues to build partnerships with community health and youth service providers to promote adolescent health and wellness visits.

AHU will continue work with providers funded through its federal Personal Responsibility and Education Program (PREP) and Perinatal Support Services (PSS) programs to reach high-risk youth. Activities include working with FQHC outreach workers to promote AWV and adolescent health through school and community venues.

Collaboration will continue with other youth-serving programs including the Title V CSHN and Family Planning programs, the Department of Health Chronic Disease School Health Program, the DOE's health education resource teachers, and other community-based organizations.

Specific activities planned for the coming fiscal year include:

- Continue to explore partnership opportunities to expand access to youth and service programs/organizations, especially on the neighbor islands.
- Update the listserv of adolescent health stakeholders and collect/share adolescent resource materials that may also be incorporated into the Adolescent Resource Toolkit (ART).
- Develop a local cadre of speakers on issues affecting adolescent behaviors.

Strategy 2: Engagement. Work with adolescents and youth service providers to develop and disseminate to promote access to preventive health services.

The Title V AHU will continue to partner with youth-serving organizations to develop innovative outreach methods with input from youth. The Coalition for a Drug Free Hawaii (CDFH) youth leadership groups will use findings from their peer survey research to develop a new youth-driven Adolescent Resource Toolkit (ART). The youth groups will also identify the most effective media platforms, designs, and tools to engage peers on health matters and disseminate information on AWVs. This input will be critical given the continued implementation of COVID-19 social distancing guidelines and revised rules pertaining to school openings in the Fall.

The youth groups will also assist with presenting ART information to peers, families, and other youth organizations.

The ART information will be included on CDFH's TeenLink Hawaii website that already contains national and local online information, service resources, and a variety of teen-centered materials.

Other activities planned for the coming fiscal year include:

- Test the new CDFH ART materials with teen informants at PREP program sites and outreach workers/educators at FQHCs.
- Collect evaluation comments and revise the ART based on feedback from both adolescents and service providers.
- Develop a dissemination plan for the ART with CDFH.

The AHU will also work with the CSHN Branch to engage Youth with Special Health Needs and their families to collect input on the new ART. Possible avenues for input include a virtual townhall meeting for CSHN program clients and/or Transition to Adulthood activities as determined by the CSHN/AHU adolescent health team.

Strategy 3: Workforce Development. Provide resources, training, and learning opportunities for youth service providers and community health workers to promote adolescent health and wellness visits.

The AHU will continue to provide adolescent health training and other technical assistance to PREP grant sub-awardees that facilitate the TOP® curriculum at the Hawaii National Guard's Youth Challenge Academy (YCA) and the Kawailoa Youth and Family Wellness Center (KYFWC, formerly known as the Hawaii Youth Correctional Facility), and to the health center outreach workers. Adolescent health training for the health centers and youth-serving providers will include topics that support healthy relationships, adult-to-teen communications skill such as motivational interviewing techniques, gender identification and orientation, and trauma-informed care. AHU will continue to provide technical assistance to KYFWC as program reforms are instituted to shift from punitive to restorative care for vulnerable adolescents that enter the juvenile justice system.

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 ART.
- Continue to introduce CSHN's "Footsteps to Transition" to providers, to encourage utilization of the infographic to discuss transition planning with adolescent patients/clients and help them prepare for adulthood.
- Continue providing training on positive youth development, teen pregnancy prevention, mental health first aid, gender orientation, and the benefits of AWVs to service providers through webinars and other training opportunities.
- Solicit input from stakeholders on topics of interest and new methods for training delivery.
- Encourage the recruitment of YCA graduates to become TOP® facilitators and teen pregnancy prevention supports on their island of residence.

The AHU will also continue work with the DOH Family Planning Program to train adolescent service providers and parents to use a modified One Key Question® approach to start a preventive health conversation with youth. The question, "*Would you like to become a parent in the next year*?" is recommended. Regardless of the answer, one of the recommended actions would be to schedule an AWV if they did not have one in the last twelve months.

The ESM 10.2 Data Collection Form that lists 10 strategy implementation components will be completed and the indicator reported for next year.

Title V Adolescent Health Programs

Adolescent Health programs under the Hawaii Title V program include some aspect of adolescent health.

Adolescent Wellness: spans across the physical, mental, and social emotional aspects of adolescents and young adults 10 to 24 years of age. Concentration on high school graduation, sexual health, positive youth development, and transitioning into adulthood.

Personal Responsibility Education Program (PREP): the purpose of the grant is to fund the implementation of evidence-based positive youth development programs that broadens the cognitive context of abstinence and contraception for the prevention of pregnancy, sexually transmitted infections, and HIV/AIDS, which includes decision-making, self-regulation, and other adulthood preparation subject areas. This program targets services to high-risk, vulnerable, and culturally underrepresented youth populations between the ages of 10 and 24. Hawaii funds are used to implement the Teen Outreach Program (TOP®) curriculum at the Youth Challenge Academy residential on facilities on Oahu and Hawaii island, and the Kawailoa Youth and Family Wellness Center (formerly known as the Hawaii Youth Correctional Facility). Both facilities serve higher risk youth.

Child Abuse and Neglect, Domestic and Sexual Violence Prevention: these programs are committed to the primary prevention of all forms of violence, and stopping violence before it begins so that all people, families, and communities are safe, healthy, and free of violence. Together known as The Family Strengthening & Violence Prevention Unit, staff and partners provide programs statewide for the prevention of child abuse and neglect, sexual violence, and domestic violence. Activities also include support for parents and provision of education targeted for teens to prevent sexual violence.

Child Death Review: statewide surveillance system for deaths among children ages
0-18 years. Aims to reduce preventable deaths to infants, children, and youth, through multidisciplinary interagency reviews.

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

Maternal Mortality Review: statewide maternal mortality surveillance reviews that identify gaps in the health care system and social services, challenges with health care access and quality (especially prenatal and perinatal care), and ways to improve the health, health behaviors, and health care of women before and during pregnancy.

Family Planning Services: assists individuals in considering the number and spacing of their children and promotes positive birth outcomes and healthy families. Education, counseling, and medical services are available through federal- and state-funded clinical programs including programs targeting adolescents. The program provides leadership for the implementation of One Key Question® (OKQ) – "*Would you like to become pregnant in the next year*?" OKQ supports reproductive life planning, decreases unplanned pregnancies, and promotes healthy birth outcomes.

Perinatal Support Services: community health clinics statewide provide case-managed support services and resources for high-risk pregnant women and teens to increase the likelihood of positive birth outcomes. Objectives include: increasing annual wellness visits; early prenatal care; decreasing incidence of preterm, low, and very low birth infants; and improving the health of participants.

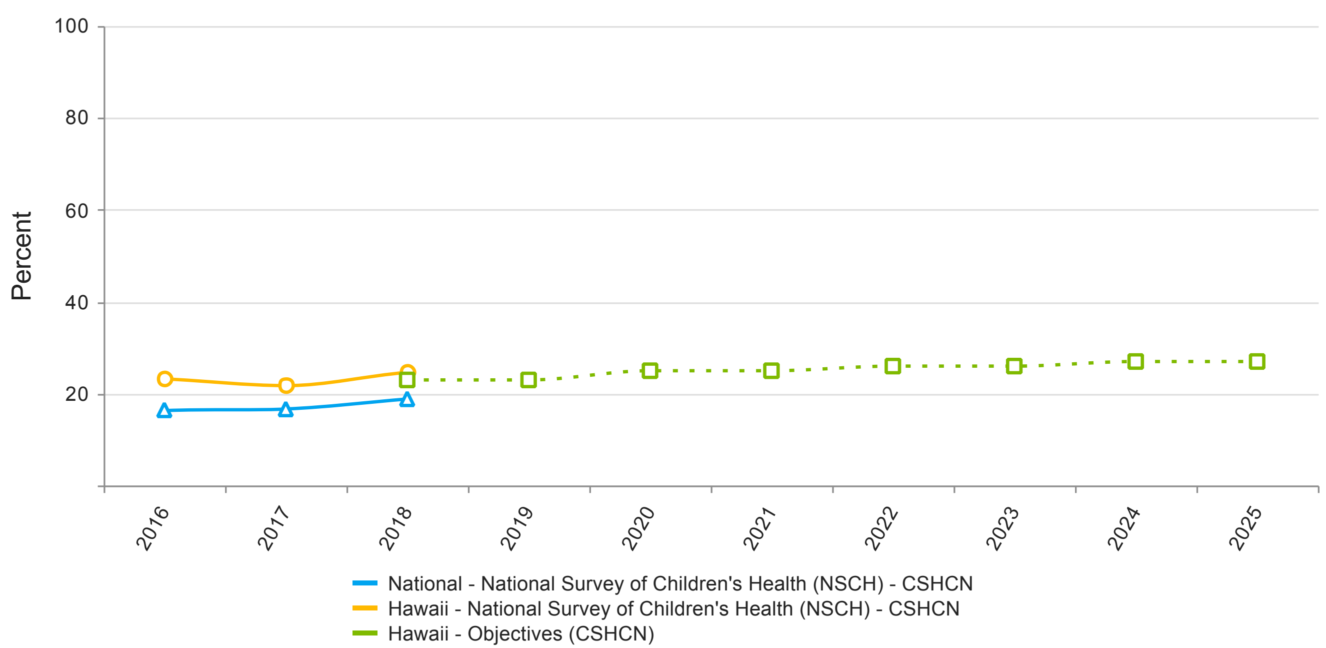
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2017_2018	16.6 %	NPM 12

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			23	23
Annual Indicator		23.3	21.9	24.7
Numerator		4,235	4,457	5,037
Denominator		18,144	20,375	20,412
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	25.0	25.0	26.0	26.0	27.0	27.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective			17	21
Annual Indicator				
Numerator	12	13	18	22
Denominator	33	33	33	33
Data Source	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	24.0	26.0	28.0	30.0	33.0	33.0

State Action Plan Table

State Action Plan Table (Hawaii) - Children with Special Health Care Needs - Entry 1

Priority Need

Improve the percentage of youth with special health care needs ages 12-21 years who receive services necessary to make transitions to adult health care

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

By July 2025, increase the percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care to 27%

Strategies

Incorporate transition planning into Children and Youth with Special Health Needs Section (CYSHNS) service coordination for CYSHNS-enrolled youths and their families.

Provide education and public awareness on transition to adult health care for children/youth with and without special health care needs, and promote the incorporation of transition into planning and practices, in collaboration with state and community partners.

ESMs	Status
ESM 12.1 - Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.	Active

NOMs

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

Children with Special Health Care Needs - Annual Report

NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Introduction: Transition Planning

For the Children with Special Health Care Needs (CSHCN) population domain, Hawaii selected NPM 12 Transition to Adult Health Care based on the results of the 5-year needs assessment. By July 2020, the state seeks to increase the percent of youth, both with and without special health care needs, who received transition services to 25%. Aggregated 2017-2018 data for CSHCN show that the estimate for Hawaii (24.7%) met the 2019 state objective (23.0%) and was statistically similar to the national estimate of 18.9%. The estimates for children without special health care needs were similar in Hawaii (16.5%) and the nation (14.2%). With this baseline data, state objectives through 2025 were updated to reflect a 10% improvement over 5 years. There were no significant differences in reported subgroups by household income, poverty level, nativity, race/ethnicity, sex, and household structure based on the single year 2017-2018 data provided.

Both optimal health and adequate health care are important for youth to successfully transition to adult health care. The majority of CSHCN do not receive needed support for transition. When compared to youth without special health care needs, CSHCN are less likely to complete high school, attend college, or be employed; thus, transition planning can help reduce these disparities and lead to greater success in adult life.

Transition to adult health care for youth with and without special health care needs continues to be a priority measure for Hawaii. The Children and Youth with Special Health Needs Section (CYSHNS) in the Hawaii State Department of Health Children with Special Health Needs Branch (CSHNB) is the lead for this priority measure. CSHNB is part of the state Title V agency. To ensure transition planning benefits all youth, CYSHNS partners with the Title V Maternal and Child Health Branch (MCHB) Adolescent Health Program to integrate transition planning into their Title V NPM 10 activities that promote adolescent wellness visits. Monthly meetings of the statewide transition team are held through Zoom to ensure statewide participation, and especially to be inclusive of all neighbor island staff.

Title V does not directly fund transition activities but does fund key CYSHNS staff including the Section Audiologist and Nutritionist. Both positions provide leadership for the Transition team. In addition, Title V funds the CSHNB Chief, Research Statistician, and administrative staff who provide support to the Transition team.

Professional, state, and community agencies and organizations in Hawaii actively support and promote transition to adult life. The American Academy of Pediatrics-Hawaii Chapter (AAP) priorities include the transition of adolescents to adult care with a focus on CSHCN. Hilopaʻa Family to Family Health Information Center (F2FHIC) trains medical providers, professionals, and families statewide in transition planning. A statewide network of youth agencies and programs, which includes MCHB Adolescent Health advisory groups, the Hawaii State Council on Developmental Disabilities, and the Hawaii Department of Education (DOE), collaborate on annual transition events.

Two strategies were selected for NPM 12 based on the 2015 Title V needs assessment, the Association of Maternal and Child Health Programs (AMCHP) NPM 12 Toolkit, MCH Evidence Center technical assistance, National Maternal and Child Health Workforce Development Center technical assistance, Got Transition website and technical assistance, as well as national best practices and recommendations. Progress on the strategies is described below.

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youth and their families.

CYSHNS transition to adult health care efforts are guided by the *Got Transition's Six Core Elements of Health Care Transition 2.0* (http://www.gottransition.org/providers/index.cfm). The Six Core Elements are integrated into CYSHNS's policy and procedures to support youth and their families who received CYSHN services, in preparation for their transition to adult health care.

Transition Policy

Updates to the CYSHNS Transition Policy are complete and include the addition of privacy and consent information. The revised policy is posted on the CSHNB website: http://health.hawaii.gov/cshcn/home/communitypage/.

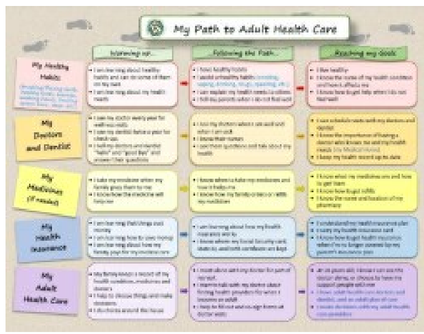
All CYSHNS staff were educated on transition approach, policy, the Six Core Elements, and the role of CYSHNS, youth/family, and pediatric/adult health care teams in the transition process. Training content and program guidelines include and reflect the importance of cultural considerations. New employees are introduced to and educated on Title V and NPM 12, as part of their new employee orientation. Information and updates to the policy are provided at

monthly Transition meetings.

Tracking and Monitoring
Procedures for identifying and tracking youth enrolled in the program were finalized. In order to better track and monitor transition activities, the client database was completely restructured. Fields were added to the database to guide and support CYSHNS workers in completing annual transition planning and review activities with families. The database generates reminders of transition milestones and prompts staff to schedule an appointment with youth and families to complete their annual transition assessment. The database also quantifies staff transition interactions and planning sessions through a numeric tally of the annual family assessment and goals.

Transition Readiness Tools

At least annually, beginning at age 12, CYSHNS staff meet with youth and families to assess transition readiness and progress, and to identify needs related to the youth managing his/her health care. With input from youth, families, and health care professionals, CYSHNS finalized the *Transition Readiness Assessment Checklist* (TRAC – see figure), adapted from the readiness assessment tool on the *Got Transition* website. The purpose of the TRAC is to assess the youth's current readiness level for transition to adult health care, and to select activities for the upcoming year that could help prepare the YSHCN to transition to adult health care. Recent changes to the TRAC includes the addition of a review of the youth's transition progress over the past year and a section for listing transition goals. Information from the TRAC can now be entered into the client database for monitoring and tracking progress.



CYSHNS staff also finalized a colorful handout titled *My Path to Adult Health Care* (PATH – see figure) which is a visual flowchart of activities to prepare and guide youth in the transition to adult health care, adapted from *Got Transition*. The PATH promotes responsibility and self-advocacy in the areas of healthy habits, adult health care providers, medication, health insurance, and adult health care. It reminds families to allow youth to practice simple life skills early to build the youth's confidence and knowledge for more complex responsibilities as they mature. The PATH was shared with health care providers for use in their practices. Feedback from providers on the PATH is positive. The PATH is currently being used in hospitals and other settings, such as Kaiser Permanente Cranial-Facial Clinic and Tripler Army Medical Center.

Finally, CSYHNS staff revised the *Follow Your Path to a Healthy Adulthood* handout (Beach flyer – see figure) to distribute at events, such as health fairs. It is an educational flyer that provides a visual illustration of steps that can be taken to reach transition goals. Information is grouped into three categories: Adult Health Care, After High School, and Taking Responsibility. The Beach flyer helps highlight areas for youth to consider when planning for their future.

Transition Planning
At least annually, CYSHN staff meet with youth and families to update their plan of care by administering the TRAC to review past and new goals focusing on adult health care providers, health insurance, and personal responsibility. Transition planning is incorporated in other CSHNB programs, including Hawaii Community Genetics Clinics, the Early Language Working Group, and neighbor island cardiac, neurology, and nutrition clinics.

Transition Transfer of Care/Transition Completion
All the above activities culminate when CYSHNS staff assist youth and their families to successfully transition from a pediatric health care system to adult health care providers. Guidance, resources and training are provided to help youth apply for health insurance coverage as an adult.

If needed, CYSHNS staff assist with referrals to partnering adult service agencies. CYSHNS is a participating agency in the state's No Wrong Door (NWD) program, which is an integrated person-centered system that supports individuals of all ages, disabilities, and payers. NWD's referral system provides a universal intake point for access to care. Each participating agency accepts and processes requests for services, then contacts and works with the appropriate agency to ensure that a link and handoff is made.

Strategy Measure Progress: ESM 12.1 measures the progress of CYSHNS work under Strategy 1. The rating scale has 11 strategy items, adapted from *Got Transition's Six Core Elements of Health Care Transition 2.0*. CYSHNS staff scores each item from 0-3, for a maximum total score of 33. For FFY 2019, the ESM score was 22 (66.7% completion), exceeding the annual target score of 21. The FFY 2019 indicator shows progress over the past year of 4 points, from the FFY 2018 indicator of 18.

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 Six Core Elements of Health Care Transition 2.0. The scores below indicate the historical progress since 2016.				
	0 Not Met	1 Partially met	2 Mostly met	3 Completely met
Transition policy (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* *2018* **2019**
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 CSHNP database.	0 *2016*	1 *2017* *2018*		**3** **2019**
4. Utilize individual flow sheet or database to track youth's transition progress.		1 *2016-17* *2018*	**2** **2019**	
Transition readiness (core element #3)				
5. At least annually assess transition readiness with youth and parent/caregiver using the TRAC, beginning at age 12, to identify needs related to the youth managing his/her health care (self-care).	0 *2016*	1 *2017*	**1.5** *2018* **2019**	
6. Jointly develop goals & prioritized actions with youth & parent/caregiver, & document in a plan of care in the TRAC.		1 *2016-17*	**1.5** *2018* **2109**	
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* *2018* **2019**		
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 *2016* *2017*	**1.5** *2018* **2019**	
9. Develop and implement referral procedures to adult service agencies.		1 *2017*	**2** *2018*	

			2019	
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 *2017* 1.5 *2018*	**1.5** **2019**	
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* **2019**	
	2019 TOTAL = 22/33 (66.7% completion)			

Strategy 2: Provide education & public awareness on transition to adult health care for children/youth with and without special health care needs, & promote the incorporation of transition into planning and practices, in collaboration with state and community partners.

This strategy is based on recommendations from national guidance and input from local stakeholders. The 2020 Federal Youth Transition Plan and other reports recommend quality professional development and close collaboration among providers working with transition-age youth. For example, the Centers for Medicare and Medicaid Services (CMS) 2014 report on *Paving the Road to Good Health* recommends developing partnerships among key stakeholders and creating adolescent-friendly materials.

Educational/Awareness Events

CYSHNS continued multiple collaborations with stakeholders, along with youth and family members, to conduct annual educational transition fairs and events. On Oahu, transition fair locations are rotated among the four Department of Education (DOE) school districts. In 2019, the DOE Leeward District hosted the Footsteps to Transition Fair held at Kapolei Middle School, with approximately 200 youth and their families in attendance. Hilopaʻa F2FHIC presented a session on the importance of transition to adult health care. Over 40 agencies had display tables for the sharing of information. CYSHNS staff distributed the PATH, Beach flyer, and the *Student Supports in Higher Education* handouts to participants. All handouts were well-received.

CYSHNS participated in the Special Parent Information Network's (SPIN) advisory board for its annual statewide conference held in March 2019, the largest annual event for families with CSHCN. SPIN is a statewide parent-to-parent organization established to enhance the participation of parents of children with disabilities in the decision-making process for their child's education. SPIN provides information, support, and referrals for parents of children and young adults with disabilities, as well as service professionals. It is funded through a unique partnership between the DOE and Department of Health Disability & Communication Access Board (DCAB). Families from the neighbor islands were able to attend the annual Oahu event through sponsorship from SPIN and other agencies. Roughly 65 vendors and over 400 family members participated in this conference which features various speakers and workshops.

Other events on transition included the Hawaii Summer Special Olympics, Malama da Mind (Hawaii Island), Kauai's Legislative Forum, Kona's Marshallese Day, Healthy From Head to Toe, You Can't Have Inclusion Without Us, Parent Child Fair, and Keiki Steps. At the Hawaii Summer Special Olympics in May 2019, transition issues were discussed with athletes, parents, and caregivers at the Healthy Hearing venue, for which the CYSHNS Audiologist was a co-director.

In 2019, the CYSHNS Public Health Nutritionist provided educational information to youth and young adults with inborn errors of metabolism, with focus on low protein foods and recipes. This annual training also included information and resources on health care, employment, education, and navigating insurance issues regarding needed formula and supplies.

Partnerships & Networking
CYSHNS was connected to a broad network of government and community groups that help with systems coordination and advocacy for health care transition. Key planning partners included: MCHB Adolescent Health Program, DOE, SPIN, DCAB, Department of Health Developmental Disabilities Division, NWD, Hawaii State Council on Developmental Disabilities, Hilopaʻa F2FHIC, Best Buddies Hawaii, Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH-LEND), Community Children's Council Office, Division of Vocational Rehabilitation, and other organizations. Kauai, West Hawaii, and Hilo Legislative Disability Forums became network partners, providing another opportunity to share transition messages.

A requirement for all DOE high school students, the Personal Transition Plan (PTP) is each student's plan of action to transition from high school to college and careers. Students, parents, and school personnel have a shared responsibility in the development and execution of the PTP during high school. Health care priorities can be included in the PTP as part of the necessary supports to attain education or training goals. Students enrolled in DOE Special Education receive additional services from the Division of Vocational Rehabilitation to plan for education and employment beyond high school. Special Education students with health-related issues are eligible to receive transition assistance in the form of equipment and training needed for employment and post-secondary education.

Educational Materials
The CYSHNS Transition workgroup met monthly to develop high impact outreach materials that can be understood across the literacy spectrum. At-risk groups targeted for messaging include those from the Federated States of Micronesia, Republic of the Marshall Islands, South America, and families with a parent or other family member with a disability.

CYSHNS revised the TRAC, PATH, and Beach flyer to include information on the transition to adult health care for youth without special health care needs, and to include the importance of having a medical home and annual wellness visits.

CYSHNS partnered with the MCHB Adolescent Health Program to develop training and educational material on the importance of adolescent wellness visits and planning for transition to adulthood and adult care.

CYSHNS applied for technical assistance from the National MCH Workforce Development Center (WDC) to advance Hawaii's Title V work on transition. The Hawaii cohort was selected to participate in the 2019 training, along with four other states. In March 2019, five core staff traveled to North Carolina to receive an intensive 4-day training on skills and tools to address health transformation challenges. Training was provided in evidence-based/informed tools for developing meaningful ESM's and for tracking and monitoring progress in meeting the ESM's.

In August 2019, a 2-day training session with all CYSHNS staff, Hilopaʻa F2FHIC, and other stakeholders was conducted on Oahu by the MCH WDC. For an additional eight months, ongoing technical assistance was provided through monthly webinars, consultation, and peer coaching with the MCH WDC staff. A Hawaii-based Coach worked with the Hawaii cohort to address specific ongoing challenges that followed the training and was available for guidance and mentorship in completing a project related to transition to adult health care.

As a result of the MCH WDC training, CYSHNS is developing a poster campaign to broadly promote transition to adult health care for all youth, with and without special health care needs. CYSHNS contracted a communications professional to design a poster on the importance of transition to adult health care that will be distributed to health care centers and providers. The next step is to conduct focus groups to determine the needs of youth and their families on the topic of transition to adult health care. Feedback from the focus groups will be used to develop the transition poster and other transition related educational material.

Current Year Highlights for FY 2020 through April 2020

Here are some highlights of current transition activities for FY 2020, including the impacts and changes during the early days of the COVID-19 pandemic in Hawaii. Most ongoing services and activities continued normally through March 2020, when stay-at-home orders where implemented. Since then, CYSHNS continues to work with providers and families who need services, but with modifications as needed. Changes include:

- CYSHNS moved to have most staff work from home, and all in-person client services continued through remote means (i.e., phone, Zoom).
    - Initial challenges and needs for families focused on necessities such as food, diapers, and rent/income assistance

- Requests for services have decreased.

- Adolescent routine health care focused on maintaining immunization schedules; thus, transitioning to adult health care may not be addressed at wellness visits for a while.
- Several in-person events/clinics were canceled.
    - All CYSHNS neighbor island clinics were canceled.
    - The April 2020 State SPIN conference was canceled. The conference is an important means to share transition information with the nearly 400 family members and service providers that typically attend. The SPIN program is exploring remote/virtual options to reach families.
    - The Footsteps to Transition Fair in Honolulu scheduled for October 2020 is canceled.

Generally, the CYSHNS staff are comfortable using Zoom technology, largely due to previous initiatives of the Branch Genetics program which lead efforts to increase the use of telehealth across all Title V programs (see narrative for SPM 1). CSHNB was one of the first Division branches to install and train on Zoom and has been using the technology for several years.

Despite the impacts of COVID-19, CYSHNS began a new partnership with the pediatric group at Kaiser Permanente Hawaii to incorporate transition to adult health care into their system of care. Kaiser Permanente Hawaii adopted Got Transition's Six Core Elements into their pediatric service. They are interested in including the CYSHNS TRAC and PATH handouts as part of patient planning for all youth. An initial meeting with Kaiser pediatrician, Dr. Kelly Kawaoka, was held in April 2020. Future remote meetings with the CYSHNS staff and the Kaiser pediatric group were scheduled. This partnership has the potential to reach a significant number of adolescents since Kaiser is the second-largest insurer in Hawaii, covering more than 250,000 members.

Review of Action Plan

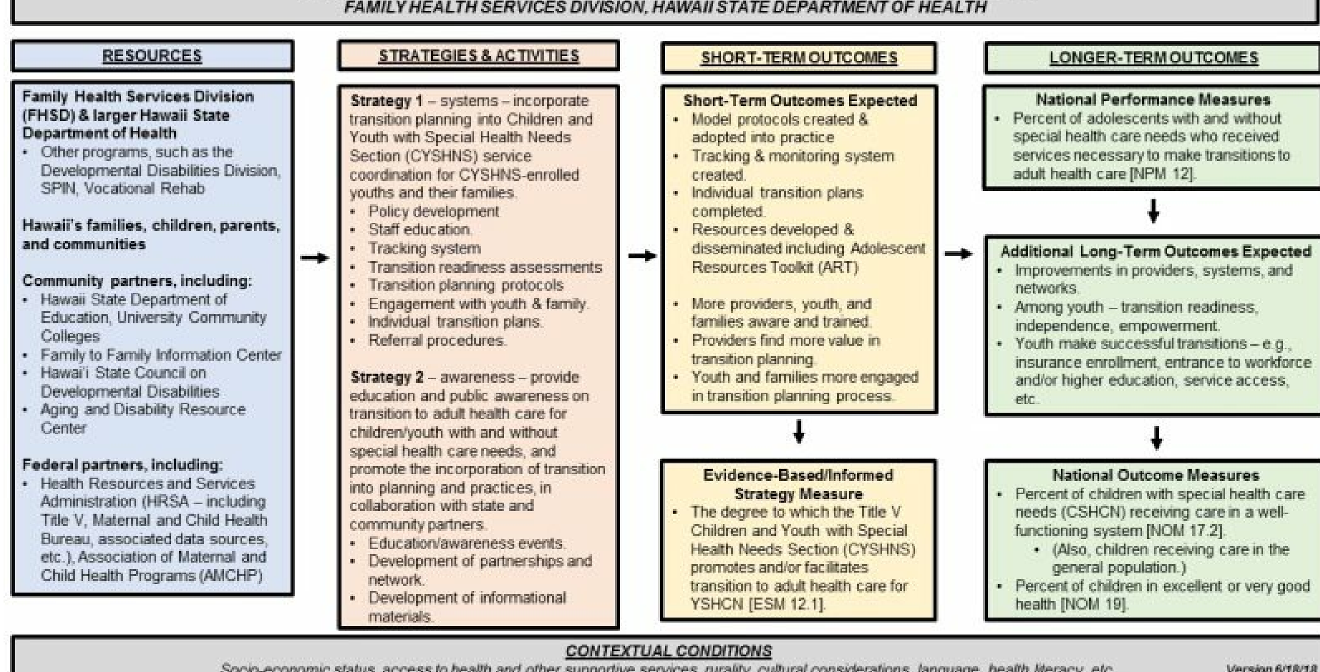
A logic model was developed for NPM 12 to review alignment among the strategies, activities, measures, and desired outcomes. By working on the following strategy areas, Hawaii aims to increase the percentage of adolescents who receive transition services to adult health care.

Strategy 1 focuses on integrating the *Got Transition's* Six *Core Elements of Health Care Transition 2.0* into CYSHNS service protocols to ensure that youth enrolled in CYSHNS and their families prepare for the transition to adult health care. This framework identifies the different planning components that need to be addressed. CYSHNS developed and established a program system of standardized policies and procedures, materials, and data collection methods that can be used by other agencies, pediatric health care providers, and community groups working with youth and transition.

Strategy 2 focuses on public health education and awareness based on national and local best practices. Through expanded partnerships, CYSHNS will reach more youth (with and without special health care needs), providers, and families to support and participate in transition planning.

In addition to assuring continual improvements in the ESM 12.1 and NPM 12, long-term outcomes include:

- Improvement in transition services offered by providers, systems, and networks;
- Among all youth – greater transition readiness, independence, and empowerment; and
- Evidence of more youth making successful transitions to adult care – e.g., increase enrollment in health insurance plans, entrance to the workforce and/or higher education, and access to adult care.



Challenges encountered

For Strategy 1, a major challenge was developing a new database system for CYSHNS. Conversion from an old DOS system to a Microsoft Office Access database is complete. The new database allows staff to update demographics, generate reports, and monitor and track transition information. However, the new database can only be accessed by Oahu CYSHNS staff at this time. Access for neighbor island staff is currently under development.

For Strategy 2, a challenge was identifying and establishing partnerships with adult health care agencies and providers to promote transition planning to adult health care for youth with and without special health care needs. To expand collaboration across sectors, the challenge is illustrating the importance of transition planning for all adolescents, not just those with special needs.

Another challenge is developing methods to measure the effectiveness of health education and awareness activities. CYSHNS will research tools to quantify outcomes with assistance from the national *Got Transition* program, the MCH Evidence Center, and the MCH WDC.

Technical assistance was needed to design more effective messaging and outreach methods to reach youth, including the use of social media and technology. Guidance from the MCH WDC helped address this need by providing staff with knowledge and tools around health communication strategies and project management. The partnership with the MCHB Adolescent Health program also helped to address this concern by sharing resources and connecting with their network of youth service partners.

Overall impact

Over the past 8 years, progress was made to build a system of service providers and agencies to help Hawaii youth transition to adulthood. CYSHNS is integrating transition planning into its services and helping to promote the message publicly in partnership with community programs and agencies. The transition workbook, TRAC, PATH, and Beach flyer developed by CYSHNS are valuable tools used to track and document life goals, including health care for youth enrolled in CYSHNS. These resources are also now broadly used by system partners including DOE, pediatricians, heath centers, and the military health care system as part of their transition planning services.

CYSHNS continues to provide leadership and partner with state and community groups through annual *Footsteps to Transition* fairs and other events on Oahu and the neighbor islands. Events are held annually across all counties and have expanded to include a comprehensive array of services and educational providers. In partnership with the DOE,

the Transition Fairs have created other outreach and educational events for public and adult health care providers, as well as workforce training events for providers.

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Children with Special Health Care Needs - Application Year

NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

For the Children with Special Health Care Needs (CSHCN) population domain, Hawaii selected NPM 12 Transition to Adult Health Care as a continuing priority, based on the results of the 2020 5-year needs assessment. By July 2025, the state seeks to increase the percent of youth with (and without) special health care needs who received transition services to 27%. Plans to address this objective and NPM are discussed below.

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youths and their families.

Transition policy

- Continue to include transition to adult health care in all aspects of CYSHNS services to make it a familiar and friendly concept.
- Continue educating CYSHNS staff regarding policy and procedures for transition, through monthly transition meetings and new employee orientation.

Transition tracking and monitoring

- The TRAC was finalized. Administer the TRAC to track and monitor the progress of transition activities.
- The upgrade of the CYSHNS client database to an Access system is complete. Provide access to the new system to all CYSHNS staff, including those on the neighbor islands.

Transition readiness

- Continue to revise the PATH, TRAC, and Beach flyer in response to changing focus and needs of youth and families.
- Obtain feedback from youth and families when reviewing the various assessment and planning tools.

Transition planning

- Implement procedures and talking points for using the TRAC and PATH as part of a youth's transition planning process.
- Develop a system for receiving referrals into the CYSHNS program, for families seeking assistance with transitioning to adult health care.
- Continue participation in the NWD network of agencies.
- Continue to partner with youth agencies and health care providers in distributing information on transition to adult health care.

Transition transfer of care

- Continue work toward helping CYSHNS-enrolled youth and families prepare for adult health care.

Transition completion

- Research ways of ensuring completion of transition, and ways of documenting and quantifying completion.
- Develop a scorecard or survey to give to the adult health care providers to verify transition completion.

Strategy 2: Provide education and public awareness on the transition to adult health care for children/youth with and without special health care needs, and promote the incorporation of transition into planning and practices, in collaboration with state and community partners.

CYSHNS will continue to work on the transition poster project with the purpose of educating all youth on the importance of transition to adult health care. CYSHNS will conduct focus groups to help develop and get input on the transition poster project.

CYSHNS will continue involvement in outreach and education events for youth with and without special health care needs and their families. Events include DOE-hosted Transition Fairs, the annual statewide SPIN Conference, Special Olympics, Malama da Mind, legislative forums, Marshallese Day, Healthy From Head to Toe, You Can't Have Inclusion Without Us, Parent Child Fair, and Keiki Steps.

All in-person events/services are currently on hold due to the COVID-19 pandemic. Even as the stay-at-home order is being eased, in-person group meetings may continue to be restricted unless essential, and only under conditions safe for both families and providers. Other means of conducting focus groups or group events will need to be considered, using virtual or remote technology.

CYSHNS will continue to partner with the MCHB Adolescent Health Program to increase outreach to all adolescents, with and without special health care needs.

CYSHNS will continue to partner with Kaiser Permanente Hawaii to integrate transition to adult health care planning services into their system of care. CYSHNS will continue to provide technical assistance, based on lessons learned from developing transition planning organizational practices and standards.

Title V CSHCN Programs

Children with Special Health Needs Branch (CSHNB) is working to assure that all children and youth with special health care needs (CSHCN) will reach optimal health, growth, and development. Programs include:

Birth Defects: provides population-based surveillance and education for birth defects in Hawaii and monitors major structural and genetic birth defects that adversely affect health and development.

Childhood Lead Poisoning Prevention: reduces children's exposure to lead by strengthening blood lead testing and surveillance, identifying and linking lead-exposed children to services, and improving population-based interventions. Program is funded by the Centers for Disease Control and Prevention (CDC).

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

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

2016-2020: State Performance Measures

2016-2020: SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			11	13
Annual Indicator				
Numerator	8	11	28	42
Denominator	72	72	72	72
Data Source	Telehealth work group, Family Health Services Divi	The preliminary 5-year plan objectives were develo	Telehealth work group, FHSD	Telehealth work group, FHSD
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services, education, and training for families and providers.

Introduction: Telehealth

Expanded use of telehealth technology was identified as a priority in the 2015 Title V 5-year needs assessment. The objective set was by July 2020, 100% of Title V programs use telehealth to provide services, education, and/or training. With the reduction in personnel resources, increases in travel costs, availability of the internet, HIPAA compliant software, and affordable devices, telehealth can be one of the tools to increase access to services, education, and training for families and providers while reducing costs and travel time especially for neighbor island and rural communities.

The National Survey of Children with Special Health Needs show that Hawaii children with special health care needs (CSHCN) have more difficulty accessing specialist care (5.9%) compared with non-CSHCN (1.1%). (Data source: NSCH 2016/17). The 2015 Hawaii Hospitals Community Health Needs Assessment noted that fewer services are available in rural parts of Oahu and Neighbor Islands. Also, many specialized services are not available on each island, requiring costly air transportation to receive needed care. Use of telehealth in Hawaii for provision of genetics and behavioral health services have families and providers reporting high satisfaction with use of the technology and services provided.

There is an increase in statewide efforts toward the use of telehealth by programs within the Department of Health (DOH), statewide hospitals, the University of Hawaii, state legislators, and Hawaii's Congressional representatives. These efforts are supported by the HRSA funded Pacific Basin Telehealth Resource Center (PBTRC) based in the University of Hawaii that works to help stakeholders collaborate on telehealth activities.

Hawaii's Congressional Senator Brian Schatz and his aides continue to communicate with the State Telehealth Collaborative and support the use of telehealth in Hawaii. In 2014, the Legislature passed Act 159 for face-to-face and telehealth reimbursement parity. In July 2016, the legislature and Governor Ige enacted Act 226 which expanded the existing telehealth law that was passed in 2014. Act 226 requires the State's Medicaid managed care and fee-for-service programs to cover any service provided through telehealth that would be covered if the service were provided through in-person consultation between a patient and a healthcare provider. The law also requires payment parity which means that a service that can be provided by telehealth that is equivalent to a face-to-face service must be reimbursed at the same rate as the face-to-face service. Act 226 also made Hawaii one of the first states to remove geographic restrictions or requirements for telehealth coverage and restrictions on originating site requirements for telehealth coverage or reimbursement. Although the law passed in 2016, Hawaii's third-party payers including Medicaid have had difficulty developing policies for using telehealth and billing for reimbursement.

Within the DOH, the Director continues to make the use of telehealth one of the top priorities in the strategic plan for the Department. To support telehealth activities, the Department was successful in obtaining funding from the 2018 and 2019 state legislatures to fund a position for a telehealth coordinator and some funding for pilot projects. Within the Family Health Services Division (FHSD) there is ongoing support for efforts to implement or increase telehealth activities for genetics, newborn screening, early intervention, and home visiting activities. The efforts are led by the Genomics Section which is the grantee for the HRSA Western States Regional Genetics Network (WSRGN). The WSRGN is a leader in the use of telegenetics and has many resources that the FHSD can leverage for the Title V telehealth initiatives.

Other FHSD telehealth activities include the Office of Primary Care and Rural Health's support of Project ECHO

Hawaii (echohawaii.org), a national innovative model that utilizes videoconferencing to build primary care workforce capacity while improving patient access to specialty health care in rural communities.

The WIC program continues to participate in pilot teledentistry programs lead by dental staff from the DOH Developmental Disabilities Division which operates several dental clinics. The pilot teledentistry programs are conducted in partnership with community-based providers and located at several early childhood locations in Kona on Hawaii Island and Maui. On Maui the project also includes a senior living facility.

There are 4 strategies for this measure: Infrastructure development, workforce development, service provision, and Education/Training. The strategies were developed by the FHSD staff, led by the CSHNB Genomics Section supervisor who serves as the FHSD lead for this priority.

FHSD funds telehealth activities through several federal grants from both HRSA and the Centers for Disease Control. Although Title V does not fund telehealth activities directly, key management and support staff funded by Title V facilitate the telehealth expansion activities described in this narrative.

Strategies to address this objective and NPM are discussed below.

Strategy 1: Telehealth infrastructure development

The Governor and the Director of Health continue to have telehealth as one of their top priorities for the state. Use of telehealth continued to increase including programs within the DOH, statewide hospitals, community organizations, and the University of Hawaii. These efforts are supported by the HRSA funded Pacific Basin Telehealth Resource Center (PBTRC) that works to help stakeholders collaborate on telehealth activities. During the Fall of 2018, the DOH Office of Planning Policy and Program Development, which houses the telehealth coordinator, led stakeholders to develop a statewide telehealth plan. This was completed in the Spring of 2019. Within FHSD, Zoom licenses were distributed to staff who use videoconferencing for their work. Zoom rooms also were implemented in FHSD offices as necessary to allow easier videoconferencing for staff when several staff are videoconferencing together in one location.

Senator Brian Schatz and his aides continue to communicate with the DOH, University of Hawaii, and hospital representatives to discuss ways to increase the use of telehealth in Hawaii.

Third party payers and providers in the state are slow to implement Act 226 (2016) that removed the originating site restrictions so telehealth can be done to a person's home or work.

Strategy 2: Service Provision

Within FHSD, telehealth use increased for meetings, training, education, and provision of services for its programs and contracted providers. FHSD continues its efforts to increase telehealth clinical and service provision for genetics, newborn screening, and early intervention. The Office of Primary Care and Rural Health continues to support Project ECHO Hawaii (echohawaii.org.) WIC continues to participate in the pilot teledentistry projects on the neighbor islands. The Early Intervention Section launched its use of telehealth to provide early intervention services to families and training to staff and providers.

The neighbor island FHSD staff use the videoconferencing equipment that was installed in 2017 to facilitate telehealth visits for their neighbor island families and participate in meetings and trainings. Genetics and neurology

visits were completed using the technology. The FHSD staff continue to work with neighbor island organizations, including the Native Hawaiian Health Center clinics, to plan and implement telehealth services at community sites outside the District Health Offices.

The Title V Genetics program is continuing to partner with the Veteran's Administration (VA) to support joint telehealth kiosks in underserved, rural communities but efforts stalled due to turnover of VA telehealth personnel. The kiosks would eliminate the concern about wireless internet reception in remote rural areas on the neighbor islands since the kiosks are hard wired to the internet.

Strategy 3: Workforce development

The telehealth training curriculum was implemented for FHSD staff. The training consists of nine on-line training modules and a one day in-person session. PBTRC worked with the Genomics Section to develop the in-person training to accompany the on-line telehealth training. The training course was delayed because of loss of personnel at the PBTRC. However, the Genetics program does provide individual short trainings for new staff as needed to use the telehealth for their work.

Strategy 4: Education/Training

FHSD programs are using videoconferencing daily for meetings and trainings. Use of Zoom videoconferencing is now a norm throughout Division program operations and activities. Video conferencing created the anticipated savings in time and costs for in-person meetings: eliminating hours spent securing meeting space, arranging for parking and other special accommodations and eliminating travel time/expenses. The Division achieved substantial cost savings by using Zoom videoconferencing to host statewide trainings; saving inter-island travel costs and accommodating greater access to these services. The Division stopped the use of expensive telephone conference services.

State Performance Measure (SPM)

The FFY 2019 indicator for the SPM is the degree to which Title V programs utilize telehealth to improve access to services and education for families and providers is 42 out of 72. The score indicates only 58% of the work was completed, however, the indicator underestimates the success of Title V telehealth systems building efforts. This is due to the data collection forms for this SPM which focus on implementing planned activities for telehealth services directly to families. Instead, the use of telehealth occurred more rapidly for program management and training (vs direct services). Expansion of FHSD telehealth capacity was largely achieved throughout much of Title V program operations and less in direct service delivery as planned.

A copy of the completed data collection form is in the supporting documents. The Data Collection Form lists 24 strategy components organized by the three areas in telehealth activities:

- Infrastructure development
- Training/education development
- Service development

Current Year Highlights for FY 2020 through April 2020

Here are some highlights of current telehealth activities for FY 2020 including the impacts & changes from the early days of the COVID-19 pandemic in Hawaii.

The planning, infrastructure development, and training that the FHSD employed to build telehealth capacity across

Title V programs prepared the Title V programs to quickly move to virtual activities during the COVID-19 public health emergency.

To quickly support provider and family adoption of telehealth, the Genetics Program developed resources and provided technical assistance (TA). Activities include:

- Developed a five-minute “Best Practices for Providers” animated video using best practices for health care providers usually presented in a more extensive training course,
- Developed an eight-minute video, “What to Expect from a Telehealth Visit”, for families and patients to explain telehealth and what to do to receive telehealth services in one’s home.
- Developed telehealth resources including quick start guides, billing policies, information for patients, checklists, and locations/providers offering telehealth services for the PBTRC website as the central resource for Hawaii.
- HRSA Office for the Advancement Telehealth and the new Health and Human Services telehealth website used the videos and website for national distribution. The contact information in the videos was changed from PBTRC to the National Consortium for Telehealth Resource Centers for national dissemination.
- As of June 30, 2020:
  - Best Practices video had 7,000 views.
  - What to Expect Video had 9,000 views.
  - PBTRC resource website went from less 1000 views annually to 14,000 views from March to July 2020.
- The Genomics program with the PBTRC held telehealth TA webinars weekly for all providers including the DOH Title V programs from March to June 2020.
- The Genomics Program also held a telehealth webinar for DOH staff to share resource information and provide TA.

Due to COVID-19, the Title V program met the proposed goal of 100% of Title V programs using telehealth by July 2020.

Factors Contributing to Success

The major factor contributing to success in expanding telehealth throughout Title V programs continues to be support from the Governor, legislature, DOH administration, Division/Program leadership, program staff, and outside agencies such as the University of Hawaii and the HRSA funded PBTRC. The legislature approved funding during the 2017 and 2018 legislative sessions for a State Telehealth Coordinator position with the DOH and development of a State Telehealth Plan. The DOH also consolidated the individual Zoom videoconferencing licenses into one HIPAA compliant corporate license to allow more efficient expansion for telehealth for all public health programs.

The prioritization of telehealth is pushing this Title V activity forward as a great example of what can be done in this area. The Title V activity also coincides with the telegenetics activities being developed and implemented as part of the HRSA funded Western States Regional Genetics Network which is administered within Hawaii Title V agency. This allows cross utilization of knowledge and resources.

Another factor contributing to supporting telehealth is the better access for families and providers to services and education while containing costs. With more access to broadband internet and applications that work well on devices like smartphones, more families and providers can be reached more often without the cost and time for travel.

Challenges

The main challenge to more rapid adoption of telehealth by Title V programs was the limitation of staff time and competing priorities. However, the COVID-19 pushed all Title V programs to quickly adopt telehealth; thus, reaching the proposed SPM objective to have 100% of Title V programs using telehealth by July 2020.

However, COVID highlighted key disparities in the state where families are not able to receive telehealth services in their homes due to a lack of devices and/or adequate internet or cellular service. Before COVID-19, FHSD setup telehealth access at the neighbor island District Health Offices to address this concern. But during the emergency, these sites were closed to outside visitors. The Genetics program is working with the State Telehealth Hui (*"hui"* is the Hawaiian word for group) and Broadband Hui to develop a plan for mobile telehealth units that will help, but not eliminate, access issues for families.

During the pandemic, there were many telehealth activities occurring statewide across sectors. Coordinating the activities to encourage collaboration, reduce duplication of work, and efficient use of resources was a challenge when programs and agencies receive funding from various sources and wanting to quickly stand up their services.

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services, education, and training for families and providers.

There are no plans for SPM 1. Telehealth was not identified for continuation as a priority by the 2020 Hawaii needs assessment because the goal of creating capacity for all Title V programs was largely achieved. Instead, telehealth activities will be integrated into the plans for the remaining Title V priorities and other Division operations.

Title V Systems Building Programs

Cross-cutting/Systems building programs administered by the Hawaii Title V program include:

Genetics Services: provides information and education about topics in genetics and services to neighbor island families.

Hawaii, Maui, and Kauai District Health Offices: located on the less populated counties outside of Honolulu county which includes all of Oahu island. Within each DOH DHO there is an FHSD program managed by a Registered Nurse. The FHSD Nurse managers oversee personnel for WIC and CSHN including Early Intervention Services. Based on the organizational structure of the DHO and community needs, FHSD Nurse coordinators also manage a substantial range of other responsibilities including convening local death review teams, participating/convening numerous coalitions and advisory groups for FHSD and other DOH and DHS programs, and may also assist with monitoring for FHSD service contracts in their counties. During emergency response events, the Registered Nurses provide an additional licensed/credentialed healthcare provider for the counties that may become cutoff/isolated from outside healthcare services.

Office of Primary Care and Rural Health: coordinates federal, state, and local efforts at improving the health of Hawaii's rural and medically underserved populations.

> **Primary Care Office**: administers primary care contracts to improve access to primary care for medically underserved populations through the Community Health Centers, including Federally Qualified Health Centers (FQHC) and recruitment and retention of health care providers.
>
> **Rural Health**: creates a focal point for rural health issues within each state, linking communities with state, federal and non-profit resources and helping to find long-term solutions. It keeps providers aware of new health care initiatives, collects and disseminate data and resources, and support workforce recruitment and retention. Contracts for rural hospitals provide essential access to inpatient, outpatient, and emergency medical services in rural communities

Critical Access Hospitals (CAH): there are 24 hospitals in Hawaii and nine are identified as Critical Access Hospitals that improve access to health services in rural communities. The program helps to support CAHs with improvements in operational, financial, and clinical functions. Medicare Rural Hospitality Flexibility Grant Program (FLEX) provides federal funding for the program.

III.F. Public Input

Overview

Family Health Services Division (FHSD) involves communities, stakeholders, and program participants, including families, in policy and program decision-making at many levels. Integrating public input into the Title V MCH Block grant is critical to assure alignment with our partners to strengthen our collective impact. Consumer input also ensures Title V efforts are effective with the populations we serve. Input on Title V performance and strategy measures is collected continuously throughout the year. Since much of the Title V work is done in partnership, community collaboratives help determine strategies, assist with implementation, evaluation, and revision of activities.

Because FHSD does not use Title V funds to fund local health departments or community-based providers, there are no stakeholders with a vested interest in Title V as a funding source. Most FHSD partners are aware of the importance of Title V funding to support FHSD programs and services provided to the community especially those who also receive HRSA/MCH Bureau funding. FHSD is continually challenged to improve current efforts to engage stakeholders, including families and consumers, in the Title V work and the importance of MCH as a field in public health.

Ongoing Solicitation of Input

Public input is solicited from stakeholders of various backgrounds throughout the grant cycle. The method/setting of collecting the feedback depend on the relationship with the person/group, context, purpose, and available resources. Examples include:

- All Title V programs engage with specific community partners in the delivery of services and implementation of activities. Some of these collaborations are formalized (e.g., MOAs and MOUs), while others are informal (e.g., partners provide content area expertise). In addition, several programs solicit feedback from partners to inform planning, implementation, and evaluation of their strategies and activities.
- MCH assessment data, priorities, strategies, performance measure trends, and outcomes are regularly presented and reviewed by stakeholders and Title V implementing partners across the State. Community partners are engaged via cross-agency/system workgroups or taskforces. FHSD convenes and/or provides leadership for some of these groups.
- Many FHSD partners participate in other needs assessment processes, and share their priorities, strengths, needs, and limitations. FHSD considers feedback provided to other organizations on similar issues and populations important information. Especially how broadly family health intersects with other public health issues, and also to avoid overburdening partners with multiple assessments.

Community Input for Overall Needs Assessment

Two community surveys–one for providers, and the other for families/community members–were administered to solicit feedback directly from FHSD stakeholders to inform the five-year needs assessment. Stakeholder input was generally favorable regarding the Title V priorities and supportive of the measures.

The provider survey was distributed to partner agencies and service-providers, via an online (Survey Monkey) format. An introductory message was sent from the FHSD Chief via email, along with the survey link, with one reminder email. The list of providers was generated collectively by Title V program leaders, and therefore reflected a broad array of partners across domains, issues, and communities. The link was open from November 2019 to February 2020, with heavy marketing in December 2019 and January 2020. The survey had three sections: 1) demographics about the participant and community(ies) they serve; 2) feedback on overall priority areas; and 3) feedback strategies within each priority area. The final email list of providers included 332 stakeholders. A total of 148 completed surveys were received, for a return rate of 45% (though the initial participants were able to forward

the link to others).

The family/community survey was distributed to community members, both those who were routine consumers of FHSD services (e.g., WIC clinics) and those who were one-time participants (e.g., health fairs, community workshops, etc.). This survey was an abridged version of the provider survey, and administered via paper-pencil format. The consumer groups and community events that served as recruitment settings were determined collectively by Title V program leaders, and reflected a broad array of people across domains, issues, and communities. The survey was implemented from September 2019 to January 2020, and had three brief sections: 1) demographics about the participant; 2) feedback on overall priority areas; and 3) a space for open-ended comments. A total of 500 completed surveys were received. Surveys were administered across nine WIC clinics, nine community events, and three other FHSD program sites throughout the State.

Community Input for Specific Strategies and Measures

Provider surveys included a section for participants to take a deeper dive into the National Performance Measures (NPM) and their associated strategies/activities. For each NPM, participants were provided with the current strategies and simply asked, “Are these the right/best strategies for Hawaii to focus on in the next five years?” Then, participants were allowed to provide open-ended comments on the existing strategies, or suggest new ones. In addition, individual programs organized additional meetings and forums to encourage two-way discussion about the details of implementation and evaluation. Examples of public feedback that changed elements of the Title V five-year plan strategies follow.

NPM 1 Women’s Wellness Visits: The work for the 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 health care administrators. Input from HMIHC’s Pre-/Inter-conception Workgroup members shape the strategies, activities, and measures for NPM 1. Strategy measures and activities evolved over time to align with HMIHC evaluation projects currently underway.

NPM 4 Breastfeeding: The State Breastfeeding Strategic Planning Workgroup, a subcommittee of the HMIHC, provides ongoing feedback on Title V strategies and data measures. For example, one discussion focused on measures such as ‘ever breastfed’ versus ‘exclusively breastfed through 6 months,’ and members cautioned that messaging should support all mothers and families who are breastfeeding for whatever the duration. Monthly HMIHC workgroup meetings focus on the implementation of the breastfeeding priorities.

NPM 5 Safe Sleep: Title V partnered with the state Child Care Licensing Program at the Department of Human Services (DHS) to develop a Safe Sleep Guide for Parents and one for Caregivers. The guides are used by the Child Care program to implement a policy mandate for training of all licensed child care providers on safe sleep. Based on input from child care providers and agency partners, some of the challenges to promoting safe sleep practices among Hawaii’s diverse ethnic groups may relate to long-standing cultural childcare practices. As a result, the Title V safe sleep program partnered with DHS and the state Office on Language Access to translate the safe sleep guide into several languages.

NPM 6 Developmental Screening: The Developmental Screening program organized a diverse statewide network of partners, and uses this network to gather ongoing feedback. Title V convenes partners through a Developmental Screening Workgroup with representatives from early childhood programs. Hawaii’s CSHNB Early Childhood Coordinator also works closely with the Family Hui Hawaii who conducts parent support groups. The Hui regularly conducts developmental screening with families both in their program and at community events. Most recently, the CSHNB Early Childhood Coordinator started working with the Institute for Human Services (IHS), one of the state’s

largest emergency shelters for homeless individuals, recognizing that children who are living in homelessness may be more susceptible to developmental delays.

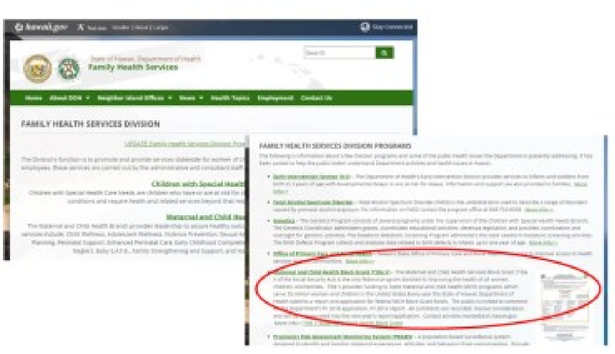
NPM 10 Adolescent Health: The Adolescent Health Unit (AHU) continues to collect input from youth, service providers, and community health workers to update its Adolescent Resource Toolkit (ART). The ART was tested with over 200 adolescents and providers at community sites such as the Youth Challenge Academy and State Personal Responsibility Education Program (PREP) service sites.

NPM 12 Transition to Adult Care: Substantial input was obtained from youth, families, and the pediatric professional community to develop key transition informational materials: The Transition Readiness Assessment Checklist (TRAC) and the My Path to Adult Health Care (PATH) handout. Input helped reduce the complexity of the materials, and improve ease of understanding and the visual design. Also, a point system was added to the TRAC to assist users quantify and qualify their transition progress.

SPM 4 Child Abuse and Neglect: CAN prevention has three primary mechanisms for community input including: 1) The Hawaii Children's Trust Fund (HCTF) Advisory Committee (eleven private and public members); 2) The HCTF Coalition with 30 active members representing key community partners working to prevent child maltreatment across the islands; and 3) The Prevent Child Abuse Hawaii, Child Abuse Prevention Planning Council comprised of 15 active members representing the military and community-based private agencies. All of these groups serve a range of consumers and participate in their respective membership to be a voice for their communities.

Public Access to the Title V Report/Application

The Title V 2018 Report and 2019 Application, as well as the Title V Quick Fact sheet, are posted on the FHSD website (https://health.hawaii.gov/fhsd/home/title-v-maternal-child-health-block-grant/). The Hawaii Title V website also archives the presentations and videos used during past years' block grant reviews.



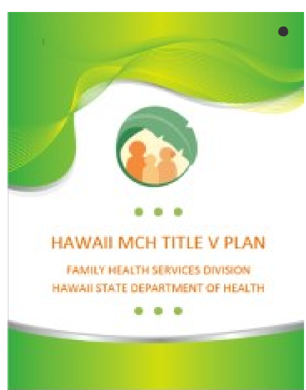
Following the submission of the 2020 Title V Report and 2021 application, FHSD will post the final document on the DOH website.

Users find the online access to the grant convenient, and comments throughout the year can be submitted through a return email function on the website. In past years, many stakeholders have asked for information on the programs

administered by the Family Health Services Division (FHSD) with names of key program managers. In this year's Title V report the program charts and short descriptions are included in the "Supporting Documents" that were developed in response to these requests.

FHSD developed several informational products to educate community stakeholders on the Title V priorities and to collect public input. These publications are updated to use for ongoing needs assessment to collect feedback on priorities and implementation strategies. The documents include:

- Title V Update on Priorities for Maternal and Child Health, with information on update of measures and activities for Hawaii Title V priorities and strategies, and information and data on the priorities.



- A summary of the Hawaii 5-year plan.

Staff frequently share information about their individual priorities at national conferences including the ECCS Impact Grantee Meeting, the national Coalition Against Domestic Violence Conference, CityMatCH Leadership and MCH Epidemiology Conference, and the CDCs Rape Prevention and Education Grantee Leadership Meeting. Staff also promoted information at various statewide meetings and events including the *Footsteps to Transition Fair*, Special Parents Information Network (SPIN) Conference, the State Medicaid Providers Meeting, and State Early Childhood Action Strategies, and Hawaii Maternal Infant Health Collaborative.

III.G. Technical Assistance

With the cessation of the University of Hawaii Office of Public Health Studies Maternal Child Health certificate program, Hawaii continues to explore technical assistance (TA) opportunities with the University's public health faculty. Since 2018, Hawaii Title V used SSDI funds to secure planning and evaluation TA with Jeanelle Sugimoto-Matsuda, Ph.D., Assistant Professor with the University's Office of Public Health Studies. Her TA is instrumental in building staff public health knowledge and practice.

The Title V agency continues to partner with the MCH Leadership Education in Neurodevelopmental Disabilities (LEND) program to provide program support for the Title V Leadership team that includes program staff serving as team leads for the national and state priority issues. In addition, LEND routinely recruits participants for their training cohorts from Title V staff including staff on the neighbor islands.

Hawaii relies on national TA to develop leadership and core public health skills and competencies. TA and support provided by the Maternal Child Health (MCH) Bureau and Association of Maternal, Child Health Programs (AMCHP) and the Georgetown University Evidence Center are helpful including learning labs, consultation with program officers and subject matter experts, Region IX conference calls, national partnership conferences, and networking with other state Title V coordinators.

Hawaii also participated in the Spring 2019 MCH Workforce Development Center Skills Building Institute with a focus to promote transition planning to adult health care for all adolescents including those with special health care needs.

Technical assistance requests are considered based on the results from the Hawaii Department of Health national Public Health Workforce survey (PH WINS). The survey helps public health agencies understand workforce strengths, gaps and opportunities to improve skills, training and employee engagement. Recommendations for improvement were:

- succession-planning
- assessment and investment in training
- workplace policies/practices that support employee engagement and job/organizational satisfaction.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - IV.TitleV-Medicaid MOU DRAFT.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - FHSD Programs Description.pdf

Supporting Document #02 - Map_of_health_care_facilities_and_shortage_need_areas.pdf

Supporting Document #03 - LM_DataForms_NPM_NOM_Summary.pdf

Supporting Document #04 - Glossary of Terms.pdf

Supporting Document #05 - NA_Family-Provider_Survey.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DOH FHSD Org Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Hawaii

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,083,027	
A. Preventive and Primary Care for Children	$ 634,665	(30.4%)
B. Children with Special Health Care Needs	$ 802,000	(38.5%)
C. Title V Administrative Costs	$ 94,134	(4.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,530,799	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 31,499,929	
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)	$ 18,439,145	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 49,939,074	
A. Your State's FY 1989 Maintenance of Effort Amount $ 11,910,549		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 52,022,101	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 37,230,305	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 89,252,406	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	$ 426,600
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 165,389
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	$ 600,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 238,913
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 2,301,492
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,678,058
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	$ 415,271
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 297,297
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 26,161,881
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Office of Rural Health	$ 230,000

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility Program	$ 446,074
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	$ 118,660
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) > Office of Adolescent Health > Coronavirus State Hospital Improvement Program	$ 843,170

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,394,340		$ 2,027,508	
A. Preventive and Primary Care for Children	$ 728,721	(30.4%)	$ 667,905	(32.9%)
B. Children with Special Health Care Needs	$ 776,638	(32.4%)	$ 750,150	(36.9%)
C. Title V Administrative Costs	$ 68,095	(2.8%)	$ 123,538	(6.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,573,454		$ 1,541,593	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 28,350,378		$ 28,133,440	
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)	$ 13,205,575		$ 7,672,215	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 41,555,953		$ 35,805,655	
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)	$ 43,950,293		$ 37,833,163	
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)	$ 51,294,329		$ 38,374,744	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 95,244,622		$ 76,207,907	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	$ 454,196	$ 508,435
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 157,925
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 161,000	$ 140,134
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 160,000	$ 235,896
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 255,086	$ 243,902
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 250,000	$ 24,779
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	$ 600,000	$ 571,846
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 12,969,228	$ 3,296,095
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 167,994	$ 163,864
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 118,792
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 273,512
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 29,760,334	$ 27,671,894

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 2,247,675	$ 2,136,271
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,157,300	$ 1,170,774
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	$ 172,000	$ 183,540
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	$ 508,435
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	$ 426,600	$ 414,039
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	$ 93,600	$ 101,700
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility Program	$ 419,316	$ 452,911

Form Notes for Form 2:

- HDOH/FHSD participation as a Title X grantee ended 3/31/2020.
- WIC services branch administers four (4) separate USDA grants totaling $26,161,881.

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**

Field Note:
Hawaii DOH changed the methodology in calculating the Administrative Costs for the FY21 application moving forward. Rather than calculating a percentage of the Administrative Officer V position, HDOH decided to use the entire salary as a Title V administrative cost. This disparity will even out in application years to come.

2.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
Budgeted $2,394,340 but only spent $2,027,509 because projected award was less than actual and actual expenditures are based on actual award.

3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
Hawaii DOH changed the methodology in calculating the Administrative Costs for FY21 application moving forward. Rather than calculating a percentage of the Administrative Officer V position, DOH decided to use the entire salary as a Title V administrative cost. The disparity will even out in application years to come.

4.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
The budgeted amount for program income was $13,205,575 but expenditures were only $7,672,215. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and the Domestic Violence and Sexual Assault Special Fund is higher than the revenues being deposited into these accounts. Annual expenditures are roughly aligned with the revenues being deposited and are not aligned with the authorized budget ceilings for these special fund accounts. The legislative authorized ceiling will continue to differ from actual expenditures moving forward. 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.

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 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 183,241	$ 224,033
2. Infants < 1 year	$ 183,241	$ 198,446
3. Children 1 through 21 Years	$ 634,665	$ 667,905
4. CSHCN	$ 802,000	$ 750,150
5. All Others	$ 185,746	$ 63,436
Federal Total of Individuals Served	$ 1,988,893	$ 1,903,970

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 5,871,525	$ 3,969,980
2. Infants < 1 year	$ 4,562,449	$ 2,805,516
3. Children 1 through 21 Years	$ 5,023,019	$ 3,215,207
4. CSHCN	$ 28,286,895	$ 21,557,064
5. All Others	$ 6,195,187	$ 4,257,888
Non-Federal Total of Individuals Served	$ 49,939,075	$ 35,805,655
Federal State MCH Block Grant Partnership Total	$ 51,927,968	$ 37,709,625

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 21 Application Budgeted	FY 19 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	$ 94,134	$ 123,537
3. Public Health Services and Systems	$ 1,988,893	$ 1,903,971
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	$ 2,083,027	$ 2,027,508

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 27,763,625	$ 18,501,709
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,405,479	$ 1,250,217
B. Preventive and Primary Care Services for Children	$ 11,903,410	$ 5,439,741
C. Services for CSHCN	$ 14,454,736	$ 11,811,751
2. Enabling Services	$ 12,127,258	$ 9,497,559
3. Public Health Services and Systems	$ 10,048,191	$ 7,957,960
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 1,479,830
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 1,311,125
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Primary and Urgent Care in Hana		$ 1,130,000
Waianae Coast Emergency Room Services		$ 1,691,657
Early Intervention Services (POS)		$ 12,889,097
Direct Services Line 4 Expended Total		$ 18,501,709
Non-Federal Total	$ 49,939,074	$ 35,957,228

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: 16,810 **Data Source Year: 2019**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	16,598 (98.7%)	1,094	49	49 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	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 2019

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	3,339	63.0	0.0	17.0	20.0	0.0
2. Infants < 1 Year of Age	544	34.0	0.0	63.0	3.0	0.0
3. Children 1 through 21 Years of Age	13,130	29.0	0.0	67.0	4.0	0.0
3a. Children with Special Health Care Needs	7,582	30.0	0.0	67.0	3.0	0.0
4. Others	24,447	13.0	0.0	83.0	4.0	0.0
Total	41,460					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	16,972	No	16,810	99	16,642	3,339
2. Infants < 1 Year of Age	17,018	No	16,810	99	16,642	544
3. Children 1 through 21 Years of Age	350,470	Yes	350,470	18	63,085	13,130
3a. Children with Special Health Care Needs	47,769	Yes	47,769	19	9,076	7,582
4. Others	1,052,797	Yes	1,052,797	4	42,112	24,447

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**

Field Note:
Programs that contributed to this count include pregnant women who received Perinatal Support Services (PSS; 934), Kauai District Health Office (5), and women who receive mailout resources from PRAMS program (2400). The family planning activities focused on unintentional pregnancies; the popularity of long-acting reversible contraception (LARC) among women and teens; and the decisions by young couples to delay pregnancies to attain more education or to advance their careers contributed to the slightly declining count compared to last year (2018: 1,013).

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**

Field Note:
Programs that contributed to this count of infants < 1 year of age include 2019 Primary Care Contracts (523), which are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. Additionally, there was no way to differentiate the primary source of coverage for those that were provided services through the underinsured due to lack of access to the data. Other programs that contributed to this count include Family Strengthening Program [home reach (16)], Kauai District Health Office (5). Note. The percentages of primary source of coverage are based on 2018 American Community Survey for Children 1-21.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**

Field Note:
Programs that contributed to this count include 2019 Primary Care Contracts (2,091), which are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. Other programs that contributed to this count include Family Planning Services (100% State Contribution; 3,024), Kauai District Health Office (200), Family Strengthening Programs [Community Based Parenting Education (140), Home Reach (93)], and Children with Special Health Care Needs in 3a (7,582). Note that Children the count for Community Based Parenting Education (140) includes infants < 1 year as there was no way to separate the count between the two groups. Note. Family Planning Services changed from 40% state funded to 100% state funded since April 2019. The percentages of primary source of coverage are based on 2018 American Community Survey for Children 1-21.

4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**

Field Note:
2019 data for the number of children serviced contributed by CSHNP (7,582). Programs that contributed to the count include Family Strengthening Program [Home Reach (2)], Kauai District Health Office (20); Children with Special Health Needs Section (811); genetics, metabolic, hemoglobinopathy, Neighbor Island genetics, telemedicine clinics (1,225); Newborn Metabolic Screening Program follow-up (1,094); Newborn Hearing Screening Program follow-up (348); Early Intervention Section (3,750); Hiʻilei Developmental Screening Program (32); Hawaii Childhood Lead Poisoning Prevention follow-up (182); and Early Childhood Comprehensive Systems developmental screening (118). The distribution of source of coverage is based on National Survey of Children's Health – CSHCN, 2017-2018

5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**

Field Note:
Programs that contributed to this count of others include 2019 Primary Care Contracts (14,259), which are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. 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. The count also included Family Planning Services (100% State Contribution; 8,129), Family Strengthening Programs [Community Based Parenting Education (587), Safe Sleep (85), Home Reach (163), Parent Line (Number of calls received on the State MCH Hotline; 1,074)], and Kauai District Health Office (150) . Note. Family Planning Services changed from 40% state funded to 100% state funded since April 2019. The percentages of primary source of coverage are based on 2018 American Community Survey for adults 22+.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**

Field Note:
Numerator : Estimated by the percentage of pregnant women who receive safe sleep education messages at the hospital (99%).

Note. The increase in percentage from 2018 (46%) was due to additional effort this year to collect data on the estimated count of individuals served through public health services/systems.

Note. Other programs that served pregnant women included Perinatal support Services (934), Kauai District Health Office (400), Maui District Health Office (1072), women who receive mailout resources from PRAMS program (2400), the use of WIC Program during pregnancy estimated by 2016 PRAMS data (6,455; 38.4% of 2018 resident births), and Home Visiting Program (79).

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**

Field Note:
Estimated by 2019 percentage of newborn metabolic screening (98.7%)

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2019**

Field Note:
Numerator: Programs contributed to the numerator (64,204) included Primary Care Contracts (2,091), Family Planning Services (3,024), Family Strengthening Programs [Community Based Parenting Education (140), Parent Line (513), Home Reach (93)], Sexual Violence Prevention Program (9,734), Participation in WIC Program (aged 1-5; state provided administrative support, 19,325), Adolescent Health (395), Project ECHO Hawaii Pediatric Series (74), Kauai District Health Office (4,500), Home Visiting (472), Home Visiting Network (692), Maui District Health Office (7,364), Parenting Support/Safe Sleep (6,500), and Children with Special Health Care Needs (8,815).
Denominator: 2018 Census Estimate (350,470)

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**

Field Note:
Programs that contributed to the count include Home Reach (2), Parent Line (9), Maui District Health Office (139) and Kauai District Health Office (150); CSHN Section (811); genetics, metabolic, hemoglobinopathy, Neighbor Island genetics, telemedicine clinics (1,225); Newborn Metabolic Screening Program follow-up (1,094); Newborn Hearing Screening Program follow-up (348); Early Intervention Section (3,750); Hi'ilei Developmental Screening Program (32); Hawaii Childhood Lead Poisoning Prevention follow-up (182); and Early Childhood Comprehensive Systems developmental screening (118). An estimated 2% of the CYSHCN population (955) was reached through various community events with CSHNB educational outreach for developmental screening, childhood lead poisoning prevention, early intervention services, and transition to adult health care. The denominator was based on reference data provided.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**

Field Note:
Numerator: Programs contributed to the numerator (45,437) included Primary Care Contracts (14,259), Family Planning Services (8,129), Family Strengthening Programs [Community Based Parenting Education (587), Parent Line (Number of calls received on the State MCH Hotline;1,074), Home Reach (163)], Sexual Violence Prevention Program (2,582), Adolescent Health (200), WIC services for postpartum women (3,370); Hawaii Public Health Training Hui (833),Parent Leadership Training Institute (PLTI) Hawaii (14), Kauai District Health Office (1,000), Hawaii Medicare Rural Hospital Flexibility Program (75), Oral Health (200), Domestic Violence Prevention Program (680), Child Abuse/Neglect Prevention (934), Maui District Health Office (980), and Parenting Support/Safe Sleep (9,000), Home Visiting (639) and Home Visiting Network (718).

Denominator: 2018 Census Estimate (1,052,797).

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Hawaii

Annual Report Year 2019

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	16,509	4,097	400	2,548	10	4,209	1,677	3,363	205
Title V Served	16,294	4,044	395	2,515	10	4,154	1,655	3,319	202
Eligible for Title XIX	21,069	1,976	241	935	335	4,539	3,705	0	9,338
2. Total Infants in State	17,223	2,553	267	2,919	31	3,708	2,174	5,571	0
Title V Served	17,001	2,520	264	2,881	31	3,660	2,146	5,499	0
Eligible for Title XIX	14,083	176	78	1,320	63	653	350	0	11,443

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2019**
	Column Name:	**Total**
	Field Note: Information obtained from maternal race as reported in 2019 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:	**2019**
	Column Name:	**Total**
	Field Note: Used overall estimate of newborn metabolic screening percentage (98.7%) in 2019 applied to overall total and each race group.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2019**
	Column Name:	**Total**
	Field Note: Data Sauce: Data from Hawaii Medicaid program in 2019 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. Also note that the increase in number in 2019 (21,069) when compared to 2018 data (6,594) is due to a different methodology in data collection. For 2019 data, in addition to using the methodology from last year (i.e., including women who had a pregnancy related eligibility group), we also looked for women who were pregnant based on claims/encounters using related ICD-10 code.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2019**
	Column Name:	**Total**
	Field Note: Total number of infants based on 2018 CDC, NCHS, Bridged-Race population estimates from https://wonder.cdc.gov. 2019 information is not available yet. The Bridged-Race population groups reported are different from that requested in Title V. To determine race specific estimates for Title V, the distribution of race based on children under 5 years based on 2010 Census was applied to total infants in state as more current data was not available for requested race groups. Additionally, American Community Survey does not report out single year age estimates. Note: Collection of race varies from that reported from vital statistics so not directly comparable. For example, more than one race reported was not available from data requested.	

5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2019**
	Column Name:	**Total**

Field Note:
Based on the proportion of infants receiving newborn metabolic screening (98.7% in 2019)

6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2019**
	Column Name:	**Total**

Field Note:
Data source: Data from Hawaii Medicaid program in 2019 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. Also note that the increase in number in 2019 (14,083) when compared to 2018 data (8,903) is due to a a change in methodology.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Hawaii

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 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"		1,074

B. Other Appropriate Methods	2021 Application Year	2019 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"		3,573
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		1,690
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

 Created on 9/11/2020 at 9:02 PM

Form 8
State MCH and CSHCN Directors Contact Information

State: Hawaii

1. Title V Maternal and Child Health (MCH) Director	
Name	Matthew J. Shim, Ph.D., M.P.H.
Title	Chief, Family Health Services Division
Address 1	1250 Punchbowl Street, Room 216
Address 2	
City/State/Zip	Honolulu / HI / 96813
Telephone	(808) 586-4122
Extension	
Email	matthew.shim@doh.hawaii.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Patricia Heu, M.D
Title	Chief, Children with Special Health Needs Branch
Address 1	741 Sunset Avenue
Address 2	CSHNP
City/State/Zip	Honolulu / HI / 96816
Telephone	(808) 733-9070
Extension	
Email	patricia.heu@doh.hawaii.gov

3. State Family or Youth Leader (Optional)	
Name	Leolinda Parlin
Title	Director, Hilopaa Family to Family Information
Address 1	2604 Pauoa Road
Address 2	
City/State/Zip	Honolulu / HI / 96813
Telephone	(808) 791-3467
Extension	
Email	leo@hilopaa.org

Form Notes for Form 8:

None

Form 9
State Priorities – Needs Assessment Year

State: Hawaii

Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Promote reproductive life planning	Continued
2.	Increase the rate of breastfeeding	Revised
3.	Increase the rate of infants sleeping in safe conditions	Revised
4.	Improve the percentage of children screened early and continuously ages 0-5 years for developmental delay	Continued
5.	Reduce the rate of confirmed child abuse and neglect cases per 1,000 with special attention to children ages 0-5 years.	Revised
6.	Improve the percentage of youth with special health care needs ages 12-21 years who receive services necessary to make transitions to adult health care	Continued
7.	Improve the healthy development, health, safety, and well-being of adolescents	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Hawaii

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2017	82.6	7.5	121	14,647
2016	86.6	7.6	130	15,010
2015	67.7	7.7	77	11,376
2014	78.7	7.3	119	15,112
2013	56.7	6.1	88	15,516
2012	63.3	6.4	99	15,632
2011	61.0	6.3	95	15,567
2010	53.9	5.9	84	15,585
2009	56.3	6.0	89	15,817
2008	59.8	6.1	97	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
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

	2019
Annual Indicator	12.5
Numerator	11
Denominator	87,878
Data Source	Vital Statistics
Data Source Year	2015-2019

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
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
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
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
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
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
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
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
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
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 - Sleep-related 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
2017	NR 🏴	NR 🏴	NR 🏴	NR 🏴
2016	94.1 ⚡	22.8 ⚡	17 ⚡	18,059 ⚡
2015	76.0 ⚡	20.3 ⚡	14 ⚡	18,420 ⚡
2014	NR 🏴	NR 🏴	NR 🏴	NR 🏴
2013	79.0 ⚡	20.4 ⚡	15 ⚡	18,987 ⚡
2012	63.2 ⚡	18.3 ⚡	12 ⚡	18,980 ⚡
2011	NR 🏴	NR 🏴	NR 🏴	NR 🏴
2010	115.9	24.7	22	18,988
2009	NR 🏴	NR 🏴	NR 🏴	NR 🏴

Legends:

🏴 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure 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
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 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	2.2	0.4	32	14,879
2016	1.1 ϟ	0.3 ϟ	16 ϟ	15,111 ϟ
2015	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2014	1.4	0.3	22	15,358
2013	0.8 ϟ	0.2 ϟ	12 ϟ	15,722 ϟ
2012	0.8 ϟ	0.2 ϟ	13 ϟ	15,869 ϟ
2011	0.8 ϟ	0.2 ϟ	13 ϟ	15,757 ϟ
2010	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2009	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2008	0.8 ϟ	0.2 ϟ	13 ϟ	16,419 ϟ

Legends:

⚑ Indicator has a numerator ≤10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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
2016_2018	8.6	1.9	20	232,911
2015_2017	11.0	2.2	26	235,446
2014_2016	10.9	2.1	26	238,506
2013_2015	9.6	2.0	23	240,137
2012_2014	8.3	1.9	20	242,273
2011_2013	11.4	2.2	28	245,750
2010_2012	11.1	2.1	28	251,412
2009_2011	12.5	2.2	32	256,302
2008_2010	11.6	2.1	30	259,537
2007_2009	10.8	2.0	28	260,274

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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
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
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
2017_2018	54.4 % ⚡	7.1 % ⚡	10,866 ⚡	19,992 ⚡
2016_2017	45.6 % ⚡	6.1 % ⚡	9,601 ⚡	21,033 ⚡
2016	38.4 % ⚡	7.4 % ⚡	8,494 ⚡	22,150 ⚡

Legends:

🏴 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2016	9.6 %	0.3 %	1,113	11,589
2014	10.3 %	0.3 %	1,343	12,987
2012	10.2 %	0.3 %	1,489	14,578
2010	9.7 %	0.3 %	1,413	14,504
2008	10.0 %	0.3 %	1,279	12,796

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	14.2 %	0.6 %	5,507	38,832
2015	12.9 %	1.1 %	5,022	39,032
2013	13.5 %	1.1 %	5,413	40,216
2011	13.1 %	1.3 %	5,482	41,970
2009	14.2 %	1.7 %	6,699	47,219
2007	15.0 %	1.4 %	7,805	51,954
2005	13.0 %	1.0 %	6,777	52,210

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
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
2018	2.9 %	0.6 %	8,796	302,389
2017	2.1 %	0.4 %	6,519	304,896
2016	2.1 %	0.4 %	6,484	306,799
2015	1.4 %	0.3 %	4,350	312,071
2014	2.0 %	0.3 %	6,246	307,392
2013	3.2 %	0.6 %	9,896	306,669
2012	2.9 %	0.5 %	8,844	301,575
2011	3.9 %	0.6 %	11,813	304,365
2010	3.7 %	0.6 %	11,134	302,473
2009	2.6 %	0.5 %	7,498	288,177

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	71.0 %	3.6 %	18,344	25,824
2017	69.8 %	3.5 %	18,046	25,841
2016	75.1 %	3.1 %	19,930	26,535
2015	73.8 %	3.2 %	19,173	25,966
2014	73.7 %	3.3 %	19,437	26,371
2013	66.5 %	4.2 %	17,471	26,291
2012	80.2 %	2.8 %	21,101	26,326
2011	74.8 %	3.7 %	20,233	27,044
2010	63.7 %	3.3 %	17,732	27,823
2009	46.7 %	3.9 %	12,642	27,068

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
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
2018	76.7 %	2.8 %	60,275	78,556
2017	69.4 %	3.1 %	55,143	79,470
2016	64.8 %	3.2 %	51,921	80,076
2015	66.8 %	2.9 %	52,911	79,172

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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
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 not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)				
	2016	**2017**	**2018**	**2019**
Annual Objective	62	63	67	70
Annual Indicator	63.0	66.7	69.4	76.6
Numerator	152,559	161,334	167,372	184,106
Denominator	242,088	241,941	241,254	240,287
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	77.0	79.0	81.0	83.0	85.0	87.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Objectives have been updated as the 2019 objective has been met. Based on the growth pattern demonstrated in the 2016-2018 data and consultation with program staff, the state objectives from 2020 to 2025 reflects an annual increase of 2 percentage points.

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	2017	2018	2019
Annual Objective	90	91	89	91
Annual Indicator	90.6	87.3	90.6	88.9
Numerator	15,214	15,007	15,313	15,129
Denominator	16,789	17,199	16,911	17,014
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	92.0	92.0	93.0	93.0	94.0	94.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The annual performance objective through 2025 reflects an approximate 5% improvement over 5 years distributed among the individual years.

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

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	34.0	34.0	34.0	35.0	35.0	35.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Objective was updated because we have already met our 2019 objective (33.0%). The annual performance objective through 2025 reflects an approximate 5% improvement over 5 years distributed among the individual years.

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

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	82.0	83.0	84.0	85.0	86.0	86.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2020**

Column Name: **Annual Objective**

Field Note:
The annual performance objectives for years 2020-2025 reflect an approximate 5% improvement over 5 years distributed among the individual years.

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2017	2018	2019
Annual Objective			1
Annual Indicator	100	100	20.3
Numerator	1	1	3,306
Denominator	1	1	16,296
Data Source	1	1	PRAMS
Data Source Year	1	1	2016
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	21.0	21.0	22.0	22.0	23.0	23.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 1 is entered because PRAMS 2016 data is not available in State	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 1 is entered because PRAMS 2017 data is not available in State	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: There was no PRAMS data collection in Hawaii from 2017 to 2018, and no data on this measure prior to 2016. This is the first year data was provided on this measure.	
4.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: The state objectives through 2025 reflect an approximate 5% improvement over 5 years.	

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			1
Annual Indicator	100	100	46.2
Numerator	1	1	5,186
Denominator	1	1	11,228
Data Source	1	1	PRAMS
Data Source Year	1	1	2016
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	33.0	33.0	34.0	34.0	35.0	35.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 1 is entered because PRAMS 2016 data is not available in State	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 1 is entered because PRAMS 2017 data is not available in State	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: There was no PRAMS data collection in Hawaii from 2017 to 2018, and no data on this measure prior to 2016. This is the first year data was provided on this measure.	
4.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: The state objectives through 2025 have been updated to reflect an approximate 5% improvement over 5 years.	

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			33	39
Annual Indicator		32.0	39.1	36.5
Numerator		12,946	14,121	13,201
Denominator		40,486	36,113	36,145
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	40.0	41.0	42.0	43.0	44.0	45.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Based on the 2019 baseline data and consultation with program staff, the state objectives from 2020 to 2025 reflect an annual increase of 1 percentage point.

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			74	75
Annual Indicator		73.5	74.6	74.6
Numerator		67,325	74,226	74,226
Denominator		91,592	99,470	99,470
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	77.0	79.0	81.0	82.0	83.0	84.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The annual performance objective for years 2020-2025 reflects an approximate 10% improvement over 5 years distributed among the individual years

 Created on 9/11/2020 at 9:02 PM

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 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			23	23
Annual Indicator		23.3	21.9	24.7
Numerator		4,235	4,457	5,037
Denominator		18,144	20,375	20,412
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	25.0	25.0	26.0	26.0	27.0	27.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2020**

Column Name: **Annual Objective**

Field Note:
Objective was updated because we have already met our 2019 objective (23.0%). The annual performance objective for years 2020-2025 reflects an approximate 10% improvement over 5 years distributed among the individual years.

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Hawaii

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			84	85
Annual Indicator		83.1	84.9	85.6
Numerator		243,681	242,790	234,467
Denominator		293,312	285,950	273,914
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Hawaii

SPM 1 - Rate of confirmed child abuse and neglect reports per 1,000 for children ages 0 to 5 years.

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			5.9
Annual Indicator		5.9	5.5
Numerator		635	584
Denominator		108,119	105,815
Data Source		DHS CAN annual report	DHS CAN annual report
Data Source Year		2017	2018
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	5.5	5.4	5.4	5.3	5.3	5.2

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Data from 2017 DHS CAN annual report (http://humanservices.hawaii.gov/reports/child-abuse-and-neglect-reports/)
represents a rate of 5.9 per 1,000 children 0-5 years of age (Numerator: 635 unique children confirmed victims; Denominator: 2017 Census Estimate 0-5 years: 108,119).

2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Baseline Data from 2018 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: 584 unique children confirmed victims; Denominator: 2017 Census Estimate 0-5 years: 105,815).

3.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Objectives for 2020-2025 were updated as we met our 2019 goal. Objectives are set at 5% improvement over 5 years spread out over individual years.

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Measure Status:				**Active**
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			11	13
Annual Indicator				
Numerator	8	11	28	42
Denominator	72	72	72	72
Data Source	Telehealth work group, Family Health Services Divi	The preliminary 5-year plan objectives were develo	Telehealth work group, FHSD	Telehealth work group, FHSD
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The measure is a scale. Converting into percentages the annual indicator would be 8/72 = 11.1%	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The measure is a scale. Converting into percentages the annual indicator would be 11/72 = 15.3%	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The measure is a scale. Converting into percentages the annual indicator would be 12/72 = 16.7%	

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

State: Hawaii

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

Measure Status:	Active

State Provided Data

	2016	2017	2018	2019
Annual Objective		34	31	31
Annual Indicator	32.7	31.8	31.9	30.9
Numerator	3,020	2,851	2,776	2,661
Denominator	9,237	8,975	8,698	8,599
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Provisional	Provisional	Provisional

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	31.0	31.0	31.0	32.0	32.0	33.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Estimate for 2016 revised due to availability of 2016 data; prior year reported 2015 provisional only.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Estimate based on 2017 provisional vital statistics data file as final 2017 data file not available.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Estimate based on 2018 provisional vital statistics data file as final 2018 data file not available

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Estimate based on 2019 provisional vital statistics data file as final 2019 data file not available

5.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The 2020-2025 objectives are set to reflect a 5% improvement over 5 years.

ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed

Measure Status:	Active

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	83.0	84.0	85.0	86.0	87.0	87.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The number is obtained for SFY 2016 (July 1,2015 to June 30, 2016).
Numerator: Unduplicated number of WIC infants by SFY 2016
Denominator: Unduplicated number of WIC infants ever breastfed by SFY 2016

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Due to changes in data collection system over the transition completed in May 2017, no comparable data was available to report with this ESM so the 2016 data was carried over to 2017.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Due to changes in data collection system over the transition completed in May 2017, no comparable data was available to report with this ESM so the 2016 data was carried over to 2018.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Due to changes in data collection system over the transition completed in May 2017, no comparable data was available to report with this ESM so the 2016 data was carried over to 2019.

5.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The annual performance objective for years 2020-2025 reflects an approximate 5% improvement over 5 years distributed among the individual years.

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	11.0	11.0	11.0	11.0	11.0	11.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Data will be based on results of the Department of Health Safe Sleep Program; Child Care Program Department of Human Services; and the State Office of Language Access project to translate Safe Sleep educational materials into other languages for use by non-English speakers.

ESM 6.1 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			12
Annual Indicator			
Numerator	9	19	23
Denominator	30	30	30
Data Source	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	18.0	24.0	27.0	30.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   The measure is a scale and the annual indicator for 2017 is 9. Converting to percentage 9/30 = 30.0%

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   The measure is a scale and the annual indicator for 2018 is 19. Converting to percentage 19/30 = 63.3%

3. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   The measure is a scale and the annual indicator for 2019 is 23. Converting to percentage 23/30 = 76.7%

4.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2020 objective will be 18/30 = 60.0%.

5.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2021 objective will be 24/30 = 80.0%.

6.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2022 objective will be 27/30 = 90.0%.

7.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2023 objective will be 30/30 = 100.0%.

8.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2024 objective will be 30/30 = 100.0%.

9.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2025 objective will be 30/30 = 100.0%.

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

Measure Status:	Active

State Provided Data		
	2018	2019
Annual Objective		
Annual Indicator		
Numerator	9	13
Denominator	30	30
Data Source	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	18.0	23.0	25.0	28.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Converting to percentage 9/30 = 30.0%

2. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   Converting to percentage 13/30 = 43.3%

3. **Field Name:** **2020**

   Column Name: **Annual Objective**

   Field Note:
   The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2020 objective will be 18/30 = 60.0%.

4.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2021 objective will be 23/30 = 76.7%.

5.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2022 objective will be 25/30 = 83.3%.

6.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2023 objective will be 28/30 = 93.3%.

7.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2024 objective will be 30/30 = 100%.

8.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2025 objective will be 30/30 = 100%.

ESM 12.1 - Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.

Measure Status:	Active

State Provided Data

	2016	2017	2018	2019
Annual Objective			17	21
Annual Indicator				
Numerator	12	13	18	22
Denominator	33	33	33	33
Data Source	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	24.0	26.0	28.0	30.0	33.0	33.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   The measure is a scale and the annual indicator for 2017 is 13. Converting into percentage 13/33 = 39.4%

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   The measure is a scale and the annual indicator for 2018 is 18. Converting into percentage 18/33 = 54.5%

3. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   The measure is a scale and the annual indicator for 2019 is 22. Converting into percentage 22/33 = 66.7%

4.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2020 objective will be 24/33 = 72.7%.

5.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2021 objective will be 26/33 = 78.8%.

6.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2022 objective will be 28/33 = 84.8%.

7.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33.Converting into percentage, the 2023 objective will be 30/33 = 90.9%.

8.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33.Converting into percentage, the 2024 objective will be 33/33 = 100%.

9.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33.Converting into percentage, the 2025 objective will be 33/33 = 100%.

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 13.2.3 - The number of organizations and individuals participating in State Oral Health Coalition meetings and activities

Measure Status:		Active
State Provided Data		
	2018	**2019**
Annual Objective		
Annual Indicator	48	64
Numerator		
Denominator		
Data Source	Hawaii Oral Health Coalition	Hawaii Oral Health Coalition
Data Source Year	2018	2019
Provisional or Final ?	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Hawaii

SPM 1 - Rate of confirmed child abuse and neglect reports per 1,000 for children ages 0 to 5 years.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.
Definition:	**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) **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Related to: IPV-37 Reduce child maltreatment deaths to 2.1 deaths per 100,000 children under age 18 years. Baseline: 2.3 child maltreatment deaths per 100,000 children under age 18 years occurred in 2008. IPV-38: Reduce nonfatal child maltreatment to 8.5 maltreatment victims per 1,000 children under age 18 years. Baseline: 9.4 victims of nonfatal child maltreatment per 1,000 children under age 18 years were reported in 2008.
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.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the use of telehealth across Title V activities to improve access to services and education for families and providers.
Definition:	**Numerator:** Total Actual Scores from three Telehealth Data Collection Forms **Denominator:** Total Possible Scores from three Telehealth Data Collection Forms (18, 24, 30) **Unit Type:** Scale **Unit Number:** 72
Healthy People 2020 Objective:	HP2020 Health Communication & Health Information Technology Goal: Use health communication strategies and health information technology (IT) to improve population health outcomes and health care quality, and to achieve health equity.
Data Sources and Data Issues:	This is a summary of the Data Collection Form that lists 24 strategy components organized by the three areas in telehealth activities: • Infrastructure development • Training/education development • Service development Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 72. Scoring is completed by FHSD staff. The data collection form is attached as a supporting document.
Significance:	With the reduction in personnel resources, increases in travel costs, and availability of high speed internet and affordable devices, telehealth can be one of the tools to increase access to families and providers while saving costs and travel time. Telehealth can be used to increase access to services for families, care coordination activities, education for providers, and workforce training for public health staff.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Hawaii

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Hawaii

ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To support reproductive life planning and healthy birth outcomes by increasing intervals of birth spacing (births spaced from 18 month to next conception).
Definition:	**Numerator:** Number of Births with interval < 18 months between birth and next conception **Denominator:** Total number of Births **Unit Type:** Percentage **Unit Number:** 100
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 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Promote Breastfeeding in all WIC clinics statewide
Definition:	**Numerator:** Unduplicated number of WIC infants ever breastfed by SFY **Denominator:** Unduplicated number of WIC infants by SFY **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Hawaii WIC Program Data
Significance:	Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Given the indisputable short- and long-term advantages of breastfeeding, infant nutrition is considered a public health priority. The American Academy of Pediatrics (AAP) recommends that all infants be exclusively breastfed for about six months with continuation of breastfeeding for one year or longer. Breastfeeding is also encouraged and supported by other agencies such as the United States Department of Agriculture's (USDA) Food and Nutrition Service (FNS). However, as rewarding as breastfeeding can be, some women choose not to breastfeed and many women who start breastfeeding often stop when they are faced with challenges. With appropriate guidance and education, women can overcome these obstacles and continue breastfeeding for longer periods. WIC is the largest public breastfeeding promotion program in the state and nation, providing mothers with education and support as a core service. Moreover, promoting and/or facilitating community activities that reinforce breastfeeding may allow for more women across the state to have access to the support they need to initiate breastfeeding and continue doing so exclusively for at least 6 months.

ESM 5.1 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Expand outreach to Non-English-speaking families and care givers through translation of educational and general awareness safe sleep messages.
Definition:	**Numerator:** Number of languages Departments of Health (DOH) & Human Services (DHS) safe sleep are available for Hawaii's communities **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	Data will be collected by Safe Sleep Hawaii about the efforts by DOH, DHS and the State Office of Language Access to translate educational materials into other languages for use by non-English speakers.
Significance:	About 3,500 US infants die suddenly and unexpectedly each year. These deaths are referred to as sudden unexpected infant deaths (SUID). SUID is one of the three leading-causes of death among infants nationally and in Hawaii (Hayes DK, Calhoun CR, Byers TJ, Chock LR, Heu PL, Tomiyasu DW, Sakamoto DT, and Fuddy LJ. Saving Babies: Reducing Infant Mortality in Hawaii. Hawaii Journal of Medicine and Public Health. 2013. 72 (2): 246-251). The American Academy of Pediatrics (AAP) recommends a safe sleep environment to reduce the risk of all sleep-related infant deaths. AAP recommendations for a safe sleep environment include supine positioning, the use of a firm sleep surface, room-sharing without bed-sharing, and the avoidance of soft bedding and overheating. Additional recommendations for SUID reduction include the avoidance of exposure to smoke, alcohol, and illicit drugs; breastfeeding; routine immunization; and use of a pacifier. The AAP recommends education should include all who care for infants, including parents, child care providers, grandparents, foster parents, and babysitters, and should include strategies for overcoming barriers to behavior change. Research on health education and SUID outreach has found that response to safe sleep messages differed among different communities and racial/ethnic groups, which may help explain some of the lingering differences in SUID rates. Therefore, campaigns should have a special focus on getting safe sleep messages to parents and caregivers in diverse communities because of the higher incidence of SUID and other sleep-related infant deaths in these groups.

ESM 6.1 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of children receiving developmental screening and referred and receiving services among Hawaii Title V direct service programs.
Definition:	**Numerator:** Total scale score based on program assessment of 10 steps **Denominator:** 30 **Unit Type:** Scale **Unit Number:** 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 Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase resources, training and practice improvement support for adolescent health and service providers to promote wellness and healthcare visits aligned to Bright Futures.
Definition:	**Numerator:** Total Actual Score from Adolescent Health Data Collection Form **Denominator:** Total Possible Score from Adolescent Health Data Collection Form (30 total) **Unit Type:** Scale **Unit Number:** 30
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 necessary to make transitions 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:	**Numerator:** Total Actual Score from Transition to Adult Health Care Data Collection Form **Denominator:** Total Possible Score from Transition to Adult Health Care Data Collection Form (33) **Unit Type:** Scale **Unit Number:** 33
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 CSHNP 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 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 13.2.3 - The number of organizations and individuals participating in State Oral Health Coalition meetings and activities
2016-2020: NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	To improve the oral health of children.
Definition:	**Numerator:** Not Applicable **Denominator:** Not Applicable **Unit Type:** Count **Unit Number:** 80
Data Sources and Data Issues:	Hawaii Children’s Action Network Roster for State Oral Health Coalition
Significance:	Cavities (also known as caries or tooth decay) are one of the most common chronic diseases of childhood in the United States. Untreated cavities can cause pain and infections that may lead to problems with eating, speaking, playing, and learning. Children who have poor oral health often miss more school and receive lower grades than children without disease. The good news is that most tooth decay is preventable when children have access to evidence-based prevention strategies. To prevent tooth decay, the American Academy of Pediatrics recommends several strategies for enhancing the oral health of young children including: parent/family education on oral health (particularly eating nutritious foods and limiting sugars, and brushing teeth with a toothpaste containing fluoride); first preventive visit to a dentist within six months of the first tooth erupting and no later than age 1, with preventive check-ups thereafter; a series of topical fluoride applications to children’s teeth; and drinking fluoridated water. With limited access for fluoridated water, a 2015 survey of Hawaii third graders documented some of the highest rates of decay in the U.S. To address this complex issue, a multi-faceted team and approach are needed which span across different settings and systems. Community collaboration and capacity, with representation across different public and private sectors, can help to address the complex issue of child oral health from multiple angles.

Form 11
Other State Data

State: Hawaii

The Form 11 data are available for review via the link below.

Form 11 Data