Maternal and Child Health Services Title V Block Grant

Hawaii

FY 2025 Application/ FY 2023 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

KENNETH S. FINK, MD, MGA, MPH
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KA LUNA HO'OKELE

STATE OF HAWAI'I
DEPARTMENT OF HEALTH
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HONOLULU, HI 96801-3378

In reply, please refer to:
File:

July 10, 2024

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) 2025 (October 1, 2024 – September 30, 2025). The FY 2025 application and FY 2023 annual report are submitted via the Health Resources and Services Administration Electronic Handbooks (EHBs).

Please note that the Title V Block 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, Family Health Services Division Planner, at (808) 733-8358 or annette.mente@doh.hawaii.gov.

Sincerely,

Kenneth Fink

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 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 2021 Title V application/Annual Report guidance.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

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. With a land mass of 6,422 square miles that span nearly 11,000 square miles, the state is home to 1.4 million residents—70% living in Honolulu, the most populous county.

Hawaii is one of the most ethnically diverse states with no single majority race (39% Asian, 25% White, 11% Native Hawaiian/Pacific Islander, 1.8% Black) and a large heterogeneous Pacific Islander and Asian population. Nearly 28.7% of the population is mixed race, with indigenous Native Hawaiians comprising 22.8% (when combined with other races). Also, about 17.1% of all residents are immigrants—mainly from Asia and the Pacific.

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

The Hawaii State Department of Health (HDOH) works to protect and improve the health and environment for all people in the state. The HDOH Family Health Services Division (FHSD) administers the federal Title V Maternal and Child Health (MCH) Block Grant (Title V) to improve the health of women, infants, and children, including those with special healthcare needs. The four guiding pillars of MCH are: 1) delivery of services using the ten Essential Public Health Services framework; 2) data-driven performance accountability; 3) partnerships with agencies, community providers, and individual families/youth; and 4) health equity for all MCH populations to achieve their full health potential. To help expand its capacity and reach, FHSD leverages state and federal grant funds with community partners.

To set priorities for the state MCH program, a comprehensive needs assessment is conducted every five years, and ongoing assessments are conducted in interim years. During the pandemic, four additional priorities were added: food insecurity, child wellness visits, child mental health, and telehealth. In 2023, two priorities were deleted: child wellness visits and telehealth. In 2024, two new ‘Universal’ priorities were added from the new Title V grant guidance: postpartum care and medical home for children and children with special healthcare needs. The current 11 Hawaii Title V priorities are listed below across the six Title V MCH population domains.

Population Domain	State Priority Need
Women's/Maternal Health	Promote reproductive life planning
	Improving postpartum care
Perinatal/Infant Health	Promote food security through WIC services
	Increase infant safe sleep conditions
Child Health	Improve the percentage of children ages 0-5 years screened early and continuously for developmental delay
	Reduce the rate of child abuse and neglect, with special attention to children ages 0-5 years
	Increasing the number of children who have a Medical Home
Adolescent Health	Improve the healthy development, health, safety, and well-being of adolescents
Children with Special Health Care Needs	Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to transition to adult healthcare
	Increasing the number of children with special health care needs who have a Medical Home
Cross-Cutting	Address health equity by expanding pediatric mental health care access in rural and underserved communities

Maui Fires. As Hawaii emerged from the COVID-19 pandemic, the state was struck with another unthinkable catastrophe. One of the deadliest natural disasters in U.S. history occurred on August 8, 2023, when a swift-moving wildfire unexpectedly destroyed the historic town of Lahaina. The fire tragically took the lives of 102 people, injuring many more, and leaving several thousand without a home or means of support. In a matter of hours, the wildfire burned 2,170 acres and destroyed more than 3,000 buildings (including schools), 5,000 cars, and 100 sea vessels. Approximately 86% were residential homes, of which nearly half were rentals. Housing on Maui, as elsewhere in the state, is very limited and costly, with the fire aftermath creating an extreme emergency for affected families and individuals. With no warning/preparation, residents escaped without basic necessities, income, and housing.

FHSD Disaster Response. FHSD Maui response efforts were extensive and included diverting funding to local agencies to provide emergency services (outreach, mobile pharmacy; mobile medical/reproductive healthcare); expansion of existing Maui service contracts to expand service areas to include Lahaina; coverage for basic necessities; and reproductive health needs. WIC expedited certification of new Maui retailers, expanded WIC food package options, and partnered with national manufacturers to ship infant formula for Maui WIC clients and the Maui Food Bank. Maui staff were engaged in initial emergency response: visiting homes surrounding the burn areas to assess needs, providing information/meals, making referrals to services if needed, and providing assistance at emergency shelters.

Funding was also redeployed to establish a new Lahaina health clinic, provide elder outreach, and support for healthcare workers and service providers (trauma supports and training). Information about water quality concerns was also shared with local area childcare facilities. Oahu staff flew to Maui to distribute resiliency kits, promote services, and conduct fun activities for families at community events. FHSD is also partnering with the Hawaii State Rural Health Association to conduct a broad healthcare assessment of the initial response and ongoing needs for West Hawaii. More specific Maui response efforts and updates are found in the population domain narratives in this report.

Economic Recovery. In the near term, the aftermath of the Maui wildfires continued to slow the state's economic recovery from COVID-19, although Maui's recovery has been better than many had predicted. Overall, the state economy has continued to grow in 2023, albeit less than forecasted. Future rebuilding efforts will fuel Maui's economic recovery, although families will continue to struggle while some have already chosen to relocate.

Prior to the Maui Wildfires, Hawaii's post-pandemic economic recovery was nearly complete. Initial COVID-19 shutdowns in 2020 resulted in the virtual closure of the Hawaii tourism market (99% decrease in travelers), causing an unprecedented collapse of the state's economy. Equally unexpected, the economy made an astounding rebound in 2022 with the return of U.S. domestic travelers, driven by healthy U.S. incomes and pent-up demand. Hawaii's real gross domestic product (GDP) for 2023 recovered to 97.6% compared to 2019.

Also critical to Hawai's economic recovery was the unprecedented level of federal COVID-19 and stimulus spending. Direct aid to state and local governments offset significant budget shortfalls. Direct stimulus payments, expanded unemployment insurance, entitlement supports, and rent/mortgage subsidies helped maintain personal income through 2020-21. Although 2022 saw the end of many federal supports, a slight increase in average earnings was reflected in real income recovery to near pre-pandemic levels.

Labor shortages. Hawaii's labor market continues to decrease slowly, with a declining population and labor force. The outmigration of working-age residents to other, more affordable states and the increasing number of retirees leaving the workforce likely contribute to this trend.

High Cost of Living. Affordability remains an enormous challenge for many residents. Data for 2021 shows that Hawaii goods and services were 13% higher than the U.S. average, making Hawaii the most expensive state in the country.

Legislation. Over the past three years, policymakers have utilized budget surpluses to support programs to alleviate financial hardships for families, including affordable housing development; raising the minimum wage; tax credits for low-income and working families; and major investments in public preschool, childcare, and healthcare.

FHSD Updates. As Hawaii continues to emerge from the pandemic and the Maui wildfires, FHSD responded by recalibrating and revising programs and initiatives to serve those disproportionately impacted communities. Although hampered by mounting vacancies, FHSD staff have shown strength and resiliency, creating new partnerships and managing expectations to address service gaps and ever-growing needs.

The secondary effects of these disasters on the MCH population are being reviewed through needs assessment activities. Some of the notable consequences include increased mental health needs; loss of social support and connection; concerns over family violence; childhood adversity and trauma; disrupted access to healthcare, social services, and education; and worsening family stress due to Hawaii's high cost of living.

As reported in Form 5a, Title V programs continued to see an increase in direct client services in 2023 with a 9% rise over 2022. However, this was still 16.9% below 2019 service levels. The 2023 increase was not consistent across all program and population groups. The reach of other public health services, as reported in Form 5b, was similar to 2022 but reflected a 94.6% increase in outreach to adults and a 19.6% increase in outreach to children compared to 2019 due to increased media initiatives.

5-Year Plan Highlights for 2021-2025

FY 2023 marks the fourth year of the Title V 5-year project period. FHSD recognizes that systematic inequities

impact physical and mental well-being in an interconnected way. Thus, Title V strategies/activities were developed using a health equity lens. For the new federal MCH Bureau universal priorities, plans include reviewing data and researching evidence-based strategies to inform planning activities. Key highlights are provided by domain and priority health issue.

DOMAIN: WOMEN'S/MATERNAL HEALTH

Promote reproductive life planning

- In partnership with the Hawaii Maternal Infant Health Collaborative (HMIHC) and the Healthcare Association of Hawaii, a state Maternal Health (MH) Steering Committee has been established to develop a state MH Strategic Plan and collaborate on needs assessment. The Title V MCH Branch continues to provide reproductive health services to underserved communities.

DOMAIN: PERINATAL/INFANT HEALTH

Promote safe sleep practices

- Conducted media messaging campaigns to promote safe sleep and resources available through the state toll-free warmline, The Parent Line. Information materials are now available in 11 languages.

Address Food Insecurity through Improving WIC services

- Strategies were revised to improve internal operations, including: 1) data analysis to strengthen program planning/evaluation and 2) workforce development to expand training opportunities for existing staff and recruitment for new staff.

DOMAIN: CHILD HEALTH

Improve early and continuous screening for developmental delay

- Staff was hired to expand a free developmental screening service for families sponsored by the Children with Special Health Needs program.

Reduce the rate of child abuse and neglect (CAN)

- Issued over $800,000 in state/federal funding to community-culturally based programs to provide critical family and parenting support services.
- Continued provision of home visiting services statewide and supporting the state network of home visiting programs.

DOMAIN: ADOLESCENT HEALTH

Improve adolescent health and well-being

- Partnered with residential youth programs to provide evidence-based youth development programs.
- Partnered with TeenLink Hawaii, a youth-driven, empowerment program to develop web-based resources and social media messages on health issues of concern to youth.

DOMAIN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Improve transitions to adult healthcare

- Developed a system for transition planning for enrolled Children and Youth with Special Health Needs Section youth using the evidence-based Six Core Elements of Health Care Transition, including guidelines, educational tools, workbook, and database tracking.
- Supported development of an active statewide network of agency/community partners that promote transition services, including the state DOE, Vocational Rehab, and family service organizations through popular in-person events.

DOMAIN: CROSS-CUTTING/SYSTEMS BUILDING

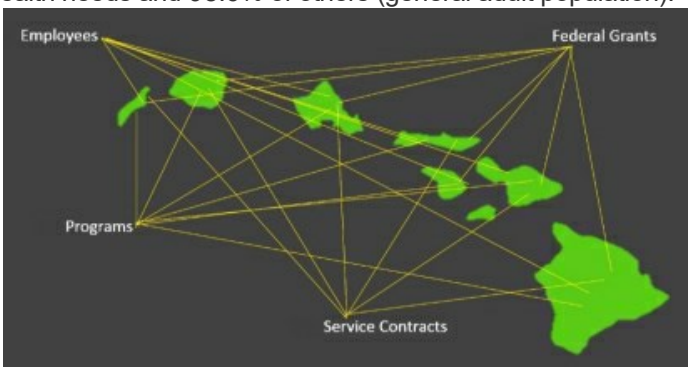
Expand pediatric mental health care access to underserved rural communities

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

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

FHSD provides all levels of service delivery: direct, enabling, and infrastructure building. FHSD's reach is statewide with no local health departments. One of the largest divisions in the Hawaii Department of Health, FHSD is comprised of three branches—Maternal and Child Health (MCH); Children with Special Health Needs (CSHN); and Women, Infants, and Children (WIC) Services. Together, the division administers 30 programs, 25 federal grants, and approximately 150 service contracts with community-based organizations, totaling roughly $55 million with 261.5 FTE positions statewide.

Title V funds played a critical role in supporting the state's overall MCH efforts. In 2023, the FHSD budget was $91.M million. Nearly $2.0 million was provided by Title V, with $48.4 million state matching funds and an additional $41.3 million in other federal funds. Of the state's overall population, FHSD programs reached an estimated 100% of pregnant women; 99.2% of all infants; 37.6% of children 1-21 years of age, including 77.1% of children with special health needs and 98.6% of others (general adult population).



Title V funds were used for key program capacity and public health infrastructure positions needed to administer MCH programs statewide (23.9 FTE). Positions included: critical data analytics staff (epidemiologists and research statisticians); administrative, fiscal, and program management for MCH and CSHN; Public Information Officer; contract specialist; and a nutritionist and audiologist for CSHN. These positions are critical to: 1) securing, leveraging, and managing a broad array of funding sources; 2) addressing statewide surveillance needs; 3) developing critical statewide partnerships and system-building efforts; 4) improving quality to ensure services are family centered, culturally relevant, and community based; 5) ensuring a statewide system of care through provision of safety-net and gap-filling services; 6) recruiting and supporting workforce needs; and 7) ensuring development/dissemination of public health messaging.

III.A.3. MCH Success Story

In 2021, the Hawaii State Department of Health, Maternal and Child Health Branch, Family Strengthening and Violence Prevention Unit, began doing paid media campaigns to promote safe sleep messaging to reach a larger audience. The creative is based on the Safe Sleep Guide created by the HDOH, Hawaii Department of Humans Services, and Safe Sleep Hawaii Coalition—based on the ABCs of Safe Sleep approved by the American Academy of Pediatrics.

A 30-second TV spot was created using copy and graphics from the guide for consistent messaging and branding. A 30-second radio spot was also created using the audio from the TV spot.

The paid media campaign for the reported period launched with a news release in October 2022 to coincide with Safe Sleep and SIDS Awareness Month. From October-December 2022, the spots ran on KHON2, local Fox affiliate, and on iHeartMedia's 20+ radio stations across the state. The broadcast TV reach was 98.6% of households with adults ages 25-54 years statewide with an average frequency of 12 and 1.544 million impressions. For Oahu, the radio reach of adults ages 25-54 years was 70% with an average frequency of 15.6. For neighbor islands, the radio reach was 33.9% of adults ages 25-54 years with an average frequency of 14.8.

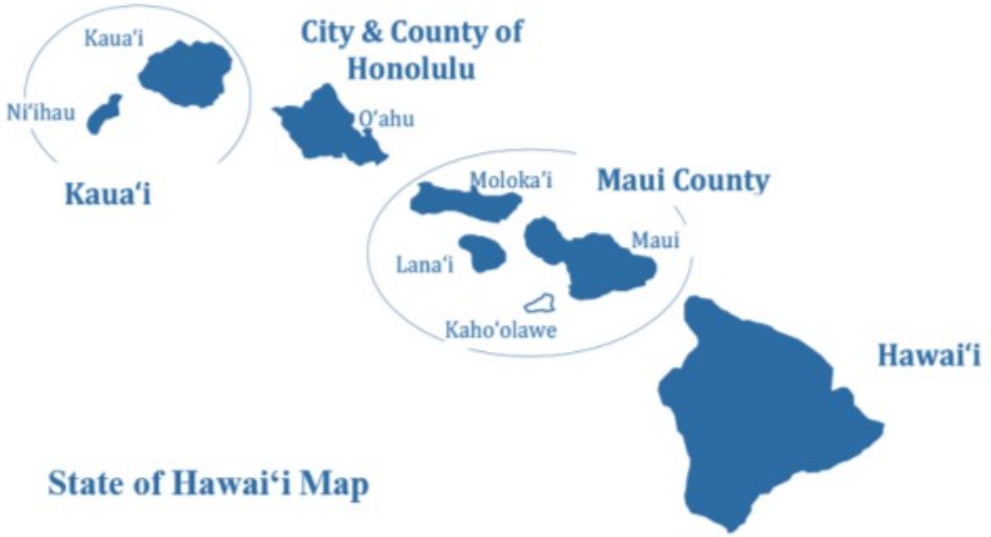
Digital ads ran on Facebook, Instagram, YouTube, Connected TV/OTT, targeted pre-roll, and targeted display for a total of two million impressions and 1,445 post/website clicks. Digital ads targeted parents of infants, households with infants, adults ages 25-54 years, and at-risk groups (Native Hawaiian, Samoan, Other Pacific Islander, Filipino, and Micronesian).

In July 2023, the FHSD Information Specialist began working on safe sleep initiatives with Karen Worthington, a children's law and policy consultant contracted to assist the SSH Coalition. Together, they planned an upcoming, sustained paid media campaign to run a full year from October 2023-September 2024. They also planned and launched a new, dedicated HDOH Safe Sleep Hawaii webpage at health.hawaii.gov/safesleep. The page houses safe sleep information and resources, including the Safe Sleep Guide in 11 languages and a Safe Sleep Hawaii E-Toolkit for individuals and organizations that educate parents and caregivers about safe sleep for infants.

III.B. Overview of the State

GEOGRAPHY

Situated in the middle of the Pacific Ocean, Hawaii is one of the most isolated yet populated 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 coast of the United States. Hawaii is the only island state, the 11th smallest state in the nation by population size, and the 4th smallest in land area. Most of the state's 1.4 million residents reside on Oahu, where the state capital of Honolulu is located.



The state comprises seven populated islands in four major counties: Hawaii, Maui, Oahu, and Kauai. The county is the lowest civil subdivision in the state, with the counties providing basic public services such as fire and police protection. Cities or towns in other states usually perform these services. The Hawaii State government is also responsible for functions usually performed by counties or cities in other states. For example, Hawaii is the only state with a single unified public school system. Similarly, Hawaii has no city- and county-specific health departments and depends on state district health offices to provide public health services for the three neighbor island counties. The neighbor island counties are Hawaii, Kauai (includes Niihau, which is privately owned with restricted access), and Maui (includes Molokai, Lanai, and Kahoolawe, which is unpopulated).

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

Geographic access to healthcare is further limited since public transportation is inadequate in many areas of the state other than the Honolulu metropolitan area. Over the past five years, the islands of Maui, Kauai, and Hawaii have established limited public bus services, but their use by residents is largely sporadic. Residents in rural communities, like the neighbor islands, rely on automobiles to travel to major population centers on their island, where healthcare services are more likely to be available. Because of the mountainous nature of the islands, road networks are sparse and, in some places, limited to a single highway along the coastline. Timely access to emergency care on neighbor islands often requires costly helicopters or fixed-wing aircrafts.

DEMOGRAPHICS

According to the 2022 American Community Survey (ACS) 1-year estimate, the estimated 2022 state population is 1,440,196 residents, the 30th most populous state in the U.S. Oahu is home to 69.1% (995,638 residents) of the state's population, while 14.3% (206,315 residents) live on Hawaii Island, 11.4% (164,365 residents) in Maui County, and 5.1% (73,810 residents) in Kauai County. Compared to 2021 (1,441,553),[1] The state's population decreased by 1,357 (0.09%). Other sources reported a larger decline over the years. For example, the Decennial Census estimated a 7,346 (0.5%) population decline from 2021 to 2022 and an 11,782 (0.8%) decline from 2020.[2] The Economic Research Organization at the University of Hawaii (UHERO) reported that Hawaii's population losses have been concentrated on Oahu and Maui, with many residents moving to less expensive/more affordable locations elsewhere.[3]

ETHNIC DIVERSITY

Hawaii is the most ethnically diverse state in the nation.[4] According to the 2022 American Community Survey (ACS) data, 28.7% of Hawaii's resident population reported two or more races, and the following single race proportions: White=22.2%; Asian=35.2%; and Native Hawaiian or Other Pacific Islander (NHOPI)=10.0%. The largest Asian single-race ethnic subgroups reported were Filipino (13.8%) and Japanese (10.6%), and the largest NHOPI single-race subgroup was the indigenous Native Hawaiians (5.8%). The individual Asian and NHOPI subgroups from the U.S. Census are listed in the table below, showing the heterogeneity of these aggregated ethnic groupings.

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

Reporting is further complicated by the growing category of those with two or more race groups. They are not included in the single-race groups commonly reported. Hawaii State Department of Health (HDOH) guidance instructs race data to be reported as "Alone" or "Alone or in Combination" with another group. For example, Native Hawaiians accounted for 22.8% of the state population when reported as "Alone or in Combination," compared to just 5.8% when reported singly. There is also variation among race subgroups, with an overall estimate of 37.7% of

those in the “Asian Alone or in Combination” reporting another race. Variation in the three largest Asian subgroups ranges from 39.6% Filipino to 61.3% Chinese. The other Asian subgroups are likely newer immigrants when compared to these three and have smaller numbers reporting more than one race.

Race	Resident Population in the State (N)	Percent of State Population (%)	Proportion Reporting at least one other Race (5)
White Alone	319,118	22.2%	0
White Alone or in Combination	631,327	43.8%	49.5%
Native Hawaiian or Other Pacific Islander (NHOPI) Alone	143,444	10.0%	0
NHOPI Alone or in Combination	404,442	28.1%	64.5%
Native Hawaiian Alone	83,655	5.8%	0
Native Hawaiian Alone or in Combination	328,724	22.8%	72.5%
Asian Alone	506,753	35.2%	0
Asian Alone or in Combination	812,862	56.4%	37.7%
Filipino Alone	198,648	13.8%	0
Filipino Alone or in Combination	367,525	25.5%	39.6%
Japanese Alone	152,062	10.6%	0
Japanese Alone or in Combination	299,756	20.8%	38.3%
Chinese Alone	92,576	6.4%	0
Chinese Alone or in Combination	*239,216*	*16.6%*	*61.3%*
Source: U.S. Census Bureau. 2022. ACS Calculations by Hawaii HDOH, FHSD.			

Immigration

Hawaii is a gateway to the U.S. for immigrants traveling from Asia and the Pacific, reflecting a sizeable immigrant community. Based on the 2022 ACS, there were 246,683 immigrants in Hawaii, or nearly one in five (17.1%) residents, the 6th highest of all states. Hawaii immigrants were 57.2% women and 4.5% children (under 18 years old). The largest ethnic group of immigrants was Asians (72.6%), followed by NHOPI (9.9%) and White (9.6%).

Most immigrants in Hawaii (81.8%) speak a language other than English as their primary language, and 49.0% speak English less than “very well.” About 20.9% reported possessing a bachelor’s degree, with 9.0% having earned a graduate or professional degree. Approximately 59.5% of immigrants 16 years and over were employed in the labor force in 2022.

Undocumented Immigrant Estimates

In 2016, an estimated 45,000 undocumented immigrants were in Hawaii (3.3.% of the population).[5] The majority were from the Philippines. Hawaii was the only state where undocumented women (55%) outnumbered men. The following table summarizes the characteristics of Hawaii's undocumented immigrant population compared to the

U.S.

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

DACA (Deferred Action for Childhood Arrivals)

As of March 2020, 340 active DACA recipients resided in Hawaii, with 368 people granted DACA status since 2012.[6] As of 2019, 11% of those DACA-eligible immigrants in Hawaii applied for DACA status.

Compacts of Free Association (COFA)

COFA migrants come from the Federated States of Micronesia, Republic of Marshall Islands, and Republic of Palau. Under these unique agreements, COFA migrants are legally residing noncitizen nationals who can live, work, and study in the U.S. indefinitely without a VISA or green card. This status was negotiated in exchange for exclusive U.S. military use of strategic areas in the region. The passage of the 1996 Welfare Reform Act removed COFA eligibility to key entitlement programs (Medicaid, Social Security, disability, and housing programs), with the state assuming most of the costs for services. However, in December 2020, Medicaid benefits were federally restored to COFA migrants once again.

Among COFA migrants, there are reports of high morbidity rates due to chronic diseases, communicable diseases, and other medical concerns that may be related to U.S. nuclear tests conducted within Micronesia in the 1950s and 60s. Health disparities are exacerbated by chronic unmet care needs, lower socioeconomic status, and cultural beliefs and behaviors with the most recent arrivals. Estimates of the COFA population in Hawaii range from 16,680 to 28,000.[7] COFA migrants are consistently overrepresented among homeless surveys and account for about 2-3% (400-600) of births annually in Hawaii, with lower rates of prenatal care, higher rates of low birth weight infants, and greater numbers of Neonatal Intensive Care Unit admissions.[8]

Languages Spoken

Because of the ethnic diversity in Hawaii, limited English proficiency may impact access to healthcare for immigrant communities and pose a challenge to service organizations targeting these populations. According to the 2022 ACS, an estimated 24.2% of Hawaii residents ages 5 years and over spoke a language other than English at home, compared to 22.0% nationally. An estimated 10.3% of Hawaii residents reported limited English proficiency (4th highest state ranking) compared to 8.4% nationally.

In School Year 2019-20, an estimated 18.0% (32,044) of the public school students are or have been English Learners (EL).[9] The top five languages spoken by Hawaii public school students are Ilokano, Chuukese, Marshallese, Tagalog, and Spanish.

Hispanics

Hawaii has experienced a growing Hispanic population, particularly in rural, predominantly agricultural areas. Anecdotally, recent Hispanic workers in the state have lessened the labor shortages in agriculture (coffee and pineapple farms) and in tourism-related and construction industries located primarily in Maui and Hawaii counties. Service organizations report that their migrant workers have relocated primarily from Mexico, Guatemala, and Honduras.[10]

Disaggregated Data

The state's unique characteristics, particularly the diversity in race, ethnicity, language, and cultural practices, underscores the serious need for disaggregated data. When diverse groups are combined, critical differences can be hidden. Disaggregating data can inform and expand understanding of the experiences of population subgroups and assist in evaluating whether programs are effective at meeting the needs of these groups. It can also help develop policies and programs that are culturally/linguistically appropriate since differences in culture and language are important considerations when implementing any Evidenced-Based Interventions.

Military

Other subpopulations within Hawaii include the U.S. Armed Forces personnel and their family members. In 2022, Active Duty, National Guard, and Reserve Personnel comprised an estimated 3.5% of the state's population (50,031 people).[11] Several major military health facilities serve this population on Oahu. The Tripler Army Medical Center is the federal tertiary care hospital for the Pacific Basin. It supports 264,000 local active-duty and retired military personnel, their families, and veteran beneficiaries. Medical services are also available on military bases, offering clinical services for active-duty members and their family members.

Homeless

The 2023 Hawaii homeless study estimates that there were 2,316 *sheltered* homeless people in the state (1,663 on Oahu and 653 on the neighbor islands).[12] Data for *unsheltered* homeless was 2,365 for Oahu and 1,542 on the neighbor islands. From 2022 to 2023, a 4.2% increase was documented in sheltered homeless on Oahu, with a 4.0% increase for sheltered homeless on neighbor islands. Compared to other states, Hawaii had the 4th highest homeless rate in the U.S. (43 per 10,000 residents), more than twice the national rate (19 per 10,000).[13]

Maternal and Child Population

The 2022 ACS data estimates indicate that there were 260,713 women of reproductive age (15-44 years old), a 3.0% decline from 2015 (268,648), representing 18.1% of the entire state population. Vital statistics data for Hawaii show the number of births have continued to decrease between 2019 (16,810) and 2023 (14,820).

ACS data also indicates there were 161,160 children 9 years of age or younger in Hawaii, representing a 9.2% decrease from 2015. This group represents 11.2% of the state population. There were 165,846 children 10-19 years of age, representing a 1.6% increase from 2015. This group represents 11.5% of the state population.

Based on 2021-2022 data, an estimated 41,437 Children with Special Health Care Needs (CSHCN) reside in Hawaii, representing 13.9% of all children ages 0-17 years. This 13.9% is significantly below the national estimate of 20.0%. The 2021-2022 Hawaii estimate was similar to the 2020-2021 estimate (13.2%).

Older Population

As in other places, Hawaii's population is rapidly aging. Based on 2022 population estimates, persons aged 65 years and over (294,654 total) comprised 20.4% of the Hawaii population, compared to 16.6% in 2015. Nationwide,

this population comprised 17.3% in 2022, compared to 14.9% in 2015. There are now more older people in proportion to younger ones residing in Hawaii, and this trend is expected to continue.

Maui Wildfires

One of the deadliest natural disasters in U.S. history occurred on August 8, 2023, when a swiftly-moving wildfire unexpectedly razed drought-prone West Maui, completely destroying the historic town of Lahaina. The fire tragically took the lives of 102 people, injuring many more and leaving several thousand without a home or means of support. The wildfire burned 2,170 acres and destroyed more than 3,000 buildings, including schools, 5,000 cars, and 100 sea vessels. Approximately 86% were residential homes, of which half were rentals. Housing on Maui, as elsewhere in the state, is very limited and costly, with the fire aftermath creating an extreme emergency for affected families and individuals.

The American Red Cross, Hawaii Emergency Management Agency, and FEMA temporarily relocated thousands of displaced families to dozens of hotels and hundreds of short-term rentals on Maui, ultimately housing more than 8,000 displaced individuals in more than 2,400 units across 40 properties in just 14 days. The town of Lahaina is considered rural by federal definitions, making this area eligible for federal grants. The consequences of the wildfires continue to impact all aspects of life for the community, county, and the entire state. Some of the more measurable impacts will be discussed throughout the report.

ECONOMY

Tourism, real estate, construction sectors, and federal/military spending largely drive the economy in Hawaii. Initial COVID-19 shutdowns in 2020 resulted in the virtual closure of the Hawaii tourism market, causing an unprecedented decline in the state's economy. Equally unexpected, the economy made an astounding rebound in 2022 with the return of U.S. domestic travelers driven by healthy U.S. incomes and pent-up demand. According to the Hawaii Department of Business, Economic Development and Tourism (DBEDT),[14] the state's major economic indicators were mixed in the fourth quarter of 2023. Wage and salary jobs and state general fund tax revenues increased, but visitor arrivals and private building authorizations decreased in 2023 compared to 2022. In the first half of 2023, Hawaii showed signs of a post-pandemic economic recovery with generally stabilized economic indicators.

The August 2023 Maui Wildfires altered the state's trajectory when economic activity slowed significantly after the fires. Maui County experienced the immediate loss of thousands of jobs, housing, and businesses, particularly in the high-end West Maui tourist destination. Lahaina town in West Maui has a rich history, serving as the Hawaiian kingdom's capital and an active center of commerce. Property losses from the 2023 fire were estimated at $6 billion, including 834 registered businesses that were closed that had previously generated $900 million in annual sales revenue.

Tourism

After the virtual shutdown of tourism during the 2020-22 pandemic, there was an eventual robust return of domestic visitor numbers to Hawaii. In 2023, the visitor industry continued to flourish despite the impact of the Maui wildfires. International visitor arrivals continued to increase, although the lucrative Japanese visitor market remained well below pre-pandemic levels due to the weak Japanese yen. Domestic visitor arrivals slowed, reflecting a waning of post-pandemic rebound travel. In 2023, the total annual international flight arrivals increased to 643,692 visitors, 71.1% of 2022 arrivals. In 2023, visitor expenditures totaled $20,708 million, which reflected an increase of 5.4% from the previous year.[15]

In the wake of the August 2023 wildfires, Maui visitor arrivals plunged by nearly three-quarters as travelers reacted to the news of the fires. Conflicting messaging about Maui's capacity and ability to host tourists amid the tragedy

affecting their residents was evident. As a result, Maui lost more than $13 million of visitor spending each day in the weeks following the fire. The October 2023 official reopening of the unaffected West Maui resort areas renewed tourism response with a strong rebound. Other counties experienced more visitors opting for alternative vacation destinations during this post-disaster period.[16]

Unemployment

Hawaii's unemployment rate soared during the early COVID-19 pandemic shutdown, from 2.4% in March 2020, the lowest rate in the nation, to 23.8% in April 2020, the highest rate nationally. Hawaii's unemployment rate has largely stabilized since 2020 to 3.0% in 2023, compared to the U.S. average of 3.6%[17] ranking Hawaii the 17th lowest among all states.

The impacts of the Maui fires on local employment were rapid and severe, with 9,000 uninsurance claims filed in September 2023 following the fire, compared to 130 in July 2023. Across Maui, local businesses also struggled due to the lower visitor numbers, with the initial impact post-wildfires pushing the Maui jobless rate to 11% in the fourth quarter of 2023.

Job Market

Labor market conditions statewide were mixed in 2023. The civilian labor force decreased, but civilian non-agricultural wage and salary jobs increased.[18] In the fourth quarter of 2023, the civilian labor force averaged 675,000 people, a decrease of 5,200 people (0.8%) compared to the same quarter of 2022.[19] Conversely, Hawaii averaged 637,700 jobs in the fourth quarter of 2023, an increase of 5,000 jobs (0.8%) over the same quarter in 2022. The job increase in the fourth quarter of 2023 was attributed to gains in jobs in both the private and government sectors. Compared to the same quarter in 2022, the largest increases in 2023 were in:

- Health Care and Social Assistance, which reported a 1.8% increase in jobs.
- Food Services and Drinking Places, which reported a 1.7% increase in jobs.
- Private Educational Services, which reported a 6.1% increase in jobs.
- Professional and Business Services, which reported a 1.0% increase in jobs.[20]

The Government sector reported a 2.6% increase in jobs in the fourth quarter of 2023 when compared to the same quarter of 2022.

Wages

During the COVID period from 2020-22, the average annual wage for employees in Hawaii increased, largely attributed to direct federal stimulus payments, including supplemental unemployment insurance benefits. The U.S. Bureau of Labor Statistics reported that Hawaii's 2022 average annual wage was $61,483, 12.1% lower than the U.S. average.[21] It reflected a 3.1% ($1,839) increase in Hawaii's average wages, when compared to the 2021 average annual wage ($59,644). In 2022, Hawaii ranked 27th among the 50 states.

Income

Per capita, personal income for Hawaii workers also increased slightly in 2022 ($61,813) compared to 2021 ($61,481).[22] As noted, income loss during COVID was offset by government stimulus/relief supports, including rental relief, essentially preventing economic collapse for many island families.[23] In 2022, Hawaii per capita income was 5.6% lower than the national average ($65,473), and after adjusting for the high cost of living, it was 12% lower than the unadjusted level.[24] The aggregated income and wage indicators do not measure the markedly disparate effect on high- versus lower-income workers. Wage and income measures also do not accurately reflect residents' economic status since the increases are nullified by Hawaii's status as having the highest cost of living in the U.S.

Poverty

Based on 2022 ACS estimates, the poverty rate in Hawaii was 10.2% (all ages in poverty), which is 2.4% lower than the U.S. rate (12.6%). This percentage represents an estimated 142,378 individuals living in poverty in the state. Over 36,568 (12.6%) of children and adolescents under 18 years old live in households that are below the Federal Poverty Level (FPL). Poverty rates remain variable across counties: Honolulu 9.7%; Maui 8.2%; Kauai 6.6%; and Hawaii 15.1%. Poverty rates remain higher among Native Hawaiians and Other Pacific Islanders (19.1%) and Blacks/African Americans (11.6%) when compared to Whites (9.8%) or Asians (7.0%).

The official FPL obscures many families' struggles in Hawaii due to the high cost of living and the relatively low minimum wage structure, given many families' dependence on low-paying service industry jobs in tourism. The Census Supplemental Poverty Measure reports that the three-year average (2019-2021) poverty rate in Hawaii was actually 10.5% when using the supplemental poverty measure, which was 0.4% higher than the official FPL (10.1%).[25]

ALICE Report

The Hawaii United Way agency report on working residents living just above the poverty level who cannot afford basic necessities more accurately reflects Hawaii's family economic status. The ALICE survey refers to families that are Asset-Limited, Income-Constrained, Employed (ALICE).[26] The most recent Hawaii ALICE study in 2022 revealed that more Hawaii households fell below the ALICE threshold compared to 2018 prior to COVID. An estimated 44% of Hawaii ALICE households in 2022 (compared to 42% in 2018) struggled to meet basic housing, childcare, food, transportation, and healthcare expenses. These ALICE households were in addition to the 11% of households below the FPL. Additionally, the percentage of households with income below the FPL increased from 9% in 2018.[27] This suggests hardship deepened for many island residents during the pandemic. Strikingly, the majority of Native Hawaiian (60%) and Filipino (59%) residents fell below the ALICE threshold, as did all households with children (54%).

The report cites the major reasons for the high percentage of ALICE households:

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

Nearly 62% of all jobs in Hawaii pay less than $20 per hour, with more than two-thirds paying less than $15 per hour. It is difficult for ALICE households in Hawaii to find affordable housing, job opportunities, and community resources. Although public and private assistance helps, it does not provide financial stability. ALICE households are often forced to make difficult financial choices with limited resources, such as forgoing healthcare, childcare, healthy food, or car insurance.

HIGH COST OF LIVING

Regional price parities data for 2022 shows that Hawaii was the third highest in regional price parity (110.8), with California (112.5) and the District of Columbia (112.8) emerging as the highest.[28] Other sources ranked Hawaii as the most expensive state in the nation in terms of cost of living.[29]

Housing Costs

One primary driver for the high cost of living is escalating housing costs, the highest in the U.S. Housing costs in Hawaii create an inordinate burden for families, resulting in significantly less income for other essential household expenses. As a result, families are often forced to live in overcrowded, substandard housing or are forced into homelessness for lack of affordable housing options.

In April 2024, the median housing cost for a single-family dwelling on Oahu was $1,100,000, with a condominium averaging $528,000.[30] The median monthly owner mortgage cost in 2022 was $2,683, 51.2% higher than the U.S. average. Among homeowners, 33.1% spent *35% or more of their household income* on housing, higher than the U.S. average of 21.3%. Hawaii ranked the highest in the nation for this indicator. Not surprisingly, the homeownership rate in Hawaii in 2022 was ranked as among the lowest in the U.S. (45th among the 50 states) at 62.6%, which was lower than the U.S. average of 65.2%.

Rental Costs

The high rent cost is out of reach for many working families in Hawaii. In 2022, an estimated 37.4% of occupied housing units in Hawaii were renter-occupied (compared to 34.8% nationally). The median monthly gross rent for the renter-occupied units was $1,813, 39.5% higher than the U.S. average of $1,300. In 2022, Hawaii ranked 3rd highest in rent cost nationally.

Multigenerational Households

For many island families, cultural preferences and traditions have increased the number of multigenerational households, but this is a reality due to high housing costs. In 2022, the percentage of multigenerational family households among all family households in Hawaii was 7.4% (36,716 out of 494,827 households), which was double the U.S. average of 3.7% (4,858,937 out of 125,031,991 households). Hawaii has the nation's highest rate of multigenerational households and some of the largest household sizes, especially among Pacific Island families. These household factors created challenges during COVID-19 social distancing/isolation efforts, which contributed to higher disparate infection rates for some ethnic groups.

Cost of Health Insurance

Overall, the cost of private employer-based health in Hawaii steadily increased for a family plan between 2013 and 2021, from $14,382 to $18,539.[31] Hawaii health plans offered through the federal marketplace increased from $330 in 2017 for the average individual premium to $469 in 2023.[32] Hawaii is widely considered to have among the lowest healthcare insurance premium costs in the nation, but the costs continue to increase nearly every year.[33]

Health Services Infrastructure

There are about 100 healthcare facilities in Hawaii.[34] Of the state's 29 hospitals, 12 offer labor and delivery services. Three pediatric hospitals have Neonatal Intensive Care Units on Oahu, while other hospitals have fewer acute pediatric services. Hawaii has 15 federally qualified health centers, 15 rural health clinics, and seven Native Hawaiian health system sites across the state. Most healthcare services, particularly specialty care providers/facilities, are concentrated in urban Honolulu on Oahu. Neighbor island residents fly to Oahu to access medical, dental, and behavioral services. Maps of these facilities are in the Supporting Documents.

Healthcare Workforce

The state has 210 family and general practitioners, 210 obstetricians and gynecologists, and 320 pediatricians.[35] Based on the 2022 population estimate, there are 14.6 per 100,000 obstetricians and gynecologists, which is higher than the national rate (6.4 per 100,000 population), though non-significant. There are 22.2 pediatricians per 100,000 population, which is similar to the national estimate (10.0). The rate for family/general practitioners (14.6 per 100,000 population) is significantly lower than the national rate (30.3). Despite the high ratio of providers to population, many of the state's medical and specialty providers are located on Oahu, and most of the state's rural communities are designated as shortage and/or medically underserved areas.

The COVID-19 pandemic exacerbated already existing healthcare workforce shortages in Hawaii. The 2023 Physician Workforce Assessment reported that Hawaii should have 757 more doctors, with the greatest need in

primary care specialties. The greatest needs are on the neighbor islands, with Maui (43%) and Hawaii County (41%) experiencing significant physician shortages.[36]

To address the workforce shortage, $30 million was allocated in 2023 for the Hawaii Health Education Loan Repayment Program for healthcare providers who agree to at least 30% public insurance recipients for their caseload. The federally funded State Loan Repayment Program provides $800,000 loan repayment a year. The programs are anticipated to assist hundreds of medical residents in training and other healthcare workers statewide every year.

Healthcare Shortage Designations

Shortage Designations represent an area's or population's needs based on several factors, including current health workforce numbers, socioeconomic and demographic data, language barriers, health indicators, access to healthcare, and travel time to the nearest available provider. Most shortage areas are on the rural neighbor islands and rural/low-income urban areas on Oahu. The entire state of Hawaii is currently designated a mental health shortage area. Maps of shortage areas in Hawaii are included in the Supporting Documents.

HEALTH INSURANCE

Hawaii has a long history of supporting health insurance initiatives universally available to residents, and was one of 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 and mandated caps on employee contributions. The PHCA is largely credited for Hawaii's high level of insurance coverage and affordability. Hawaii is the only state with a federally enacted exemption from the federal Employee Retirement Income Security Act (ERISA), which sets the minimum standards for health plans for private industry.

In conjunction with the Affordable Care Act (ACA), Hawaii implemented further Medicaid expansion in 2017, utilizing the federally run ACA exchange. Hawaii is one of the few states where enrollment in health plans through the ACA exchange increased, from 18,938 enrollees in 2017 to 22,327 enrollees in 2022.[37]

Under Medicaid expansion, coverage was increased to 138% of FPL. Prior to the COVID public health emergency, the number of people enrolled rose significantly from 292,423 in 2013 to about 345,231 in 2019.[38] This mirrors the national average of roughly 25% Medicaid coverage of the state population. In Hawaii, Medicaid provides health coverage for more than 40% of the state’s children.

In 2018, state lawmakers integrated several components of the ACA into the PHCA to ensure that health benefits remained available under Hawaii law. This included dependent coverage for children through 26 years of age and prohibiting any preexisting condition exclusion or the use of gender to determine premiums.

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

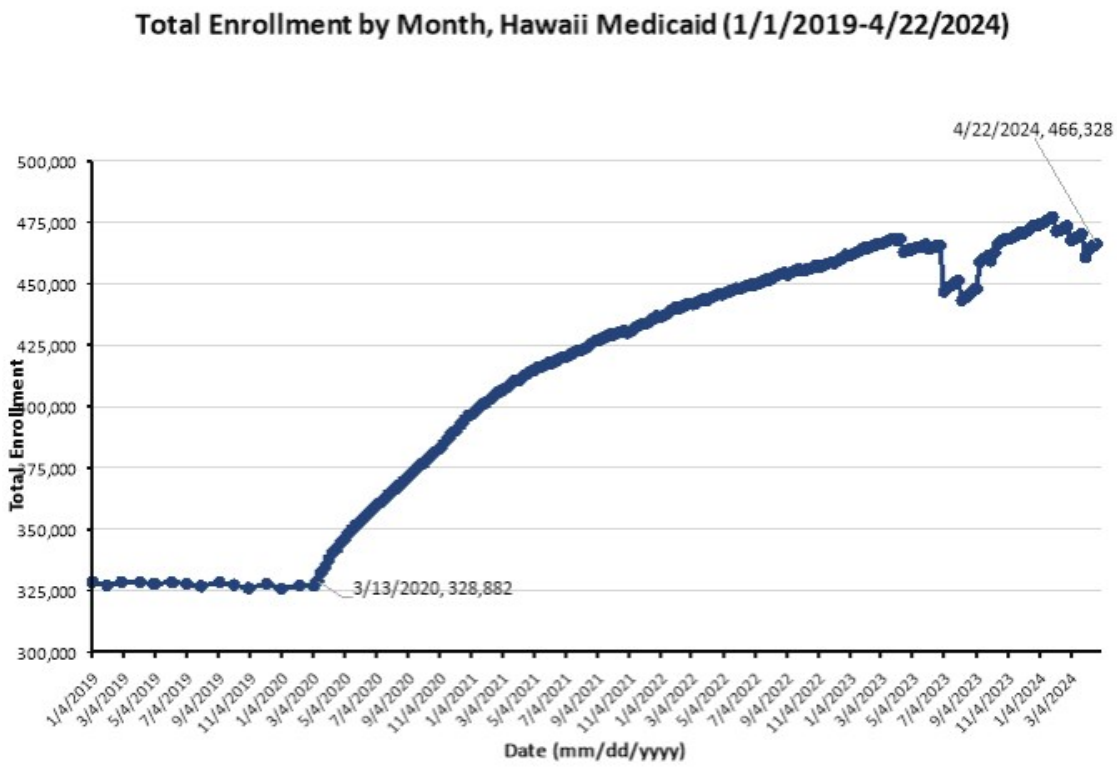
MEDICAID

The Department of Human Services (HDHS) Med-QUEST Division (MQD) administers the state Medicaid program (QUEST). QUEST stands for **Q**uality care, **U**niversal access, **E**fficient utilization, **S**tabilizing costs, and **T**ransform the way healthcare is provided to recipients. QUEST's objectives are to expand medical coverage to more residents and contain costs by shifting to a managed care delivery system, with savings realized to expand coverage. Under this federal waiver, Medicaid beneficiaries with disabilities and those over 65 receive services through fee for services.

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

- Children ages 0-18 qualify, with family income up to 308% of the FPL.
- Pregnant women qualify, with family income up to 191% of the FPL.
- Parents and other adults qualify, with family income up to 133% of the FPL.

These eligibility limits do not include a built-in 5% income disregard used for income-based (MAGI) Medicaid eligibility determinations. During the COVID public health emergency, Hawaii's Medicaid enrollments increased by 37.0%, with over 448,193 enrollees statewide. In 2022, Hawaii extended postpartum coverage for 12 months, and the state recently reinstated preventative adult dental benefits to Medicaid adults in 2023.



Of the 466,328 individuals enrolled in Medicaid, 133,996 are children.[39] The Medicaid Program also covered 2,529 pregnant women. Additionally, the program continues to support medically needy children who require nursing home care.

Federal Medicaid eligibility was restored to COFA migrants in 2020. As of February 2022, 9,257 COFA adults were enrolled with Med-QUEST.

The state's CHIP program, a Medicaid expansion, covers all Hawaii children under 19 years of age with family incomes up to 308% of the FPL. There is no waiting period for CHIP eligibility. All immigrant children who are Legal Permanent Residents or citizens of a COFA nation are eligible to be enrolled in the Medicaid program.

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

Medicaid Redeterminations. Hawaii began disenrolling ineligible Med-QUEST members in May 2023. Due to the Maui wildfires, Hawaii paused all eligibility redeterminations through the end of 2023. Redeterminations resumed for Maui residents in April 2024 and for West Maui residents in June 2024.

The Medicaid media campaign to ensure all eligible Medicaid enrollees remain covered is called *Stay Well, Stay Covered*. It includes a website with information available in 14 languages.

GOVERNMENT

The state's Executive Branch is organized into 16 cabinet-level agencies. HDOH and HDHS administer the major health programs. HDHS administers the Medicaid program, while HDOH serves as the state's public health agency. HDHS also houses the major social service/entitlement programs (Child Welfare, Temporary Assistance for needy families, Supplemental Nutrition Assistance Program, and Vocational Rehabilitation).

HDOH is the state's sole public health agency, as Hawaii has no local health departments. The state's three neighbor island counties (Hawaii, Maui, and Kauai) are represented by District Health Offices that oversee HDOH services at the county level. The central Title V programs on Oahu handle contractor services on the neighbor islands.

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

Hawaii remains a largely Democratic-leaning state, with few Republicans holding public office. Hawaii elected a new democratic Governor, Josh Green, MD. The new HDOH Director is Kenneth S. Fink, MD, MGA, MPH, with Debbie Kim Morikawa as the Deputy Director for HRA. Matthew J. Shim, PhD, MPH, remains the FHSD Chief/Title V Director.

STATUTORY AUTHORITY

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

LEGISLATURE

Over the past three years, the State Legislature utilized large budget surpluses bolstered by federal COVID relief funds to augment and support programs to alleviate financial hardships for resident families, including affordable housing development; raising the minimum wage; tax credits for low-income and working families; and major investments in public preschool classrooms, childcare supports, expansion of rural hospital facilities, and loan payment for hundreds of healthcare workers.

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

In 2024, the Legislature approved over $1 billion for Maui recovery and passed the largest tax cut in state history, expected to save Hawaii taxpayers more than $5 billion by 2030. The bill will double the standard deduction that state taxpayers can claim for the 2024 tax year and then adjust income tax brackets and standard deductions upward in a series of steps in later years as Hawaii's minimum wage gradually increases. The sweeping tax legislation has raised concerns that the bill may adversely affect state revenues, potentially resulting in substantial

downsizing of government programs and services.

COVID Update

Hawaii managed the COVID-19 pandemic challenges more effectively than other states, as reflected in the low COVID-19 case numbers, fewer hospitalizations, and fewer deaths. The state's success relied on restricting all travel early in the pandemic and closely adhering to Centers for Disease Control safety guidelines. Hawaii was the last state to end an indoor mask mandate nationally. The HDOH is one of a few states that continues to maintain and keep the public informed via a COVID dashboard, with weekly confirmed cases, hospitalizations, deaths, and vaccinations. https://health.hawaii.gov/coronavirusdisease2019/

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[1] Due to the impact of COVID-19, 2020 Census data for population estimates is unavailable. Instead of providing the standard 1-year data products, the Census Bureau released experimental estimates from the 1-year data and later released 5-year aggregated data. Therefore, a comparison with 2020 data is not available for ACS data.

[2] State Population Totals and Components of Change: 2020-2023 https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html

[3] UHERO Forecast for the State of Hawaii (p.18) https://uhero.hawaii.edu/uhero-forecast-for-the-state-of-hawai%ca%bbi-near-term-slowing-expected-as-pandemic-recovery-ends/

[4] with no single-race majority.

Diversity Index by State: 2020, Racial and Ethnic Diversity in the United States, U.S. Census Bureau, accessed at Racial and Ethnic Diversity in the U.S.: 2010 Census and 2020 Census

[5] Pew Research Center. (2016). https://www.pewresearch.org/hispanic/interactives/u-s-unauthorized-immigrants-by-state/

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

[7] State of Hawaii Department of Business, Economic Development, & Tourism Research and Economic Analysis Division 2020. https://files.hawaii.gov/dbedt/economic/reports/COFA_Migrants_in_Hawaii_Final.pdf

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

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[10] Civil Beat. The Fastest-Growing Ethnic Group In Hawaii Is Also The Most Invisible - Honolulu Civil Beat

[11] Active Duty and Reserve Personnel by Service (Table 10.04) at https://dbedt.hawaii.gov/economic/databook/2022-individual/_10/

[12] For Oahu: https://www.partnersincareoahu.org/pit;
for neighbor islands, https://www.btghawaii.org/reports/housing-inventory-counts-point-in-time/

[13] U.S. Department of Housing and Urban Development. The 2023 Annual Homelessness Assessment Report to Congress. https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf

[14] State DBEDT, Report on the economic condition of Hawaii http://dbedt.hawaii.gov/economic/qser/

[15] Visitor expenditures by air (Tourism data tables: Table D-11). http://dbedt.hawaii.gov/economic/qser/tourism/

[16] UHERO (University of Hawaii Economic Research Organization, Expansion Intact, But Counties Poised for Slower Growth, May 19, 2024 https://uhero.hawaii.edu/wp-content/uploads/2024/05/24Q2_Forecast.pdf

[17] 2023 unemployment rate is found at www.bls.gov/lau/lastrk23.htm,

[18] Note: Non-agricultural jobs do not include farm/ranch workers.

[19] State DBEDT, 2024 1st quarter report on labor force https://dbedt.hawaii.gov/economic/qser/labor-force/

[20] Labor Data Tables from 2024 1st quarter report, https://dbedt.hawaii.gov/economic/qser/labor-force/

[21] U.S. Bureau of Labor Statistics, 2022 Annual Averages. https://data.bls.gov/cew/apps/table_maker/v4/table_maker.htm#type=0&year=2022&qtr=A&own=0&ind=10&supp=0 1

[22]Personal income, population, per capita personal income table (SAINC1-51) obtained from Bureau of Economic Analysis https://apps.bea.gov/itable/?ReqID=70&step=1&_gl=1*1qzqwko*_ga*MTE2Nzk0NTM0OC4xNjY0MzIwNjg3*_ga_J4698JNNFT*MTcxNTIwNDU3Mi4xMC4xLjE3MTUyMDU

[23] University of Hawaii Economic Research Organization (UHERO), Recovery Resumes but Omicron Looms, December 17, 2021. https://uhero.hawaii.edu/focus-areas/forecast-project/

[24]UHERO, Forecast for the State of Hawaii, May 12, 2023. Hawaii's high cost of living (p.13), forecast document downloaded from https://uhero.hawaii.edu/uhero-forecast-for-the-state-of-hawai%ca%bbi-promise-and-peril-for-the-hawaii-economy/

[25] Poverty in the United States. Number and Percentage of People in Poverty by States (Table B-5) https://www.census.gov/library/publications/2022/demo/p60-277.html

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[27]2022 Alice Report: https://www.boh.com/siteassets/files/community/alice-report-2022.pdf
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[30] Honolulu Board of Realtors https://www.hicentral.com/
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[32] KFF website https://www.kff.org/ Marketplace Average Benchmark Premiums
[33] Hawaii Insurance Division, Health Care, Health Insurance, PPT. https://cca.hawaii.gov/ins/files/2023/01/Health-Insurance-2022-State-of-Reform.pdf
[34] Based on the facility address provided on https://health.hawaii.gov/shpda/agency-resources-and-publications/health-care-utilization-reports-and-survey-instructions/2022-data/
[35] Based on 2022 state data provided in Form 11.
[36] Annual Report on Findings from the Hawai'i Physician Workforce Assessment Project, December 2023 https://www.hawaii.edu/govrel/docs/reports/2023/act18-sslh2009_2023_physician-workforce_annual-report_508.pdf
[37] KKF.org Health Insurance Marketplace Enrollment.
[38] Based on the Department of Human Services, State of Hawaii, 2019 Annual Report found on http://humanservices.hawaii.gov/reports/annual-reports/
[39] Based on 2024 data provided by the State of Hawaii Department of Human Services, Med-QUEST Division

III.C. Needs Assessment
FY 2025 Application/FY 2023 Annual Report Update

C.1 Needs Assessment Update Background and Context

The Needs Assessment (NA) update

In 2023, Hawaii began work on the 5-year needs assessment. The Title V Federally Available Data (FAD)[1] continued to serve as the primary data source for both ongoing and the five-year needs assessment. The FHSD research statistician reviewed the FAD dataset and completed a summary highlighting trends, national comparisons, and disparities. The summary can be found in the Supporting Documents.

C.1.a. Ongoing Needs Assessment Activities

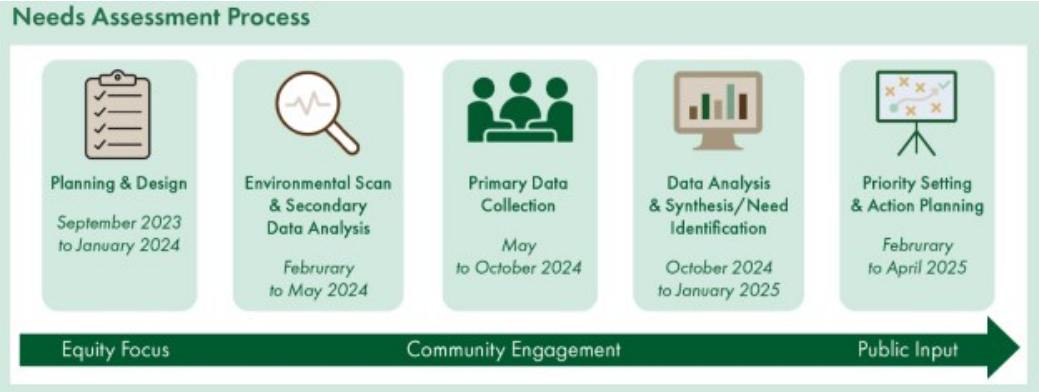
Several needs assessment activities were completed or in progress through contractual services:

Needs Assessment Contractors. Given limited epidemiology capacity, FHSD contracted with the University of Alabama Birmingham (UAB) MCH and Applied Evaluation & Assessment Collaborative for Title V data support for this annual report and five-year needs assessment.

Five-Year Needs Assessment. UAB supports the ongoing facilitation of the 2025 MCH Needs Assessment, which has included multiple internal and external advisory groups, an environmental scan of recent related needs assessment or evaluation reports, and a review and synthesis of secondary, quantitative data representing key MCH indicators by population domain. While FAD has been an important data source, additional data from the Hawai‘i Health Data Warehouse and Hawai‘i Health Matters were reviewed to allow for disaggregation by important sociodemographic factors, including relevant Hawaii race/ethnicity categories and county to better identify disparities in outcomes. During a May 2024 two-day planning meeting, internal and external stakeholders participated in quantitative data presentations and provided feedback on:

- gaps/limitations in the available data
- additional topics of interest
- missing voices of subgroups and persons with lived experiences
- highest priority indicators for the MCH population, including social determinants of health

These identified gaps and additional feedback are guiding plans for primary data collection this summer, including qualitative methods (surveys, focus groups, listening sessions, key informant interviews) to hear directly from persons with lived experiences, providers, and community partners. Meeting participants also provided input in developing guiding principles for collecting data from communities and supporting accountability back to the community. A synthesis of indicators presented in the May stakeholder meeting is presented by MCH population domain in section C.1.b.



Maui Needs Assessment. There are several studies underway to monitor the primary and secondary impacts of the wildfires on displaced families, the system of services, and socio-economic indicators for the island generally. The University of Hawaii Economic Research Organization (UHERO) is conducting an ongoing needs assessment focused on recovery efforts related to the devastating Maui wildfires. The Maui Wildfire Exposure Cohort Study (MauiWES) will follow at least 1,000 participants over at least 10 years to monitor and address impacts on acute and chronic health and social conditions. An initial report was released in February 2024, highlighting key findings, including social impacts, self-reported physical health, and both physical and mental health. Only 24% of participants remain in pre-wildfire homes and 58% have lost jobs. Almost half of participants said their health is worse and 24% do not have steady access to medical care. In addition to elevated risks to cardiovascular and respiratory health, 55% were exhibiting depressive symptoms (compared to 33% prior to the fires). Further, 35% of households were experiencing food insecurity, up from 23.7% prior to the fires. Initial recommendations include increased capacity for health, medical, and mental health services; housing stability and supports; environmental health and safety; health monitoring and registry; and community-based support and engagement.

CSHCN Assessment. The University of Hawaii (UH) Center for Disabilities Studies conducted a survey of youth with special health needs (translated into several languages) and a follow-up focus group. Data and select survey questions were used from the National Survey of Children's Health (NSCH) to develop the Hawaii survey. A final report is anticipated in July 2024.

WIC Profiles. The University of Hawaii Center on the Family is completing a series of county profiles of WIC clients, part of an ongoing analysis of Hawaii's WIC data. The factsheets are expected to be done by July 2024.

Workforce Survey. The national Public Health Workforce Interests and Needs Survey (PH WINS) epidemiologist provided analysis of the workforce data for FHSD planning. Results can be found in the Workforce Development narrative for the report. Results will be used to develop an FHSD staff survey in Fall 2024.

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

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

indicators, reflecting structural discrimination and a need for greater investment/partnership to improve health outcomes.

It is important to note that most of the data reviewed may not fully capture the impacts of the COVID-19 pandemic due to time lags or other surveillance limitations. Also, some worsening trends may reflect health and healthcare system access, as well as economic and social barriers experienced during the COVID-19 pandemic which may not represent actual performance trends over time. Bibliographic references for this section are available as the Supporting Document.

Methodology

For all NPMs and NOMs associated with each population domain, data were reviewed from the 11-27-2023 federally available data (FAD) update. Additional quantitative indicators from previous needs assessment processes and social determinants of health were also included. FAD data were supplemented with source data from the Hawai‘i Health Data Warehouse and Hawai‘i Health Matters to allow for disaggregation by important sociodemographic factors, including relevant Hawaii race/ethnicity categories and county to better identify disparities in outcomes.

Quantitative data were reviewed in a two-step process and presented in both synthesized and detailed format in working documents organized by MCH population domain.

Step 1. Trends

- Most recently available year of data presented as indicator value
- Hawaii value was compared with U.S. overall value
- Noted whether Hawaii value is higher (and better or worse), lower (and better or worse), or no difference
- State trends over time were reported when available (at least 4 data points)
- Noted whether Hawaii values are trending higher (and better or worse), trending lower (and better or worse), or no difference
- Noted whether trends are statistically significant; non-statistically significant trends are also presented as they are important to monitor related to overall progress and identification of disparities
- Both state vs. U.S. overall and state trends over time were reported as analyzed and presented on Hawai‘i Health Matters website or in FAD update
- The HHDW analysis may not reflect the FAD data analysis for certain measures, including maternal mortality

Step 2: Disparities

- NPMs and NOMs were accessed in their original data sources on the Hawai‘i Health Data Warehouse (except the National Survey of Children’s Health, which is unavailable in the Hawai‘i Health Data Warehouse) so that Hawaii race/ethnicity categories and county could be considered
- Additional indicators that were included in the review were also accessed in the Hawai‘i Health Data Warehouse
- Data were stratified (disaggregated) by sociodemographic characteristics (Hawaii race/ethnicity, Hispanic origin, poverty level, gender, and sexual orientation or gender minority) and county to examine potential disparities (when available)
- Disparities were primarily identified based on analyses presented on Hawai’i Health Matters website
- If the Hawai’i Health Matters website did not present analyses to identify disparities, confidence interval comparisons were made to examine differences between sociodemographic subgroup values

- Multiple years of data were combined when sample sizes were small or data were listed as unstable (when possible)

Limitations of the data and analyses caveats

- Data are only as good as the source
  - Values are based on national surveys and are limited by how the questions are worded, how they are asked, who responds, etc.
- Stratifiers were limited for some data and data sources
  - Hawaii race/ethnicity and county were not available for all indicators
- Small sample size for some indicators
  - Some values were suppressed if they did not meet privacy and/or reliability standards
  - Confidence intervals were often large, even when data were listed as ”stable”
- All reported data, analyses, and syntheses should be interpreted with caution
  - The limitations may mask disparities that are actually present and/or may suggest disparities exist when they actually may not
  - Numbers alone do not tell a full story – individual and group experiences should guide interpretation

Population-Specific Health Data at a Glance

A four-quadrant graphic is used to “sort” indicators to support synthesis and review. This reduces the “overwhelmingness” of the data and provides a high-level summary for planning purposes. The quadrants are oriented as follows:

- **Upper left quadrant**: Positive trends (HI vs. U.S. and/or HI over time), no disparities observable based on available data [*NOTE*: This does not necessarily mean that no disparities exist.]
- **Upper right quadrant**: Positive trends (HI vs. U.S. and/or HI over time), but disparities observable in available data
- **Lower left quadrant**: Negative trends (HI vs. U.S. and/or HI over time), no disparities observable based on available data [*NOTE*: This does not necessarily mean that no disparities exist.]
- **Lower right quadrant**: Negative trends (HI vs. U.S. and/or HI over time) and disparities observable in available data

Maternal/Women’s Health

Females represent 49.7% of Hawaii's population, while an estimated 261,931 women ages 15-44 years are women of reproductive age (WRA).[1] There were 15,570 births in 2022, the fewest births in the past 22 years.[2] The crude birth rate in Hawaii in 2022 was 10.8 births per 1,000 persons, which is lower than the nation. This value has been decreasing over time, most notably since 2008. Birth rates are significantly higher for the following racial groups: AIAN (17.1), Black/African American (16.0), Chinese (12.7), Other Asian (17.4), Native Hawaiian (14.0), and Other Pacific Islanders (25.1). Birth rates are significantly lower for the following racial groups: Japanese (5.9) and Other Races (1.7).[3] The fertility rate was consistent in 2022 at 58.9 births per 1,000 women ages 15-44 years. In 2022, Kauai County had the highest rate at 63.1 per 1,000, while Maui County had the lowest rate at 55.6 per 1,000.[4]

According to 2022 U.S. Census Bureau updates, the total population in Hawaii includes higher percentages of individuals who identify as Asian (37.1%), Native Hawaiian and Other Pacific Islander (10.3%), and Two or More Races (24.7%) compared to the nation; lower percentages identify as White (25.2%), Black/African American (2.2%), American Indian/Alaska Native (0.4%), and Hispanic/Latino (11.1%).[5] Women ages 18-44 years living in Hawaii identify as Native Hawaiian (25.5%), White (21.0%), Filipino (19.2%), Japanese (9.0%), Other Pacific Islander (8.0%), Chinese (5.8%), Other Asian (5.2%), Black (4.1%), and American Indian/Alaska Native (2.1%).[6]

The median family income for households with children in Hawaii is $103,000 – higher than the national median of $91,100.[7]. During 2018-2022 (average), 9.6% of the total population and 10.2% of women in Hawaii had incomes below the Federal Poverty Level (FPL).[8] This is lower than the national population average of 12.5%. However, these measures may not account for Hawaii's higher cost of living. Most women in Hawaii have health insurance coverage (97.5%).[9] In 2020, 78.8% of WRA were reported to have private insurance, 9.5% were reported to have Medicare, and 11.7% were reported to have Medicaid.[10]

In general, women and WRA in Hawaii fare well on most indicators compared to the nation and state trends over time. However, outcomes are not equal for all women across the 38 indicators reviewed. While 15 indicators had positive outcomes compared to the nation or in state trends over time, 12 of those had disparities observable in available data. Further, 15 indicators had worse outcomes compared to the nation or in-state trends over time, and 12 of those also had disparities observable in available data. (See graphic below.)

Positive trends (HI vs. US and/or HI over time), no disparities observable based on available data *NOTE: This does not necessarily mean that no disparities exist.*	Positive trends (HI vs. US and/or HI over time), but disparities observable in available data
Heart disease (Coronary Artery Disease) High cholesterol Breast cancer exam	Women's health status (Good or better) Overweight Low-risk cesarean delivery (first births) Preterm birth Well-woman visit* Preventive dental visit Took folic acid/vitamins prior to pregnancy* Postpartum visit Current drinker Current tobacco user* Smoking during pregnancy Drinking during pregnancy
Negative trends (HI vs. US and/or HI over time), no disparities observable based on available data *NOTE: This does not necessarily mean that no disparities exist.*	**Negative trends (HI vs. US and/or HI over time), and disparities observable in available data**
Maternal mortality* Severe maternal morbidity* Heavy or binge drinking * = trends are statistically significant	Diabetes* High blood pressure 2 or more chronic conditions Depressive disorder Mental/physical disability, at least 1* Obesity* Depression before pregnancy Postpartum depression* Early prenatal care Early and adequate prenatal care Preventive dental visit during pregnancy Current e-cigarette user*

Of the eight additional indicators, two had trends similar to the nation and/or over time, but both had disparities observable in available data. The remaining six indicators needed more data to examine outcome trends, but three had disparities observable in available data. (See graphic below.)

Similar trends (HI vs. US and/or HI over time
Cervical cancer screening # Current marijuana user # # = Disparities observable in available data
Insufficient data to examine trends (HI vs. US and HI over time)
Women's mental health status = good # Overweight or obese # At least one HPV vaccine # Early elective delivery Postpartum contraceptive use Postpartum mental health screening # = Disparities observable in available data

Disparities, when present, were most frequently worse outcomes for individuals with lower incomes, individuals who identify as a sexual orientation or gender minority, and for specific race/ethnic groups (especially Native Hawaiian, Other Pacific Islander, Black, and Hispanic).

Perinatal/Infant Health

There were 15,570 births in 2022, the fewest births in the past 22 years.[2] The crude birth rate in Hawaii in 2022 was 10.8 births per 1,000 persons, which is lower than the nation. This value has been decreasing over time, most notably since 2008. Birth rates are significantly higher for the following racial groups: AIAN (17.1), Black/African American (16.0), Chinese (12.7), Other Asian (17.4), Native Hawaiian (14.0), and Other Pacific Islanders (25.1). Birth rates are significantly lower for the following racial groups: Japanese (5.9) and Other Races (1.7).[3] The fertility rate was consistent in 2022 at 58.9 births per 1,000 women ages 15-44 years. In 2022, Kauai County had the highest rate at 63.1 per 1,000, while Maui County had the lowest rate at 55.6 per 1,000.[4]

Most young children ages 5 years and under in Hawaii have health insurance coverage (93.7%).[11] In 2021-22, 15.6% of children ages 5 years and under were living in households below FPL. While this is lower than the nation (18.9%), these measures may not account for Hawaii's higher cost of living.[12]

Hawaii's perinatal and infant population generally fare well on most indicators compared to the nation and in-state trends over time. However, outcomes are not equal for all infants across the 16 indicators reviewed. While 10 had positive outcomes compared to the nation or in-state trends over time, six of those had disparities observable in available data. Further, six indicators had worse outcomes than the nation or state trends over time, and three of those also had disparities observable in available data. (See graphic below.)

Positive trends (HI vs. US and/or HI over time), no disparities observable based on available data *NOTE: This does not necessarily mean that no disparities exist.* Infant mortality Neonatal mortality Breastfeeding initiation Breastfeeding exclusively through 6 mos	Positive trends (HI vs. US and/or HI over time), but disparities observable in available data Postneonatal mortality Preterm-related mortality Preterm birth Infants breastfeed at 8 weeks* Safe sleep – infant placed on back Safe sleep – no soft bedding
Negative trends (HI vs. US and/or HI over time), no disparities observable based on available data *NOTE: This does not necessarily mean that no disparities exist.* Perinatal mortality SUID mortality Neonatal abstinence syndrome * = trends are statistically significant	Negative trends (HI vs. US and/or HI over time), and disparities observable in available data Low birth weight Early term birth Safe sleep – separate approved sleep surface

No additional indicators had trends similar to the nation and/or over time or for which there was insufficient data to examine outcome trends.

Disparities, when present, were most frequently worse outcomes for individuals with lower incomes and specific race/ethnic groups (especially Native Hawaiian, Other Pacific Islander, and Filipino).

Child Health

In 2022, children under age 18 years were 20.6% of the Hawaii population, which is slightly lower compared with national estimates (21.7%). This percentage has been declining slightly over the past 10 years.[13] In 2018-2022, 36.1% of families had children under age 18 years.[14]

National surveys do not capture the full breadth of the racial and ethnic diversity of Hawaii, and Native Hawaiian and Other Pacific Islander races are often combined into a single category. However, significant differences are still apparent even with these category limitations. Compared to the nation, children living in Hawaii are more likely to identify as Two or More Race Groups (32% vs. 5%), Asian (22% vs. 6%), or Native Hawaiian and Other Pacific Islander (11% vs. <0.5%) and are less likely to identify as White (14% vs. 49%), Black (2% vs. 14%), American Indian/Alaska Native (<0.5% vs. 1%), or Hispanic (20% vs. 26%).[15] There are also population shifts emerging based on race identification; compared to adults in Hawaii, children are more likely to identify as Two or More Race Groups (32% vs. 17%) or Hispanic or Latino (20% vs. 9%) and less likely to identify as Asian (22% vs 40%) or White (14% vs 23%).[16]

The median family income in households with children in Hawaii is $103,000 – higher than the national median of $91,100.[17]. At the same time, 38% of children in Hawaii live in a household experiencing a high housing cost burden, compared to 30% of children in the U.S.[18] Although a lower percentage of children in Hawaii are in households below FPL compared to the nation (14.9% vs. 18.8%)[19], Hawaii's higher costs of living may not be captured in this measure and families that earn above this level may still struggle to make ends meet to afford the basic necessities and yet may not qualify for public assistance programs. Hawaii participates in the ALICE (Asset Limited, Income Constrained, Employed) movement to better understand financial hardship. In 2022, 30% of married households were below the ALICE threshold, while single family households fared worse at 79% below ALICE threshold for

females and 67% for males.[20]

Most children in Hawaii have health insurance coverage (96.9%).[21] Most children are covered by private insurance only (65.2%), followed by public only (26.5%), and both public and private (5.1%)[22]

In general, the child population in Hawaii fares well on most indicators compared to the nation and in-state trends over time. However, outcomes are not equal for all children across the 41 indicators reviewed. While 22 had positive outcomes compared to the nation or in-state trends over time, 11 of those had disparities observable in available data. Further, 14 indicators had worse outcomes than the nation or state trends over time, and 5 of those also had disparities observable in available data. (See graphic below.)

Positive trends (HI vs. US and/or HI over time), no disparities observable based on available data *NOTE: This does not necessarily mean that no disparities exist.* Non-fatal injury hospitalization Child mortality, overall, (1-4 yrs) and (5-9 yrs) Children (3-17 yrs) with mental health treatment Children (6-11 yrs) with a medical home Medical home components: care coordination, family-centered care Adequate and continuous insurance (0-5 yrs) and (6-11 yrs) Developmental screening Preventative dental visit (1-5 yrs) and (6-11 yrs) Children with annual flu vaccination (2-4 yrs) and (5-12 yrs) Someone living in household who smokes (6-11 yrs)	**Positive trends (HI vs. US and/or HI over time), but disparities observable in available data** Children (0-17 yrs) in very good or excellent health Attempted suicide resulting in injury or treatment Preventative dental visit (1-17 yrs) Adequate and continuous insurance (0-17 yrs) Child vaccination- 7-vaccine series by 24 months Someone living in household who smokes (0-17 yrs) Ever tried cigarettes* Current cigarette smoker* Current e-cigarette (vape) user Current drinker* Binge drinker
Negative trends (HI vs. US and/or HI over time), no disparities observable based on available data *NOTE: This does not necessarily mean that no disparities exist.* Children in very good or excellent health (0-5 yrs) and (6-11 yrs) Children (6-11 yrs) with mental health treatment Physical activity (everyday) Children (0-5 yrs) with a medical home Medical home components: personal doctor/nurse, referrals, usual source of care Preventive health visit (0-17 yrs), (0-5 yrs), and (6-11 yrs) Children with annual flu vaccination (6 mos-17 yrs) and (6-23 mos)	**Negative trends (HI vs. US and/or HI over time), and disparities observable in available data** Children (1-17 yrs) with decayed teeth or cavities Had depression within ever* Children (0-17 yrs) with a medical home Someone living in the household who smokes (0-17 yrs) Marijuana use * = trends are statistically significant

Of the five additional indicators, one had trends similar to the nation and/or over time but had disparities observable in available data. The remaining four indicators did not have sufficient data to examine outcome trends, but two had disparities observable in available data. (See graphic below.)

Similar trends (HI vs. US and/or HI over time Ever tried vaping # # = Disparities observable in available data
Insufficient data to examine trends (HI vs. US and HI over time) Children with decayed teeth or cavities (1-5 yrs) and (6-11) Overweight # Ever had sex# Used birth control last time had sex # = Disparities observable in available data

Disparities, when present, were most frequently worse for individuals with lower incomes, individuals who identify as a sexual orientation or gender minority, and for specific race/ethnic groups (especially Native Hawaiian, Other Pacific Islander, and Hispanic).

Adolescent Health

In 2021-2022, about one-third of Hawaii's children under 18 years were ages 12-17 years (33.1%).[23] Adolescents between 16-19 years who are not attending school and not working are known as "disconnected youth." Hawaii's rate of disconnected youth was 8.5% between 2018-2022.[24] In 2021-2022, most youth ages 14-17 years (90.0%) had at least one adult mentor in the community who provides advice or guidance.[25] Over 2018-2022, 83% of youth and young adults ages 14-24 years in Hawaii had access to a computer and high-speed internet in their home.[26] See Child Health domain above for race/ethnicity and income information on the under 18 population.

In general, the adolescent population in Hawaii fares well on most indicators compared to the nation and in-state trends over time. However, outcomes are not equal for all adolescents across the 48 indicators reviewed. While 25 had positive outcomes compared to the nation or in-state trends over time, 12 of those had disparities observable in available data. Further, 17 indicators had worse outcomes than the nation or state trends over time, and six of those also had disparities observable in available data. (See graphic below.)

Positive trends (HI vs. US and/or HI over time), no disparities observable based on available data *NOTE: This does not necessarily mean that no disparities exist.* Children (12-17 yrs) with decayed teeth or cavities Adolescent mortality (10-14 years) and (15-19 years) Adolescent motor vehicle death Non-fatal injuries hospitalizations, ages 10-14 yrs and ages 15-19 yrs Teen births (15-17 years) and (18-19 years) Bullying-perpetration Medical home components: care coordination, family-centered care Adequate and continuous insurance (12-17 yrs) Transition components – active work with child, time alone with provider HPV vaccination Current cigarette smoker*	**Positive trends (HI vs. US and/or HI over time), but disparities observable in available data** Children in very good or excellent health Adolescent mortality Non-fatal injuries hospitalizations Bullying-victimization Attempted suicide* Teen births* Adequate and continuous insurance Ever tried cigarettes* Ever tried vaping Current vape user Current drinker* Binge drinker
Negative trends (HI vs. US and/or HI over time), no disparities observable based on available data *NOTE: This does not necessarily mean that no disparities exist.* Adolescent suicide Obesity ages 10-17 Medical home components: personal doctor/nurse, referrals, usual source of care Children with a medical home (12-17 yrs) Transition to adult health care Transition component – anticipatory guidance Physical activity (everyday) T-dap vaccination Meningitis vaccination	**Negative trends (HI vs. US and/or HI over time), and disparities observable in available data** Depression within last 12 months Obesity – grades 9-12 Overweight – grades 9-12 Children with a medical home Adolescent well visit Used birth control last time had sex* * = trends are statistically significant

Of the six additional indicators, three had trends similar to the nation and/or over time and none had disparities observable in available data. The remaining three indicators did not have sufficient data to examine outcome trends, but two had disparities observable in available data. (See graphic below.)

Similar trends (HI vs. US and/or HI over time
Children in very good or excellent health (12-17) Children with decayed teeth or cavities (1-17) Children with mental health treatment (3-17) # - Disparities observable in available data
Insufficient data to examine trends (HI vs. US and HI over time)
Children with mental health treatment (12-17) (no data) Currently sexually active * Marijuana user, ever * # – Disparities observable in available data

Disparities, when present, were most frequently worse outcomes for individuals with lower incomes, males, individuals who identify as a sexual orientation or gender minority, and for specific race/ethnic groups (especially Native Hawaiian, Other Pacific Islander, and Hispanic).

CYSHCN

At 13.2%, CYSCHN in Hawaii represent a significantly lower percentage of children and youth ages 0-17 years compared to national estimates for CYSHCN (20.0%) for 2021-2022.[27] The most frequent qualification consequence for CYSHCN in Hawaii (based on CYSHCN screening tool) is use or need of prescription medication (8.3%),[28] followed by above average use or need of medical, mental health or educational services (7.4%)[29], treatment or counseling for emotional or developmental problems (7.1%),[30] use or need of specialized therapies (OT, PT, speech, etc.) (3.9%),[31] and functional limitations compared with others of same age (3.4%).[32] Most Hawaii CYSHCN qualified on one screener criterion alone (41.3%); however, 17.8% qualified on four or five criteria.[33]

The National Survey of Children's Health does not capture the full breadth of the racial and ethnic diversity of Hawaii, and sample sizes for CYSHCN are too small to disaggregate for many sociodemographic characteristics. Only the following racial/ethnic estimates are available for Hawaii CYSHCN for 2021-2022: Other (14.4%), Hispanic (16.7%), White (13.5%), and Asian (10.6%).[34]

In 2021-2022, 11.6% of Hawaii CYSHCN lived in households at <100% of FPL. Further, 15.0% lived in households between 100%-199% of FPL, 15.3% at 200%-399% of FPL, and 12.9% at ≥400% FPL.[35] It was estimated that 61.1% of Hawaii CYSHCN had private insurance only, while 30.2% had public insurance only and 5.8% had both private and public insurance.[36]

In general, children and youth with special health care needs fare well on indicators when compared to the nation. However, limited data and sample sizes preclude determination of trends over time and disparities for most indicators. Most of the 19 indicators reviewed had positive outcomes compared to the nation. However, 2 components of medical home (referrals and usual source of care) had worse compared to the nation or in state trends over time. (See graphic below.)

Positive trends (HI vs. US and/or HI over time), no disparities observable based on available data *NOTE: This does not necessarily mean that no disparities exist.* CYSHCN (0-17 yrs)* CYSHCN (0-17 yrs) in very good or excellent health CYSHCN (1-17 yrs) with decayed teeth or cavities CYSHCN Obesity, 10-17 yrs CYSHCN Bullying, perpetration CYSHCN Bullying, victimization CYSHCN (0-17 yrs) with a medical home CYSHCN medical home components: care coordination, family-centered care, personal doctor/nurse CYSHCN adequate and continuous insurance CYSHCN transition to adult health care CYSHCN transition to adult health care components: anticipatory guidance, time alone with provider CYSHCN systems of care* (overall and all components) CYSHCN preventative dental visit (1-17 yrs) CYSHCN, Someone living in the household who smokes	**Positive trends (HI vs. US and/or HI over time), but disparities observable in available data** Unable to determine based on data source limitations
Negative trends (HI vs. US and/or HI over time), no disparities observable based on available data *NOTE: This does not necessarily mean that no disparities exist.* CYSHCN Medical home components: referrals, usual source of care	**Negative trends (HI vs. US and/or HI over time), and disparities observable in available data** Unable to determine based on data source limitations

No additional indicators were reviewed at the time of submission; however, additional social determinants of health related to family hardship overall and family financial hardship. Initial analyses suggest significant disparities for CYSHCN on many of these indicators.

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

Title V programs continue to provide all levels of services statewide. A list of programs is in the Supporting Documents. Through 2023, direct service programs continued to offer clients telehealth service options. Some staff also opted to telework part-time and continued cross-agency/community partnerships remotely.

FHSD has 261.5 FTE staff, of which 23.9 FTE are Title V-funded, and 37 FTE are located on neighbor islands.

	Total FTE	Title V FTE*	Hawaii FTE	Maui FTE	Kauai FTE
FHSD	29.5	4.5	2.0	2.0	2.0
MCH Branch	30	10.3	1.0	0	0
CSHN Branch	133	9.1	3.0	3.0	1.0
WIC Branch	67	0	13.0	6.0	4.0
TOTAL	**261.5**	**23.9**	**19.0**	**11.0**	**7.0**

**Includes vacant positions.*

FHSD's staffing continued to decrease by 4 FTE, while Title V positions increased. Most positions were lost due to long-standing vacancies. Although the number fluctuates, the Division vacancies numbered roughly 78 positions.

New CSHN Branch Chief: In FY2023, FHSD welcomed a new CSHN branch chief, Dr. Ruben Frescas, M.D. Dr. Frescas is a board certified family medicine physician with a Master of Public Health who has over 15 years of experience in public and global health. He has worked academically as an Associate Faculty while at the Johns Hopkins Institute for Patient Safety and Quality and consultant for the World Health Organization working on addressing quality of care needs at national levels, particularly in primary care settings. He also has leadership experience as a project director and deputy director for two US HIV/AIDS funded projects in Mozambique and

Vietnam working with both an international and a domestic NGO, respectively. Dr Frescas has also worked clinically and supporting public health needs throughout Central and South America, Sub-Saharan Africa and South and Southeast Asia.

C.1.d. Title V Partnerships and Collaboration

The Title V program continues to work closely with a diverse set of agency and community partners across population domains. Formal and informal partnerships are in place with other programs within HDOH (e.g., Chronic Disease Branch, Child/Adolescent Mental Health); other state and county organizations (Department of Education, Department of Human Services, Medicaid, Youth Correctional Facilities, Executive Office of Early Learning); over 25 healthcare organizations (Federally Qualified Health Care Centers, Critical Access/rural hospitals); over 45 community-based organizations (Hawaii Maternal Infant Health Coalition, Coalition for a Drug-Free Hawaii, Healthy Mothers, Healthy Babies, Hawaii Youth Services Network); and national partners (Centers for Disease Control and Prevention, Department of Agriculture). A list of Title V partners can be found in the 2020 NA summary, and new partners/contractors are identified throughout this report.

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

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

5-Year Plan Changes for 2021-2025

State Priorities: Two state measures identified during COVID-19 have been inactivated:

- Child Wellness Visits/Immunizations
- Telehealth expansion to underserved communities.

Medical offices have opened after the COVID-19 shutdowns and the State Medicaid program is convening regular child health (EPSDT) meetings with health plans and service providers. This group is now tracking and working to improve access and coordination of care for children.

Hawaii has worked on telehealth as a state priority for nine years. This helped position FHSD programs to quickly transition to providing telehealth services and remote meetings during the COVID-19 pandemic. Post-COVID-19, there are now substantial federal, state, and departmental resources deployed to expand broadband services throughout the state. FHSD will continue to support the establishment of telehealth hubs in selected rural public libraries, but this project is no longer a major priority.

The other two COVID-related priorities are continuing:

- Food Insecurity through WIC services
- Pediatric Mental Health

Health Equity: Achieving health and well-being for all Hawaii residents means acknowledging and addressing health disparities. FHSD recognizes that systematic inequities based on race/ethnicity, gender, sexual orientation, disability, poverty, geography, trauma and other social and environmental factors have an interconnected impact of physical and mental well-being. Hawaii ensured health equity strategies/activities were integrated into all Title V priorities. Equity activities were selected from national guidance and in collaboration with community partners.

Other Plan Changes: Coming out of COVID-19, FHSD remains burdened by staff vacancies, and some planned FY

2023 activities were delayed or revised as a consequence. Although FHSD has acquired more epidemiology staffing, the agency continues to be hindered by limited detailed data analysis and evaluation resources. The Title V program has supported ongoing assessment through collaboration with local and national university programs.

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

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

No organizational changes were made to State or HDOH structure in FY 2024. The HDOH and Title V leadership remain the same and is reflected in the report org chart.

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

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

2024 Application/2022 Annual Report – Needs Assessment Update

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,083,027	$2,021,007	$2,319,160	$1,587,890
State Funds	$31,499,929	$26,180,239	$29,759,413	$28,217,762
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$18,439,145	$19,530,529	$18,474,919	$5,837,054
SubTotal	$52,022,101	$47,731,775	$50,553,492	$35,642,706
Other Federal Funds	$37,230,305	$37,566,837	$40,729,830	$35,299,951
Total	$89,252,406	$85,298,612	$91,283,322	$70,942,657

	2023		2024	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,138,833	$2,202,574	$2,195,700	
State Funds	$29,962,854	$28,087,784	$34,554,745	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$18,474,919	$7,106,191	$18,334,030	
SubTotal	$50,576,606	$37,396,549	$55,084,475	
Other Federal Funds	$41,413,149	$42,533,302	$40,373,086	
Total	$91,989,755	$79,929,851	$95,457,561	

	2025	
	Budgeted	Expended
Federal Allocation	$2,249,007	
State Funds	$35,134,031	
Local Funds	$0	
Other Funds	$0	
Program Funds	$18,324,188	
SubTotal	$55,707,226	
Other Federal Funds	$47,195,259	
Total	$102,902,485	

III.D.1. Expenditures

The State ensures meticulous tracking and reporting of all Block Grant funding allocations and expenditures using Datamart, the state's accounting system, which captures comprehensive details of both federal and non-federal spending for the state fiscal year (SFY).

FY 2023 Expenditures as reported on the FY 2025 Application:
The Hawaii State Department of Health (HDOH) Family Health Services Division (FHSD) is dedicated to improving the health of women, infants, and children across the state. In FY 2025, with a team of approximately 261.5 full and part-time employees, FHSD delivered vital services through its administrative and consultant staff and three dynamic branches. With around 30 programs under its umbrella, FHSD is committed to promoting and enhancing the health and well-being of Hawaii's mothers and children, including those with special health care needs (CSHCN). This grant application details how our budget and expenditures are strategically aligned to support these critical programs, focusing on Title V priorities.

Uniquely Positioned to Serve
As Hawaii's only public health agency, HDOH's FHSD must provide a comprehensive range of services statewide. This includes direct care, enabling services, population-based initiatives, and infrastructure development. FHSD's three branches—Maternal and Child Health (MCH), Children with Special Health Needs (CSHN), and Women, Infants & Children (WIC) Services—met these demands with a FY 2023 Program Income budget of $18.3M and expenditures totaling $7,106,191. This funding is carefully managed through five specialized state funds:

- **Newborn Metabolic Screening Special Fund**: Supported by reimbursements for newborn screening test kits.
- **Birth Defects Special Fund**: Funded with $10 from each marriage license fee.
- **Domestic Violence & Sexual Assault Special Fund**: Partiall funded by fees from birth, marriage and death certificates.
- **Community Health Centers Special Fund**: Sustained through a portion of cigarette taxes.
- **Early Intervention Special Fund**: Back by funds from Medicare, Tricare, and the Random Moments Survey.

Form 2 also notes that expenditures from other federal funds administered through various FHSD programs in FY 2023 amounted to $45,398,296. These other federal fund expenditures supported programs such as WIC ($33M), Home Visiting (MIECHV) ($2.7M), Early Intervention (Part C) ($2.4M), State Office of Rural Health ($221K), and over 21 other federal programs.

Clients Served
Form 5a reports on the number of clients receiving direct or enabling services with Title V and state matching funds. The total served is 34,433 broken out as follows:

Pregnant Women: 923
Infants < 1 Years of Age: 1,307
Children 1 through 21 Years of Age: 16,076
Children with Special Health Care Needs: 13,472
Others: 16,127

Form 5b estimates FHSD programs using all funding sources were able to reach: 100% of the Pregnant Women, 99.2% of all Infants < 1 year of age, 37.6% of Children 1-21 years of age, 77.1% of Children with Special Health Needs (0-21 years of age) and 98.6% of Others.

Strategic Use of Title V Funds

Title V funds in FY 2023 were pivotal in supporting essential staff positions (23.9 FTE), including epidemiologists, statisticians, program managers, nurses, nutritionists, audiologists, contract specialists, and general support staff. These roles are crucial for managing FHSD's statewide system, leveraging diverse funding, conducting surveillance, forming partnerships, and ensuring services are family-centered, culturally competent, and community-based.

Legislative Requirements Met

Hawaii meticulously maintains documentation for all MCH Block Grant funding, in line with Title V requirements. Expenses are tracked through Datamart, with fiscal and program staff closely monitoring them. FHSD also undergoes an annual audit, reinforcing our commitment to accountability.

Title V legislation mandates that at least 30% of block grant funds are allocated to preventive and primary care services for children and another 30% for CSHCN, with no more than 10% for administrative costs. In FY 2023, Hawaii exceeded these requirements: 31.5% of Title V expenditures supported preventive and primary care for children, 55.9% supported CSHCN, and 0% were allocated to administrative costs, as HDOH waives all indirect costs for the Title V grant. For other federal grants, an 18.2% indirect cost was applied in SFY24.

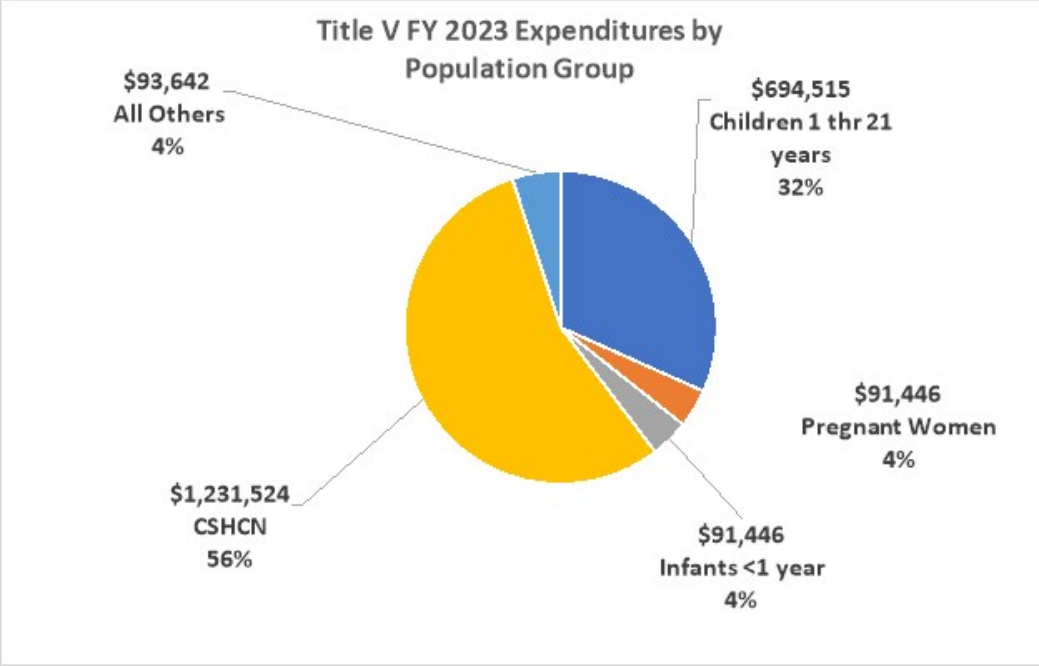
Category	FY 2025 Budgeted		FY 2023 Expended	
Preventive and Primary Care for Children	$838,726	**37.2%**	$694,515	**31.5%**
Children with Special Health Care Needs	$1,091,841	**48.5%**	$1,231,524	**55.9%**
Title V Administrative Costs	$0	**0.0%**	$0	**0%**

Maintaining Funding Levels

Section 505(a)(4) mandates that the state must maintain funding levels provided by state MCH programs at the level of fiscal year 1989 ($11,910,549). In FY 2023, the Total State Match of $35.2M significantly exceeded this requirement, reflecting FHSD's growth since 1989.

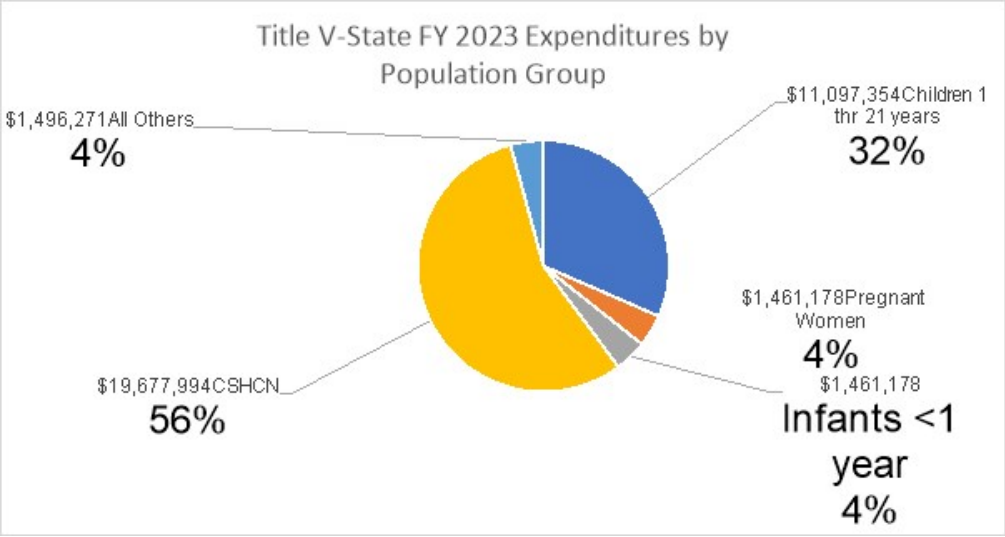
Expenditures by Population Group

The FY 2023 ($2.2M) were allocated to serve the five Title V population groups, primarily supporting personnel (23.9 FTE) across FHSD programs. Expenditures included 55.9% for CSHCN, 31.5% for Children 1-21 Years, and 4% each for Infants < 1-year, Pregnant Women, and All Others.



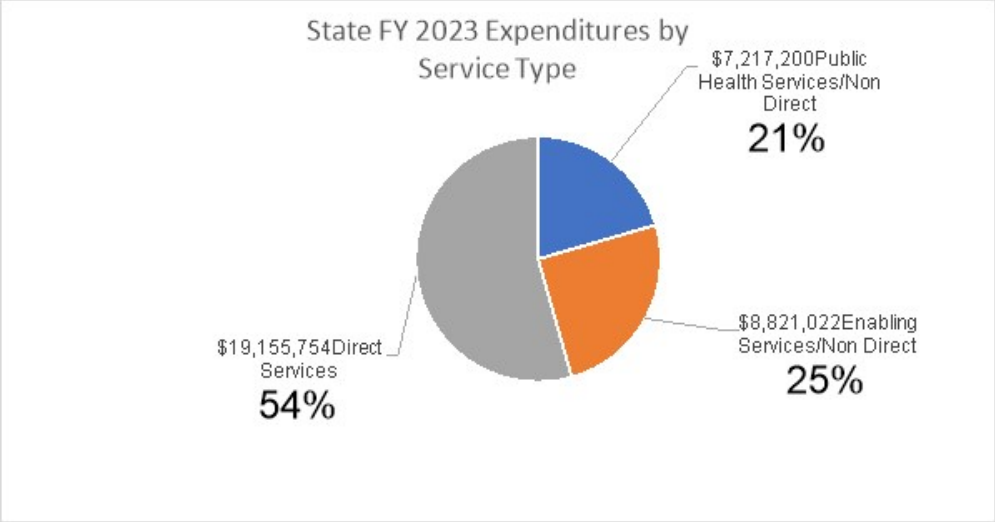
State Matching Funds Expenditures

FY 2023 state matching funds ($35.2M) were used for personnel and operating costs (including service delivery contracts) to serve the five Title V population groups. Nearly half of FHSD's state funds supported CSHCN (56%), with the remainder divided among the general adult population/families, pregnant women, infants < 1 year, and children 1-21 years.



Expenditures by Service Type

Non-Federal MCH Block Grant expenditures by service type showed that direct services for CSHCN comprised over half of all FHSD direct service expenditures. Non-federal total expenditures included 54% for direct services, 25% for enabling services, and 21% for public health services. This distribution indicates strategic leveraging of Title V funds to support MCH program infrastructure.



FHSD Programs by Service Type

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

*Programs that perform multiple types of service are listed under their primary function.

Significant Variations – Form 2 and Form 3 (Federal Fiscal Year 2023) – Expenditures
Form 2, Item 1. A. Preventative and Primary Care for Children. There were $90,007 more in expenditures than was budgeted in FY 2023. The variance is directly related to position vacancies after the budget was forecast vs. actual expenditures attributed to CSHCN.

Form 2, Item 3. State MCH Funds. Actual FY 2023 expenditures as reported in Datamart. Expenditures are usually

lower than the budgeted amount due to position vacancies and changes or reduction in contractual execution and performance. In FY 2023, expenditures were only 6.6% lower than budgeted. This variance is an improvement from years past.

Form 2, Item 6. Program Income. In FY 2023, the budgeted amount for program income was $18,474,919 but expenditures were $11,368,728 less than budgeted. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and Domestic Violence and Sexual Assault Special Fund are higher than the revenues being deposited into these accounts. The legislative authorized ceiling will continue to differ from actual expenditures moving forward. Note that this disparity proportionally affects the budgeted vs. expended reporting on Form 2, Items 7 and 8, which both incorporate Program Income into their overall calculations.

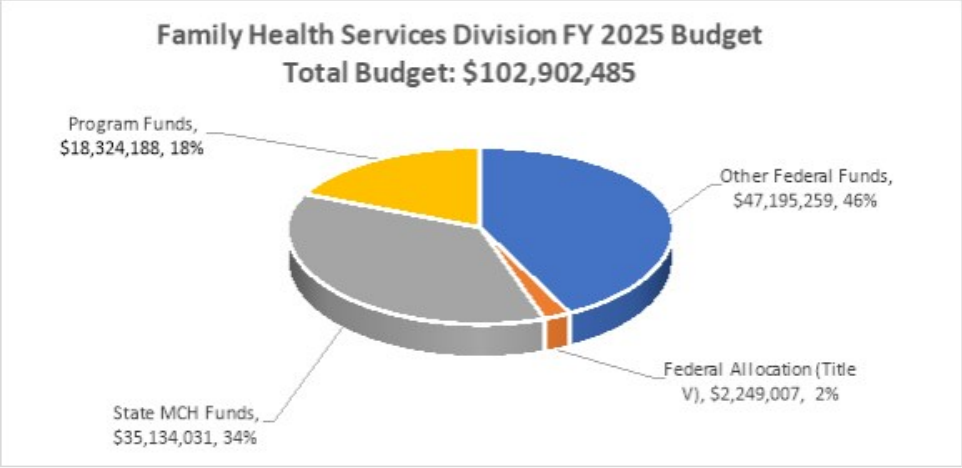
III.D.2. Budget

Budget (FY 2025 Narrative for the FY 2025 Application)

The Hawaii State Department of Health (HDOH), Family Health Services Division (FHSD) is dedicated to enhancing the health of women, children, and families across Hawaii. FHSD achieves its goals through various divisions, branches, and District Health Offices, encompassing around 30 programs and nearly 150 annual service contracts. In federal fiscal year (FY) 2025, FHSD's total state Maternal and Child Health (MCH) budget is approximately $103 million, with Title V funding 23.9 unique FHSD positions out of a total of 261.9 Full-Time Equivalents (FTEs). The FY 2025 budget plan reflects a thorough assessment of state MCH population needs and Title V program requirements, adhering to legislative financial mandates and block grant program regulations (e.g., the 30% - 30% - 10% requirements).

Budget Overview

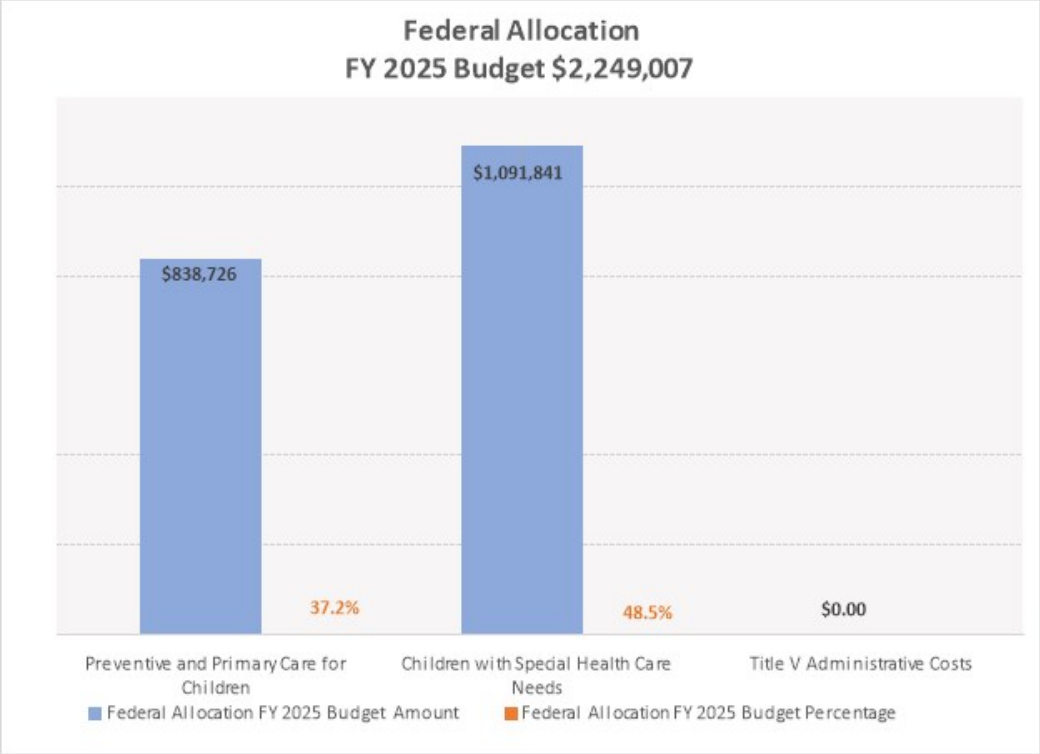
The chart below summarizes FHSD's FY 2025 budget as reported on Form 2. The $103 million budget comprises $2,249,007 from Title V, a State Match of $35.1 million (including Program Income of $18.3 million), and Other Federal Funds totaling $47.2 million.



Legislative Requirements Met

FHSD remains committed to meeting the legislative financial requirements for Title V. The State will maintain detailed expenditure and budget documentation for all MCH Block Grant funding allocations via the state accounting system, Datamart, and comply with the state annual audit. Additionally, the state will meet the required matching funds, which include a $3 match in non-federal funds for every $4 of federal MCH Block Grant funds expended [Section 503(a)] and maintain the effort from 1989 [Section 505(a)(4)].

FHSD also ensures compliance with legislative financial requirements that mandate at least 30% of Title V funds be used for preventive and primary care services for children, at least another 30% for services for children with special healthcare needs (CSHCN), and no more than 10% for administrative purposes. For FY 2025, Hawaii allocates $838,726 (37.2%) for Preventive and Primary Care for Children, $1,091,841 (48.5%) for CSHCN, and $0 (0%) for Title V Administrative Costs as reported on Form 2, Lines 1. A, B, and C.



Federal Funds

The FY 2024 Other Federal Funds budget included 25 federal grants totaling $47.2 million (excluding Title V). The Title V allocation was $2.2 million, representing roughly 4.77% of all FHSD federal fund appropriations and 2.19% of the overall FHSD total budget.

In FY 2025, FHSD anticipates a 16.9% increase in its overall federal fund budget, amounting to $6,822,172. Despite the conclusion of many COVID and ARPA grants, WIC's annual Nutrition Services and Administration (NSA) budget increased by 26.8% to address inflation. Additionally, FHSD received a $295,000 Maternal Mortality Review Grant, an increase in ARPA Pediatric Mental Health Care Access Program funding, and an $800,000 ARPA grant for WIC.

FHSD heavily relies on federal funding, comprising 46% of the current budget, primarily to fund positions managing and administering federally funded programs. Rising operating and personnel costs have posed significant challenges, with federal grants like Title V, Pregnancy Risk Assessment Monitoring System (PRAMS), and Infants and Toddlers with Disabilities IDEA Part C facing budgetary strains. Collective bargaining agreements for public employees contribute to increased salaries and fringe benefits.

The FY 2024 indirect cost rate approved in April 2024 is 18.2%, with a fringe benefit rate of 64.25%. For programs dependent on grant funding for positions, this is a substantial expense. For instance, the Hawaii WIC program's indirect costs were $843,810 in FY 2023. FHSD has occasionally requested and received departmental waivers of indirect costs to offset fixed costs, with Title V being one of the few grants allowed an annual indirect cost waiver to maximize grant dollars for personnel and operating expenses.

FHSD continues to leverage funding from other federal grants to support its programs and seeks state funds through the legislative process. Given the level funding amidst rising operating and personnel expenses due to inflation and collective bargaining, programs are considering reorganizations for efficiency and often delay filling positions vacated through retirement or attrition. Programs also redescribe and recruit for vacated positions from high-salary

medical professionals (e.g., nurses) to public health program specialists. State and federal budget cuts, along with rising operating costs, have reduced FHSD personnel from 337.5 FTEs in state fiscal year (SFY) 2018 to 261.50 budgeted positions for SFY 2024, a 22.5% decrease over six years.

Maximizing and leveraging FHSD federal and state resources will remain challenging in FY 2025. While inflation spikes in 2023-2024 are expected to decrease, Hawaii faced another economic setback when wildfires in August 2023 devastated Maui's historic Lahaina district, causing an estimated $4-6 billion in economic losses. The state legislature must allocate resources for ongoing relief efforts. Labor shortages since COVID-19 and high vacancy rates in FHSD positions and among contracted community partners persist. Although pandemic effects have subsided, the waning federal spending support for COVID-19 actions impacts the state. However, the Early Intervention Program is expected to receive a $4.9 million recurring state fund appropriation increase from SFY 2025 for purchase of services (POS) contracts.

In FY 2022, FHSD received a $7.6 million carveout for rural health initiatives through a $24.5 million CDC grant to address COVID-19 health disparities. These funds and other federal assistance received during the pandemic will continue positively impacting Hawaii's public health efforts into FY 2025, though some reside outside the FHSD budget and are not included in the Title V budget.

State Funds

The FY 2025 state funds budget totals approximately $35.1 million. Program Income generated state funds remain unchanged at $18.3 million for FY 2025, as per the SFY 2024 legislative budget worksheets. The economic effects of the pandemic are expected to linger, particularly in hiring and retaining new staff for vacated positions.

Leveraging Resources

FHSD continues to leverage resources through national, state, and community partnerships, especially with Title V funding, which supports public health infrastructure staffing for FHSD's programs. The 23.9 Title V-funded positions are crucial for securing, leveraging, and managing a variety of funding sources, addressing statewide surveillance needs, developing vital statewide partnerships, and ensuring service quality that is family-centered, culturally competent, and community-based.

Though WIC does not receive Title V or state funds, it benefits from FHSD administrative and media support, epidemiology/data assistance, and technical assistance through collaboration with other FHSD programs. As FHSD's largest direct service program, WIC serves a key MCH demographic, providing food security and access to health education and resources for low-income families. WIC's broad reach helps broker services from other Title V programs, such as Home Visiting and Early Intervention, and ensures screenings and wellness visits for new mothers and children. WIC's diverse service population plays a crucial role in addressing health equity and disparities.

By leveraging MCH Block Grant funds through Title V-funded personnel, FHSD enhances the health and well-being of Hawaii's mothers, children, and families. The Title V program efforts and outcomes detailed in the State Action Plan and other application sections are supported significantly by federal MCH Block Grant funding.

Given that HDOH is the sole public health agency in Hawaii, the absence of local health departments necessitates a disproportionate number of infrastructure personnel within FHSD to plan and administer statewide resources. The Title V MCH Block Grant is a vital funding source for FHSD infrastructure positions. For instance, in FY 2020, a Title V-funded position provided critical support to use state funding for the Child Death Review and Maternal Mortality Review and continued efforts of the Lead Poisoning Screening and Prevention program, which is applying for renewed CDC funding.

Title V funding also supports key positions within FHSD, such as the CSHN Branch Chief/CYSHCN Director, funded 100% by Title V, who supervises Hawaii's IDEA Part C Early Intervention Services program. Additionally, the Title V funded CDC Maternal Child Health Epidemiology Assignee position was filled in October 2023, with plans to use Title V funds for various epidemiological activities and public awareness media campaigns entering FY 2025.

Program and Staff Support

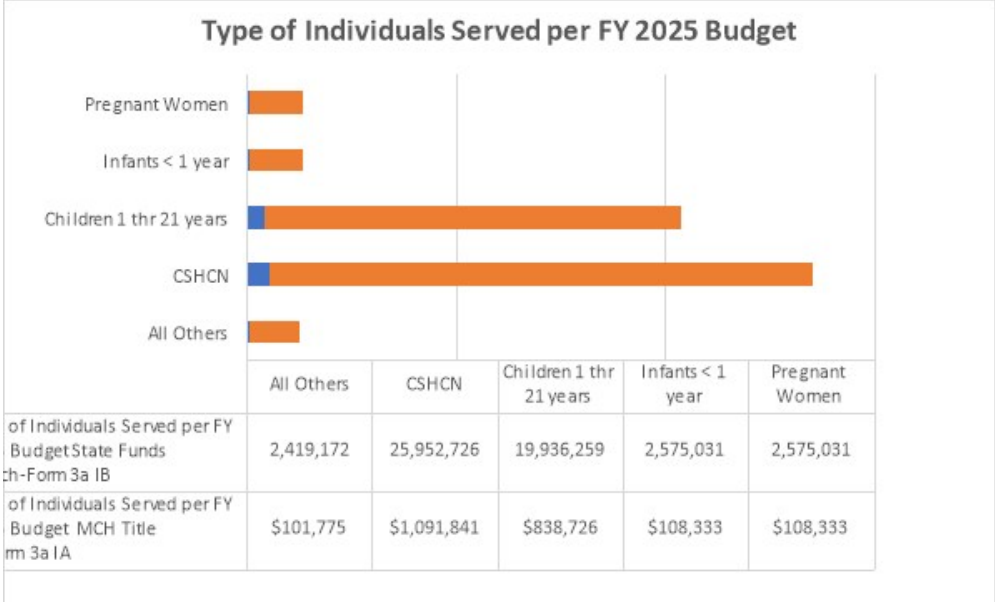
The program and staff support for Title V priorities reflect FHSD's budget diversity and the importance of leveraging funding to support these priorities. Both state and federal funding are used to address priority issues.

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

The performance measure narratives detail the program leads for each priority and their primary funding sources. Partnerships within FHSD, HDOH, and the community are essential for program progress and are described in the plan narratives.

Form 3a, Budget and Expenditure Details by Types of Individuals Served

The FY 2025 application budget demonstrates the federal and non-federal budget allocation for each of the five population health domains. The 2025 Title V Federal Allocation budget is approximately $2.2 million, with a State Match of $53.5 million, forming a Federal-State Title V Partnership budget of around $55.7 million. These combined resources support strategic collaborations with community providers and partners statewide. Annually, FHSD administers about 150 contracts with community organizations serving Hawaii's MCH population, including Federally Qualified Health Centers (FQHCs), local hospitals, and private and nonprofit providers in urban and rural communities. These funds are crucial in building statewide capacity to ensure the availability of services for all Hawaii's families.



	All Others	CSHCN	Children 1 thr 21 years	Infants < 1 year	Pregnant Women
of Individuals Served per FY Budget State Funds ch-Form 3a IB	2,419,172	25,952,726	19,936,259	2,575,031	2,575,031
of Individuals Served per FY Budget MCH Title rm 3a IA	$101,775	$1,091,841	$838,726	$108,333	$108,333

FHSD will continue efforts to ensure statewide infrastructure for needs assessment, surveillance, planning, evaluation, systems/policy development, training, and technical assistance to assure quality of care into the FY 2025 budget year.

Significant Variations – Form 2 and Form 3 (Fiscal Year 2025) – Budget

Additional comments regarding significant variations are addressed in the TVIS note section on each form's respective page due to TVIS character limits.

III.E. Five-Year State Action Plan

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

State: Hawaii

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

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

One MCH Agency. Because the Department of Health is the only public health agency in the state, FHSD is the only MCH agency and provides all levels of service delivery: direct, enabling, and infrastructure building for all counties. Most service contracts for county/community providers are executed through FHSD central program offices located on Oahu in consultation/coordination with county staff. However, during the pandemic, FHSD county nurse managers have been able to partner with local community organizations to procure services to address emerging needs using both federal and state funds. The sharing of procurement duties with county offices, albeit limited, effectively addressed critical administrative vacancies in the central office and helped to distribute the increase in COVID-related relief funding to rural communities.

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

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

Division Programs. At the division level, FHSD oversees the following programs:

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

The ***Maternal and Child Health Branch (MCHB)*** administers a statewide system of services to reduce health disparities for Hawaii's women, children, and families. MCHB programs provide core public health services that establish and maintain public and private partnerships to share information; support program planning; workforce training; and collaborate to promote policies that improve outcomes for women, children, and families. Services include reproductive health and interconception care; child and youth wellness; violence prevention programs (child abuse and neglect, sexual assault, domestic violence); home visiting services; fatality reviews; and family supports. Some programs include The Parent Line, Safe Sleep, Child Death Review, and Maternal Mortality Review. The branch has over 35 community provider contracts for women’s health, violence prevention, and family support services.

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

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

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

Blueprint for Change (BFC): BFC is a national framework for a system of services for children and youth with special health care needs, where they can enjoy a fulfilling life and thrive in the community across their lifespan. The federal MCH Bureau worked with CSHCN and their families, health care providers, and public health professionals to develop the Blueprint.

Hawaii CSHN Branch (CSHNB) staff were oriented on the BFC through three branch sections meetings (genomics, early intervention, and children and youth with special health needs). The format for the one-day meetings included a plenary with open audience participation to share ideas and experiences around each of the four domains of the BFC. This format allowed for a guided and interactive approach to relating each of the four domains with the day-to-day work of each section, helping staff to see how their programs related to each of the four BFC domains (health equity, family & child well-being/quality of life, access to services, and financing for services).

In the afternoon, small groups formed to engage all staff in discussions on how current programs align across each of the four domains. Engagement on the framework and their reflection and input on how current programs align with the four BFC domains were collected. A standard tool was used to record and analyze responses to create a 'landscape' and assess needs.

Next, external CSHN partners, including DOE, MedQuest, Health system providers, payers, community organizations, and families, will be engaged in a meeting. This input will contribute to and inform the 5-year strategic plan for the state's CSHCN programs, which will identify opportunities for systems strengthening and improvement to optimize the services available for these children and youth, as well as their families.

Five identified cross-cutting themes will be further explored and addressed: policy, finance, data systems, workforce, and engagement. This strategic plan will:

- describe and inform how current work aligns with the BFC
- identify opportunities for program strengthening and improvement to better provide necessary support and services to CYSHCN in alignment with the BFC
- provide framing for priority technical areas within each of the respective themes identified to guide resources and effort
- seek additional funding support in areas that are a need for the state population but not otherwise already being addressed

CSHNB has shared the Hawaii approach and methodology with colleagues at HRSA to help inform how the framework can be applied to support the shared vision of the framework for state Title V programs. This includes the current engagement activities, tools for recording information and analyzing input, and engaging key partners and providing them an opportunity to contribute to the design and plan. Metrics will also be defined, and the strategic report will be available in a publication for transparency and accountability to the community and our partners.

Staffing Concerns: Emerging from the pandemic and the Maui Wildfires, FHSD continues to support self-care, promote resiliency, and honor those who retire or choose to leave FHSD. Staffing vacancies and recruitment challenges exacerbated by COVID continue throughout FHSD and the state. Many staff are covering for vacant positions, which may create more work stress. Supportive work conditions, flexible work options (telework), professional development opportunities, and other employee engagement/appreciation activities are critical in maintaining current staff.

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

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

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

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

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

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

With 265 employees, the Family Health Services Division (FHSD) is the third largest division in the Hawaii State Department of Health (DOH). FHSD staff have varied professional experience and training. Few FHSD program staff have training in public health. The FHSD staff have program management experience or subject matter knowledge in their respective program areas and would benefit from more public health-specific skill building.

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

MCH LEND. The UH Medical School administers the MCH Leadership Education in Neurodevelopmental and Related Disabilities (LEND) grant, directed by pediatric faculty at the school. Several FHSD staff are LEND graduates, and FHSD continues to encourage existing program staff to enroll in LEND, particularly the Children with Special Health Needs staff. LEND annually shares its curriculum calendar and invites Title V staff to participate in specific trainings to enhance skill building. Title V and LEND maintain its partnership primarily through a parent leader, Susan Wood, who serves as LEND faculty and collaborates with the CSHN Branch.

Most workforce development opportunities for Title V staff are funded by the 20+ federal grants supporting staff participation in national conferences, access to national MCH subject matter experts, current research, technical assistance (TA), and state peer networking. State-funded staff generally need more access to these invaluable resources.

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

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

Reinitiating this MCH leadership program in Hawaii is critical in light of growing MCH/Title V vacancies, difficulties in recruitment and retention, greater emphasis on workforce diversity, and emerging healthcare challenges. FHSD is partnering with OPHS to re-establish an MCH certificate program.

Federal Workforce Support. In Spring 2023, FHSD met with the federal MCH Bureau Workforce Development Director, Lauren Ramos, to discuss ways to support re-establishing an MCH program at UH. Hawaii shared information regarding workforce challenges, including the struggle to fill vacancies (particularly epidemiologists), the difficulty recruiting out-of-state due to the high cost of living in Hawaii, and the struggle to find workable university partnerships (including those with UH and MCH Centers of Excellence (COE) in other states). Ms. Ramos suggested Hawaii could apply for a Catalyst Grant, a small grant available to accredited university public health programs to

build MCH curriculum/programs. A new grant announcement will be released in the Fall of 2024 if federal funding is available.

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

Association of Teachers of MCH (ATMCH). OPHS faculty received an ATMCH mentorship award from Drexel University to develop MCH foundational courses for graduate and undergraduate students, rebuild the MCH certificate program, and apply for an MCH Bureau Catalyst grant. Drexel is currently one of nine university programs with a Catalyst award.

MCH Workforce Development Center (WDC) Faculty Development Fellowship
Dr. Jon Huang, the new epidemiology faculty member at the UH OPHS, received an MCH WDC faculty development fellowship. FHSD informed Jon about the fellowship opportunity and was happy to support his application. Dr. Huang is using the fellowship to develop an MCH epi course he will pilot in the Fall of 2024. FHSD is in discussion to offer scholarships for the class to ensure maximum enrollment. Dr. Huang is assisting FHSD with the needs assessment planning as part of an Advisory Committee.

Public Health Workforce Interests & Needs Survey (PH WINS). PH WINS is designed to help public health agencies understand workforce strengths, gaps, and opportunities to improve skills, training, and employee engagement. The survey is usually conducted every three years, with the last conducted in Fall 2021 (after a COVID-19 delay). The 2021 survey included new modules on COVID-19, well-being, and an MCH module sponsored by the MCH Workforce Development Center (WDC). The Association of State and Territorial Health Officials (ASTHO) and the de Beaumont Foundation (dBF) conducted the survey. Working with the dBF PH WINS epidemiologist, FHSD secured specific workforce survey findings for its staff, with comparisons to the DOH and the U.S. national public health workforce. A presentation of results was shared with FHSD program managers. Key findings for FHSD follow.

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

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

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

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

The MCH survey module measured leadership development opportunities, organizational supports for leadership

development, and readiness to lead. Among FHSD staff, rates were relatively low, ranging from 26% to 40%, pointing to areas of need and opportunity for further staff training. PH WINS will field again in Fall 2024.

Plans for Employee Survey: FHSD is planning to conduct an employee survey to capture staff demographics, assess staff well-being, and suggest organizational improvement as part of the Title V needs assessment. The data will also be used to assess staffing diversity, inform succession planning, and create workforce training plans. The survey will be coordinated and complement the PH WINS survey.

Title V Public Health Capacity: FHSD uses Title V as an opportunity to build public health capacity for program staff. Since 2020, Hawaii has provided continued TA for staff to assist with evaluation and planning. Ms. Partika served as director and lead faculty for the former MCH Leadership Certificate program at OPHS from 2007-2011. Her TA supports building staff public health knowledge and skills, assists with reviewing evidence research, and assists with reviewing and updating logic models.

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

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

These TA opportunities help develop staff and community capacity and also provide an opportunity to share Hawaii's unique MCH issues nationally.

Hawaii Public Health Training Hui: Another workforce development effort supported by FSHD is the Hawaii Public Health Training Hui (HPHTH) steering committee. The HPHTH was established to provide statewide leadership and coordination to meet public health training and TA needs. FHSD's Rural Health coordinator serves on the HPHTH steering committee. Training topics are based on online surveys to public and private health professionals, with guidance from the Western Region Public Health Training Center, which funds the Hui. Training sessions are recorded and posted on the HPHTH website: https://www.hiphi.org/phth/.

Health Equity Training: In FY 2023, several trainings on health disparities, structural racism, and systemic inequities were open to FHSD staff to help integrate an equity focus for MCH programs, including:

- The Early Childhood Comprehensive Systems grant sponsored a training by the Racial Equity Institute (REI), 'Building a Practical Understanding of Structural Racism.'
- DOH Office of Health Equity invited FHSD staff to participate in ongong health equity speakers/discussions as well as an ASTHO health equity policy institute.
- In partnership with DOH, Hawaii Maternal Infant Health Collaborative received a CDC Foundation/ Association of State and Territorial Health Officials (ASTHO) sponsored Strategies to Repair Equity and Transform Community Health (STRETCH) TA award to address health inequities in maternal health. A series of health equity trainings and coaching from the Michigan Public Health Institute is currently being used to establish a state maternal health steering committee and strategic plan.

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

- Maternal Infant Early Childhood Home Visiting grant supports regular trainings for the Hawaii Home Visiting Network.

- Early Childhood Comprehensive Systems (ECCS) grant supports training for providers on developmental screening tools and protocols, as well as other infant/toddler health and safety conferences.
- Hawaii Medicare Rural Hospital Flexibility Program grant is used to conduct training on healthcare quality improvement for healthcare professionals and operational and financial performance improvement for Critical Access Hospitals.
- The State Office of Rural Health sponsors numerous training projects, including the annual Healthcare Workforce Summit and telehealth training through the Project ECHO's telehealth learning network. FHSD programs have sponsored an ECHO training series to highlight MCH programs, services, and pediatric concerns, including mental health training.
- The Office of Primary Care sponsored two 2024 trainings for state Rural Health Centers: one to build operational capacity and the other to provide an overview of Health Professional Shortage Designations.
- The Child Abuse and Neglect (CAN) Prevention program co-sponsors several virtual trainings with national speakers that focus on addressing Adverse Childhood Experiences, Trauma-Informed Care, and Protective Factors to Prevent CAN.
- The Domestic Violence (DV) and Sex Assault Prevention programs collaborate to support training and technical assistance for DV prevention for neighbor island and community coalitions, as well as violence prevention professionals statewide.
- A consortium of Title V programs supports the Parent Leadership Training Institute which is coordinated through the Hawaii Children’s Action Network (HCAN).

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

- Safe Sleep Summit
- Hawaii State Rural Health Association Annual Conference
- Hawaii Health Workforce Summit
- Early Intervention Stakeholder Conference
- Hawaii Home Visiting providers meetings
- WIC Services Branch annual staff meeting
- MCH Needs Assessment Staff Kick-Off Meeting.

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

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

Hawaii is committed to increasing engagement of families across all Title V programs. In this complex and evolving social and healthcare environment, FHSD recognizes the crucial importance of parent and family involvement and is steadily building Title V staff and program capacity in this area. This section highlights FHSD efforts to build agency capacity for family partnership/engagement.

A number of FHSD programs have an existing strong family engagement (FE) component to their work (i.e., CSHN programs), as well as grant-funded programs with a FE requirement, such as the Early Childhood Comprehensive Systems (ECCS) grant. The main goal is to build FE capacity across all FHSD Title V programs. Recent efforts to do this include:

- Convening of a FE workgroup
- Drafting compensation guidelines with the non-profit agency, Hawaii Children's Action Network (HCAN), which has assisted in providing family engagement and support to increase participation in an array of FHSD programs
- Conducting needs assessment surveys, to assess FHSD program needs to better address FE (both pre- and post-COVID)
- Contracting for an FE-specific Title V family representative
- Providing dedicated funding for programs within FHSD to conduct more family engagement activities, and
- Providing continued funding for the HCAN-led Parent Leadership Training Institute and utilize PLTI alumni in FHSD program activities.

Unfortunately, the work of the FE workgroup has been put on temporary hold, due to limited staffing capacity and shifting programmatic priorities. The remaining initiatives continue, with individual programs increasing their efforts to better engage parents, families and clients with 'lived experience' to participate in program efforts. Additionally, the 2024-25 Title V needs assessment process is currently developing a more robust qualitative data plan, in order to collect more qualitative and quantitative 'lived experience' input, from parents, families, youth, and pregnant/postpartum individuals.

Family Engagement Surveys. To help better inform and guide the FE Workgroup's activities, a series of surveys of FHSD programs were conducted from 2018 to 2022 to:

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

Since 2018, FHSD surveyed its 30 programs/organizational units to more effectively assess the current level of FE activities and knowledge across all FHSD programs. The second survey focused on specific programmatic opportunities to enhance FE, as well as how to best support expansion of FE activities. The last survey was completed in June 2022, just as COVID impacts began to wane. Surveyed programs were asked about changes and challenges with engaging families, given the COVID- environment. The most common reported method of engagement that shifted during COVID, was contacts moving from in-person to more remote outreach and more use of surveys to collect input. This approach was followed by direct outreach, advisory committee, and the use of focus groups.

Other key findings from the 2018-22 FE surveys included:

- Programs needed more incentive methods/funding sources to compensate families for their participation, more information-sharing between programs was needed, and more staff training.

- Family/youth input was often collected to develop more targeted educational materials/health messaging, followed closely by needs assessments.
- Over the years, there was an increase in the numbers of programs that regularly seek to engage families in program planning, priority, and goal setting.
- Programs expressed a greater need for more information-sharing between and among FHSD programs, especially regarding research/survey findings, as well as cross-promotion of offered family/youth research (surveys), program events, and trainings.

Based on these survey findings, the new 2024-25 Title V needs assessment working group created a new website that is specifically dedicated to sharing updates on FE-related community engagement plans, information, and findings. The new needs assessment process also includes another program survey that is designed to update all family partnership activities.

FHSD Advisory Committees. FHSD has six long-standing advisory committees/task forces that require FE participation with parent or family volunteers: the Violence Prevention programs, the Early Intervention Coordinating Council, the Hawaii Children's Trust Fund Coalition, the Newborn Hearing Program, the Early Intervention program, the Deaf and Blind Taskforce, as well as several service contracts that require community/client “lived experience” input, to ensure quality improvement.

Peer Support. The WIC Branch is the only program that employs/compensates breastfeeding-experienced mothers part-time, for its breastfeeding peer counseling program. The Hearing Screening program also utilizes volunteer peer-led family supports for its clients.

AMCHP/Title V Family Leader. In FY2024, FHSD is contracting for technical support from the Hawaii Family to Family Health Information Center director, who also served for several years as the Director of the MCH Leadership Education in Neurodevelopmental and Related Disabilities (LEND)Program, Leolinda Iokepa. She possesses “lived experience”, as the mother of a special needs adult son, and has been a long-standing partner/contractor with the Title V program, as well as other DOH and agency programs.

ECCS grant: The ECCS HIPP grant was awarded to Hawaii in 2021, and its guidance places a strong emphasis on ensuring parents serve as partners for the grant’s early childhood system-building program and key policy decisions. The Family Leadership Engagement Coordinator (FLEC), Jessica Kaneakua, who is Native Hawaiian, was hired in 2023 and is paid through a contract with the Healthy Mothers, Healthy Babies. As a family inclusion expert, Ms. Kaneakua is the mother of a 2-year-old daughter and a 6-year-old son. She has extensive community service experience serving on Hawaii island, and received her Master’s degree in Human Development, Family Studies, and Legal Studies, with an emphasis on Indigenous Peoples’ Law. She has also supported the development of a several community coalitions on Hawaii island that focus on assuring that ‘family voices’ integrated into programmatic decision-making.

Ms. Kaneakua currently leads the ECCS Infrastructure Development (ID) Work Group that created several prototypes for engaging family leaders in the grant systems building work. She ensured that family leaders are engaged in this process, through group and individual key informant assessment interviews. She and other family leaders have provided critical guidance to plan and implement an in-person two-day ECCS Summit held in 2023, which utilized family input for improving program design and deliverables. Findings from these family interviews was shared, identified preferred/recommended family leader engagement methods. Family input shared at the Summit was used to formulate a list of ‘relational agreements’, that guide how all participants should work together on a particular project (those with ‘lived experience’ as well as program professionals), in an equitable manner, and as equal

partners.

Family partnership is now supported at all levels of grant decision-making, including the FHSD grant leadership team. To further enhance and strengthen family input, a Community of Practice of Family Leaders is being established by the FLEC, which will serve to review, provide feedback on, and approve decisions by the FHSD grant leadership group. Currently, family leaders are compensated for their time, but more formal long-term guidelines for improving family supports will be developed, in order to ensure successful and sustained FE participation. The grant activities to date have indicated a dedicated commitment to support family leaders with increasing participation in programmatic activities across the system. The family partnership practices are being documented, with useful handouts to help inform and educate on other state systems-building efforts.

Funds to Support FHSD FE Activities

FHSD contracted with a community partner, the Hawaii Children's Action Network (HCAN), to help to strengthen and support program engagement activities with families for all FHSD programs. The funds are used to provide parent/family incentives so that they will more readily be able to participate in projects. This includes:

- Incentives for participation in online and surveys of parents and youth with special health care needs
- Compensation for parents/families to participate in specific focus groups, conferences, and meetings.
- Funds for the development, printing, and purchasing of materials to assist with community educational FE outreach
- Sponsorship of an array of community health/outreach events designed for parents and families.

Family/Community Compensation In response to FHSD's request for assistance, HCAN developed a draft compensation policy to address FE for families and community members with lived experience. HCAN now compensates family leaders utilizing this new policy, and is sharing it as a model policy for other organizations to consider adopting and using.

Parent Leadership Training Institute (PLTI) FHSD programs continued to provide technical assistance and financial support to PLTI Hawaii, an evidence-based parent leadership curriculum that is administered by HCAN. FHSD also serves on the PLTI advisory board. The PLTI curriculum consists of a 20-week training on leadership and civic engagement, where all parent participants are required to plan, implement, and evaluate a community project that aims to improve child and family outcomes. A graduation ceremony is held at the end of the training, where new parent leaders present on their community projects. Members from the FHSD FE committee periodically participate in PLTI sessions, including presentations on community projects and graduation ceremonies. Information about PLTI Hawaii is available on the website http://www.hawaii-can.org/plti.

Delays Due to Maui Fires: In 2023, the scheduled PLTI training was temporarily postponed, in order to give Maui parents time for recovery after the August Lahaina wildfires, which impacted all Maui residents. The January 2024 kick-off event was a hybrid session, with the in-person meetings located on Maui. There was parent participation from several islands, with travel and childcare for the first meeting covered for all participants, as needed.; There was

much larger response via virtual participation for the kick-off event.

The primary challenge with PLTI continues to be parent/family attrition, as we started with 17 parent leaders who were accepted into the program, but only 7 completed the entire 20 session program. There was substantial effort dedicated to prevent dropouts, including assignment of a mentor to each participant, as well as other supports to ongoing participation. Many parents however, found the commitment over 20 sessions to be daunting, particularly when trying to balance family/work demands, and especially for virtual participants. PLTI mentors continue to maintain active ongoing connections with parents who do not complete the full PLTI program, and they are invited to PLTI Alumni events and to participate in future cohorts.

PLTI Alumni: The more than 100 PLTI Hawaii alumni continue to remain active, serving as mentors for new cohorts, and over half of HCAN facilitation staff are currently PLTI alumni. The alumni group convenes quarterly, communicating via a quarterly newsletter as well as use of social media, via Facebook pages/groups and Twitter. In 2023-2024, PLTI alumni utilized their acquired knowledge/skills to become actively involved in the 2024 State Legislative session, providing testimony on bills that were affecting families, attending Lobby Days, and public speaking at the Keiki Strong Rally and March to the Capitol for Paid Family Leave and Childcare bills. PLTI alumni helped plan and lead Lobby Days at the State Capitol, also via activities on Maui and Hawaii island.

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

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

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

For five years, the two FHSD epidemiologist positions remained vacant. These two division-level epidemiologists provided critical guidance and support to the Title V and SSDI grants, PRAMS program, and overall technical assistance to FHSD programs with data presentations, research, and publications.

MCH Epidemiology Assignee In October 2023, NaeHyung Lee, PhD, MS, was selected by Hawaii as the new CDC MCH Epidemiology Assignee. She is an epidemiologist at the CDC National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) Division of Reproductive Health (DRH). Before joining her role, she worked as an epidemiologist for the CDC National Center for Injury Prevention and Control. She holds a PhD in Public Health from Georgia State University and an M.S. in Public Policy and Management from Carnegie Mellon University. During her doctoral and postdoctoral years, she has researched adverse and positive childhood experiences in both the U.S. and internationally. She has also engaged in adapting an evidence-based parenting program to specific immigrant populations and evaluating the effectiveness of a mental health promotion program provided to traumatized youth. Her research has been published in peer-reviewed journals, including Trauma, Violence, and Abuse, Journal of Interpersonal Violence, Public Health Reports, Journal of Child and Adolescent Trauma, and BMC Public Health.

Dr. Lee has been attending the state DOH FHSD biweekly/monthly leadership meetings, state workgroup discussions (e.g., Title V needs assessment, Pregnancy Risk Assessment Monitoring System, Enhancing Reviews and Surveillance to Eliminate Maternal Mortality ERASE MM, Hawaii data warehouse monthly webinar, and Behavioral Risk Factor Surveillance System) as well as HRSA technical assistance and SSDI webinars. She has attended national meetings and conferences, such as Title V MCH federal-state partnership meeting, Maternal Mortality Review Information App User Meeting, and AMCHP. She has networked with MCH professionals from state and federal agencies. In the remainder of 2024, Dr. Lee plans to attend MCH epidemiology training, a Hawaii site visit for block grant review, and conferences, including CityMatCH, and contribute to PRAMS data analysis and dissemination of the findings with the funding agency and other states.

Our recruitment efforts for the Epi II position are in full swing. The posting is currently listed with 12 other epidemiology/data-related positions under recruitment for Hawaii's Department of Health. We have received assistance from the federal SSDI program officer and MCH Bureau staff in circulating/posting the job announcement. The position was posted to the MCH Listserv, ASTHO Job Board, and via LinkedIn. The FHSD Division Chief is actively recruiting at national conferences. We are optimistic about finding the right candidate to fill this crucial role.

Our FHSD division and CSHN and MCH branches are fortunate to have three FTE research statistician positions. These positions play a vital role in providing data analysis support, contributing significantly to the success of our programs. We greatly appreciate their valuable contributions.

Carlotta Fok, Ph.D., has served as the Division Research Statistician since 2016. She received her Ph.D. in quantitative psychology in 2006 from McGill University, Canada, and was a postdoctoral fellow and then a research scientist at the Center for Alaska Native Health Research (CANHR). She focused her research on health disparities, cross-cultural measurement development, theory testing, and analysis of intervention effects. Her expertise is in longitudinal and functional data analysis, measurement development, small sample methodology, and developing quantitative methodology for program evaluation. Dr. Fok provides statistical assistance and data analysis for the Title V and PRAMS programs. She also works with the DOH vital statistics office to draw the PRAMS monthly sampling and annual birth files. In 2022, Dr. Fok assisted the Department's Disease Investigation Branch program with data reporting for COVID-19 case counts.

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

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

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

Access to Key Datasets: Form 12 provides information on the Hawaii Title V program's ability to access these datasets electronically, routinely, and promptly. The form also tracks linkage of the datasets with birth records, where appropriate. This narrative reflects reporting on Year 5 of a five-year project period.

Generally, Hawaii maintained consistent access to most SSDI datasets, with a few exceptions: Medicaid and hospital discharge data. Electronic datasets were available for newborn screening programs, PRAMS, and vital statistics.

Vital Statistics: In 2017, enforcement of a Hawaii Revised Statute related to data-sharing policies severely limited and terminated access to the Hawaii Vital Records office data. In 2018, FHSD successfully helped to advocate for legislation to amend the statute. In March 2019, FHSD regained access to the electronic vital statistics dataset upon approval by a newly established DOH Institutional Review Committee, which was required by the new statute.

PRAMS: Hawaii first began collecting statewide PRAMS data in 2000. While changes were made to the data sharing statute, the Hawaii PRAMS survey operations were halted for 18 months from 2017 to 2018, lacking access to birth records to draw the survey sample. Survey operations resumed in December 2018, but there is no Hawaii PRAMS data for 2017 and 2018. Additionally, issues with the 2019 sample resulted in only six months of usable data. Data for 2020 is the first full year of PRAMS data since 2016.

WIC: In 2020, WIC completed installation of its new data system. A private third-party vendor now houses, analyzes, and reports data for the WIC program. While the FHSD WIC Branch no longer has direct access to the electronic dataset, it does have regular access to standard and special data reports. WIC can also request a copy of specific elements of the program dataset for analysis. A subset of the WIC dataset relating to food insecurity is now being analyzed through a contract with the University of Hawaii Center on the Family. More information on this data can be found in the Other Data activities narrative and the SPM on food insecurity.

Medicaid Data: In 2021, FHSD executed a Memorandum of Agreement (MOA) with the state Medicaid program to comply with Title V requirements for an interagency agreement. This agreement formalizes existing agency collaborative efforts to work together to improve the health of mothers, children, and families. It includes specific provisions for FHSD to be able to request and receive selected Medicaid data. The MOA states that the Medicaid program will respond to data requests within 60 days of submission. Currently, Medicaid provides data that is needed to complete the Title V annual report, including:

- Information for Form 6 (Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX)
- SSDI Core Measures (child immunizations)
- Medicaid enrollment data (including numbers of children and pregnant women)
- Data for several federal Medicaid quality measures used for Title V performance measures on developmental screening and child wellness visits.
- Data that will enable WIC program to identify potential new Maui families affected by the August 8, 2023 Maui wildfires. Medicaid has provided enrollment numbers for children birth to 5 years for this request.

The Medicaid MOA expires in 2025 and is anticipated to be renewed next year.

Hospital data: In 2021, FHSD received access to a new hospital data portal established between DOH and the new statewide hospital data administrator, the Laulima Data Alliance. The Data Alliance is a subsidiary of the Healthcare Association of Hawaii (HAH), the nonprofit trade organization representing all Hawaii hospitals, skilled nursing facilities, assisted living facilities, home care companies, and hospices. The data portal only provides summary utilization reports. Record-level data is available for purchase for specific research and programmatic needs. FHSD utilizes SSDI funds to purchase hospital datasets as needed.

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

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

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

Epi Vacancies: SSDI data activity was limited due to the vacancies of FHSD's two epidemiology positions. In October 2023, DrNaeHyung Lee was selected by Hawaii as its CDC MCH Epidemiology assignee. She has been learning about Hawaii's programs, data sources, and needs by attending numerous meetings and trainings and assisting with Hawaii's maternal mortality review. Because she is not trained/experienced in MCH, she will participate in the HRSA, CDC, and CityMatch MCH Epidemiology training in June 2024. See more information in the Epidemiology Workforce section of this report.

Title V Data Support: Given epidemiology-related DOH staffing vacancies, University of Hawaii faculty, and resources have been utilized to help strengthen and supplement FHSD data activities. From 2018-2021, Hawaii used SSDI funds to contract with the University of Hawaii's Office of Public Health Studies (OPHS) faculty to complete the 2020 Title V needs assessment, provide technical assistance for planning and evaluation, and help with ongoing assessment.

An OPHS MPH graduate assistant helped complete the 2021 Title V grant report as a summer intern for the Title V grant coordinator. FHSD was able to sponsor her attendance at the 2021 AMCHP conference. In 2022, her poster presentation was accepted by AMCHP on the importance of disaggregated race/ethnicity data to understand infant mortality disparities in Hawaii. After graduation, the student was hired to work on the FHSD Pediatric Mental Health Access grant. This experience highlights the importance of establishing an MCH academic pathway to benefit FHSD and the larger MCH workforce in Hawaii.

Planning/Evaluation: In FY 2022-2023, SSDI funds were used to continue TA for staff by Nancy Partika. Ms. Partika served as administrator and faculty for the former MCH Certificate program at OPHS. She also has extensive public health experience working for the Department of Health and leading community nonprofits like Healthy Mothers,

Healthy Babies. Her TA supported building staff's public health knowledge and helped staff assess and respond to the challenges posed by the COVID-19 pandemic. Ms. Partika also assisted staff with reviewing updated research by the MCH Evidence Center (EC) to support strategy selection, assist with planning and evaluating strategies/activities, and update logic models.

There is no dedicated MCH faculty at UH-OPHS, and faculty have declined repeated offers to work on Title V, given academic program demands and research interests. With limited faculty prospects at OPHS, Hawaii searched out-of-state for MCH epi support to assist with the 2024 Title V report.

MCH Centers of Excellence: With assistance from the MCH Bureau staff (the Hawaii Title V Project Officer, Data Scientist, SSDI Grant Coordinator, and Workforce Development program), Hawaii contacted several MCH Centers of Excellence (COE) for potential technical assistance. While COE Directors were very supportive, finding EPI assistance was challenging due to a stated lack of qualified or available faculty or graduate assistants.

University of Alabama Birmingham In 2023, FHSD contracted the University of Alabama Birmingham (UAB) Public Health Program for data support services. UAB is one of a few public health programs nationally, with a robust MCH program and faculty. A team of several faculty and researchers from the UAB Applied Evaluation and Assessment Collaborative are providing technical assistance to review and interpret the Title V data to assist FHSD and its partners in developing and sharing a clear picture of the MCH population in Hawaii. Their ongoing work is reflected in the Needs Assessment update section of this year's Title V report.

Title V Needs Assessment Hawaii also contracted with UAB to plan/assist with implementing the Title V 5-year needs assessment. The needs assessment summary of this report updates the work to date, including a secondary data review, engaging FHSD staff and community partners in the needs assessment process, and planning for qualitative data collection, including persons with lived experience.

Child and Family Mental Health data: In May 2023, National Mental Health Month, FHSD partnered with the Hawaii Health Data Warehouse (HHDW) to launch an MCH mental health data dashboard on the HHDW website. Mental health emerged as a growing concern due to the COVID-19 pandemic. The dashboard provides a user-friendly summary of over 40 mental health measures from major public health surveillance surveys, including the (Adult) Behavioral Risk Factor Survey, the Youth Behavioral Risk Survey, PRAMS, and the National Survey on Child Health. Healthy People 2030 targets are also provided when available. Other measures include suicide fatality data and behavioral health workforce data. The advisory committee for the FHSD Pediatric Mental Health Access grant and other behavioral health partners provided significant input to the dashboard's development.

Data Products/resources:
Without epidemiology staff, FHSD data products are limited.

Publications

- Fok, C. C. T., Shim, M. J. Prevalence and Risk Factors for Adolescent Alcohol Use in Hawai'i, Youth Risk Behavior Survey 2017-2021. *In Progress.*

Factsheet

- Fok, CCT, Awakuni, J, Shim, M. Preconception Obesity Factsheet" Honolulu, HI: Hawaii State Department of Health, Family Health Services Division; September 2023.
- Fok, CCT; Awakuni, J; Shim, M. "Postpartum Depression Factsheet" Honolulu, HI: Hawaii State Department of Health, Family Health Services Division; December 2023.

Presentations

- Takahashi, K. & Matheis, M. (2024, April). Experiences of youth with special healthcare needs: Perspectives on their healthcare needs. Paper presentation at the 39th Pacific Rim International Conference on Disability and Diversity, Honolulu, HI.

Websites/Data Trackers (Dashboards)

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

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

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

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

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

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

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

CSHN Ongoing Needs Assessment**:** The CSHN Branch is collaborating with the University of Hawaii Center on Disability Studies (CDS) to conduct ongoing needs assessment of children with special healthcare needs (CSHCN) in Hawaii. This effort includes a high-level overview of the Hawaii CYSHCN population, informed by data sources such as the National Survey on Children's Health (NSCH). In February 2024, findings from the 2019-2020 NSCH dataset were presented at the Pacific Rim International Conference on Disability and Diversity. Data from 2019-2020 is being updaated.

Primary data collection was collected through a survey of youth aged 12-22 with special healthcare needs and focus groups with youth and parents. The assessment was designed to:

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

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

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

Focus groups with YSHN and/or their caregivers were initiated; however, CDS had a difficult time recruiting participants. Partnerships with youth-serving organizations are being considered to develop more effective recruitment strategies.

Results of the needs assessment will be integrated into the CDS 5-year needs assessment required for their grant funding along with other data for CSHN families.

WIC Family Research: The University Center on the Family (COF) was contracted to analyze WIC program data to better understand the WIC service population characteristics, how clients utilize benefits, and enrollment patterns. WIC has limited internal resources for data analysis. COF worked with a WIC Community Advisory Committee to help develop the analysis plan. Findings and fact sheets will be available later in 2024. See the narrative for SPM 2 (food insecurity) for preliminary data results.

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

Small Sample Sizes: While the survey provides standard state-level estimates, the state sample size is small,

requiring aggregation of data across multiple years. For measures that examine a subset of data (ages 1-3 years for developmental screening), even aggregated data does not necessarily provide stable estimates, and states are advised to use the data with caution.

Disaggregated Data: Unlike many states, the population of Hawaii is largely comprised of Asian and Native Hawaiian/Pacific Islander groups. As described in the Overview, these categories represent diverse and distinct populations with differing historical, cultural, and socioeconomic experiences. When diverse groups are aggregated into large classifications, critical differences in health status are hidden. Thus, data findings can be misleading and contribute to policies and programs that do not address fundamental community concerns or exacerbate existing inequities. Unfortunately, the NSCH data are reported using standard federal race classifications that combine all Asian groups and Native Hawaiian with all Pacific Islanders.

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

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

State Over-sampling: The MCH Bureau does allow states to fund and develop survey oversampling to generate detailed county and race/ethnicity data. Oversampling is costly and the process to develop the oversample is complex. Without an epidemiologist on staff, designing the oversample would be difficult. To reduce costs, the Bureau recommends generating aggregated datasets over multiple years which means substantial time lags before useable data is available. This approach does not allow for trend analysis since it produces only a point-in-time estimate. The cost to generate the county and race/ethnicity data for Hawaii on an annual basis – far exceeds SSDI funds. Because Hawaii uses Title V funding largely for personnel, funds are not available annually to support an oversampling.

In addition to the funding challenges, accessing data from a Census Regional Data Center (RDC) created additional challenges. Hawaii does not have an in-state RDC. The MCH Bureau recently announced that in-person access to an RDC is no longer required. Without an oversample, the NSCH data will continue to have limited value for program planning and policy development. Hawaii encourages the MCH Bureau to consider expanding the survey sample sizes for states, especially those with ethnically diverse populations.

Public Health Workforce Interests & Needs Survey (PH WINS). In 2022, FHSD began working with the de Beaumont Foundation (DBF) PH WINS epidemiologist, to analyze Hawaii's Department of Health (DOH) and Title V agency 2021 survey data. The FHSD sample size was large enough to generate usable results, including data from a new MCH module. Given FHSD's work with PH WINS, the new DOH administration appointed the Hawaii Title V director as the Department's lead for the PH WINS survey. The raw dataset was recently acquired, and an analysis plan was developed to address manager/employee questions to help with program planning and policy in the future. Findings of the survey results will be used to develop further workforce surveys for the Title V needs assessment. Highlights of the findings are reported in the Workforce Development narrative. DOH will be participating in the 2024 PH WINS scheduled to field in the Fall.

P-20 Project CSHNB programs are participating in Hawaii's P-20 Partnerships for Education project designed to analyze data across state agencies to track the progress of student cohorts to improve educational and workforce outcomes. The Statewide Longitudinal Data System (SLDS) administered by the University of Hawaii, links cross-agency information on residents of the state from infancy, early learning, K-12, postsecondary education, and the workforce. The data is used to inform strategies and drive resource allocations to strengthen student transitions and outcomes, support program evaluation, and allow partners to understand the longitudinal outcomes of their populations. CSHNB has an agreement to share data from both the early intervention and newborn hearing screening programs. With this data, P-20 can research how newborn hearing screening and early intervention services affect these children's development, education and later life outcomes.

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

Hawaii Emergency Management Structure

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

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

The last HI-EOP basic plan was completed in 2022. By statute, the HI-EOP is updated every two years.

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

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

Department of Health (DOH): Within DOH, the lead for emergency management is the Office of Public Health Preparedness (OPHP), located directly under the Director of Health. OPHP works to prevent, mitigate, plan for, respond to, and recover from natural and human-caused health emergencies and threats.

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

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

Maternal Child Health (MCH): Both the HI-EOP and HI-DOH have limited language that addresses the needs of maternal and child health. There is also minimal language for those with access and functional needs, including pregnant women and children. In the situational analysis, HI-EOP does acknowledge specific populations that are particularly vulnerable to the impacts of emergencies, including individuals with disabilities or access and functional needs and people with limited English proficiency:

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

Incident Management Structure (IMS)

HI-EMA: When an imminent or actual emergency threatens the state, HI-EMA coordinates the state's response by activating the State Emergency Operations Center (SEOC) and State Emergency Response Team. The Title V Director serves as the DOH ESF-8 (Public Health & Medical) liaison to the SEOC before and during the pandemic.

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

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

Hurricane Season Preparedness

In Hawaii, Hurricane season is from June 1 through November. The season begins with major forecasts by the national weather service and a major emergency preparation informational campaign from June through August. Although forecasters warn of below-average hurricane season for 2024, it is still important to prepare. Some of the state's worse hurricane damage occurred in year's predicted for 'low' activity.

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

Building Resilience in Children

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

Maui Wildfires

The August 8, 2023 Maui Wildfires took the County and State emergency management agencies largely by surprise. Until that time Hawaii's experience with wildifires was relatively limited, although increasingly more areas of Hawaii has been riddled my drought conditions. A passing storm with unusually high winds drove the fire through the Lahaina community

The American Red Cross, the Hawaii Emergency Management Agency, and FEMA relocated thousands of displaced families to dozens of hotels and hundreds of short-term rentals on Maui, housing more than 8,000 displaced individuals in more than 2,400 units across 40 properties in just 14 days.

Title V Response. The Hawaii State Department of Health received emergency approval to use the CDC COVID Health Disparities grant funding for the Maui natural disaster. FHSD's Rural Health Office worked with four local organizations to carry out Maui wildfire community-based recovery efforts. Branded the Maui Together activities

included:

- community health worker outreach
- community pharmacy outreach
- renovation of the Lahaina Comprehensive Health Center.
- a Kupuna outreach program
- health profession subsidies
- health equity training
- social service navigation
- social media outreach
- a post-wildfire assessment

OPHS was essential to help expedite some of the critical funding for healthcare and facilities.

Other FHSD response included:

- WIC assistance to secure infant formula for Maui Foodbank & WIC offices
- Secured WIC waivers to expand the food package and the number of Maui WIC retailers.
- Supported Healthy Mothers Healthy Mothers mobile healthcare van to provide first aid, primary and reproductive health care in burn affected areas
- Supported Maui service agencies to provide immediate hygiene, clothing, school supplies for youth
- Lahaina included as home visiting service area for pregnant and postpartum women with young children
- Newborn hearing & metabolic supplies provided
- Training for Maui childcare providers on Trauma-Informed Care
- Partnered with the DOH Safe Water Branch to ensure childcare providers in the affected areas were in safe water zones & assisted families to access immunization records to enroll in childcare.
- Outreach to families with 'resiliency/self care kits' and child activities at community events.

Red Hill Water Crisis

Approximately 10,000 households on Oahu were impacted by the contamination of drinking water from the Navy's underground storage tanks located at Red Hill, which was identified in November 2021. The Red Hill Fuel Storage Facility supports military operations in the Pacific and can store up to 250 million gallons of fuel.

The DOH's public FAQ document included a response for pregnant women exposed to contaminated drinking water based on what was known then. The WIC program supported its affected clients by changing from powered or concentrated formulas to ready-to-drink formula, as well as providing advice on how to increase milk supply for lactating mothers.

Currently, the Navy has expedited drainage of all remaining fuel in the Red Hill tanks and is now in the process of cleaning the tanks before they are decommissioned; however families on the Navy water system continue to report complaints of tainted water and medical issues.

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

OPHS/Title V collaboration

The Hawaii Title V program has a history of collaboration with OPHS. OPHS provides updates for this Title V narrative every year. In 2019, Hawaii participated in an AMCHP Emergency Preparedness and Response Learning Collaborative (ALC) opportunity to address the maternal and infant health population. The Hawaii team included

representatives from the Title V CSHN Branch, OPHP, DOH Planning Office, and Hawaii State Medicaid agency. Relationships from the ALC help support ongoing information sharing and project collaboration when opportunities arise. In 2023, this collaboration proved vital to help expedite FHSD's procurement efforts to assist with Maui Wildfire recovery.

PRAMS Emergency Preparedness Data

In 2016, Hawaii was one of the first states to include an eight-part, pre-tested, standardized disaster preparedness question that measured family preparedness behaviors on the PRAMS questionnaire. The eight preparedness behaviors can be generalized into three categories: having plans, having copies of important documents, and having emergency supplies. The questions from the 2019-2022 survey found Hawaii mothers were relatively well aware and prepared for emergencies, with 97.5% reporting at least one preparedness behavior. The high rate may be attributed to the state's experience enduring severe and active hurricane seasons and the annual state hurricane season educational campaigns.

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

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

The Hawaii Title V program and staff use a collaborative approach to leverage federal and state resources to ensure quality healthcare services delivery capacity. Hawaii partners with many public and private entities to promote optimal health, which contributes to the steady improvement of the local healthcare system. FHSD works at all levels of services (direct, enabling, and infrastructure building) to assure healthcare service delivery statewide.

FHSD also strives to ensure a statewide system and network of care exists by providing safety-net and gap-filling community-based services via targeted purchase of service contracts and/or subsidies.

Reproductive Health Care & Support Services provides services and resources for all women and men of reproductive age who are either uninsured or underinsured. The program provides services for eligible youth and adults to plan for the number and spacing of births to improve positive pregnancy and birth outcomes. Services include reproductive health education, health screening, wellness checks, birth control options, and pregnancy and perinatal support services.

In 2023, the Title V MCHB began fund the Healthy Mothers Healthy Babies mobile van servicesreach women and families in rural areas of Oahu, Hawaii island, and Maui, which has been experiencing a shortage of OB-GYN providers. The mobile van was also instrumental in addressing first aid needs after the Lahaina wildfires. In 2024, mental health services were also included as part of prenatal and postpartum care.

Early Intervention Services (EI). FHSD is responsible for the statewide early intervention services to assist families with young children (ages birth to age 3) with screening, diagnosis, and services to help address a range of developmental delays. An array of coordinated EI services are offered to those meeting eligibility in all five counties via contracted providers and state office programs.

Hospital Subsidies are supported by state general funds and administered by FHSD to the following entities.

- Hana Urgent Care - In partnership with American Medical Response and Maui Memorial Medical Center, Hana Health provides urgent medical care around the clock. As the only medical provider in this remote area, Hāna Health physicians are on-call 24 hours a day, 365 days a year.
- Waianae Coast Emergency Services - The Health Center's Emergency Services have operated at its main site in Waianae since 1975, and since 1986, the health center has provided 24-hour emergency department services. Recognized as a Trauma Support Facility by the state, it serves as a critical safety net for the residents of Oahu's Leeward Coast.
- Molokai General Hospital, a member of The Queen's Health Systems family of companies, is the only hospital on the island of Molokai. It provides 24/7 care for the island's 7,500 residents and visitors. Services include a blood banking laboratory, digital CT, digital X-ray, mammography, outpatient chemotherapy, acute care, skilled nursing physical therapy, and a full-service midwifery program.

Community Health Centers - Funded by the Community Health Center Special Fund for contractual services to improve access to healthcare for medically underserved populations through Federally Qualified Health Centers (FQHC). The services offered by the 14 FQHCs statewide include primary care, mental health care, dental health care, and pharmacy. They are mandated to provide comprehensive primary care services and supportive services such as translation and transportation services that promote access to health care. The core mission of FQHCs is to provide access to primary care services for the most vulnerable populations, regardless of the patient's ability to pay. These services are provided to uninsured and underinsured individuals who are at or below 250% of the federal poverty level.

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

- State Primary Care Office (PCO): Funded by the federal Bureau of Health Workforce to designate statewide health professional shortage areas that increase eligibility of skilled healthcare professionals for federal and state scholarships and loan repayments in exchange for a commitment to work in needy communities. This makes it possible for healthcare providers to recruit and retain health professionals, thereby improving the health of underserved populations.
- State Office of Rural Health (SORH): Funded by the federal Office of Rural Health Policy to create a focal point for rural health issues for the state, linking communities with state, federal, and nonprofit resources and helping to find long-term solutions. Program goals include educating providers about healthcare initiatives, collecting and disseminating data, and supporting workforce recruitment and retention.
- Medicare Rural Hospital Flexibility Program (FLEX): Funded by the Federal Office of Rural Health Policy, this program focuses on strategic planning activities emphasizing quality assurance and financial and operational improvements for Hawaii's nine Critical Access Hospitals (CAH). This program assists small rural hospitals to improve access to health services in rural communities via data tracking, analysis, and benchmarking toward quality improvement. Rural hospitals' provide essential access to inpatient, outpatient, and emergency medical services in rural communities.

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

- The Early Learning Board (ELB), established in 2017, is tasked with formulating statewide policy relating to early learning and guiding the Executive Office on Early Learning (EOEL) on how best to meet the developmental and educational needs of young children ages 0-5. FHSD Chief Matthew Shim serves as an ex officio member, representing the Director of Health.
- The Hawaii Early Intervention Coordinating Council advises the Early Intervention Section and was established in 1989 by state law and Part C of the Individuals with Disabilities Education Act. This council is responsible for helping to develop the programs, services, and system for Hawaii's children with special needs in partnership with families. The Hawaii Title V CYSHN Director serves as the DOH ex-officio member.
- The Hawaii Maternal Infant Health Collaborative is a public-private partnership whose goal is to improve birth outcomes and reduce infant mortality in Hawaii. Currently, FHSD's MCHB staff sit on the Steering Committee and workgroups.
- The Hawaii State Commission on Fatherhood is a state-mandated commission established in 2003. Its mission is to promote healthy family relationships by supporting and highlighting the critical role that fathers play in their children's lives. The Commission serves in an advisory capacity to state agencies and makes recommendations on relevant programs, services, and policies relating to children and families. FHSD Chief Matthew Shim serves as an ex officio member representing the Director of Health.

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

- Hawaii's Home Visiting Program promotes evidence-based home visiting programs through the Maternal Infant Early Childhood Home Visiting (MIECHV) model, manages contracts, and ensures contractors maintain fidelity to its model and meets program benchmarks. Currently, six contractors provide services statewide. These services are selected based on a state needs assessment.

  MIECHV also maintains the Hawaii Home Visiting Network. This network is a public-private partnership with home visiting programs that strengthen families and promote positive parent-child relationships. The network

consists of evidence-based home visiting programs and includes several service delivery models.

- Early Intervention Section provides services required by Individuals with Disabilities Education Act Part C through a mix of EIS programs and contracted providers and ensures services are family-centered and community-based, which are tenets of IDEA. Currently, there are four state-run programs and 15 contracted agencies.

Ensuring development/dissemination of public health messaging.

- The Hawaii Childhood Lead Poisoning Prevention Program has developed an array of educational and informational resource materials for parents, providers, and community members. Many of these materials are in 12 different languages most commonly found in Hawaii.
- The Hawaii Adolescent Wellness Program works with TeenLink Hawaii youth groups to develop an youth-driven website resource with social media platforms covering a wide range of health topics to support teens, families, and providers.

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

In 2021, FHSD executed a new Memorandum of Agreement (MOU) with the state Medicaid program to comply with Title V requirements for an interagency agreement. The agreement formalizes existing agency collaborative efforts to improve the health of mothers, children, and families and is an attachment to this report.

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

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

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

Given Medicaid and DOH share values and vision toward the health and well-being of Hawaii's children and families, collaboration between MQD and FHSD is common. For instance, the MQD Quality Improvement/Community Relations Nurse and Medical Director participate regularly in DOH Advisory Councils and workgroups such as the Early Intervention Coordinating Council, the ECCS HIPP Strategic Implementation Team, the Pediatric Mental Health Care Access Advisory, MIECHV Home Visiting Advisory, Project LAUNCH Young Child Wellness Council, and several other workgroups. FHSD has helped support Med-QUEST with the Public Health Emergency Unwinding and with the rollout of the new Child Wellness Incentive Program (C WIP) to provide incentives for parents on Med-QUEST to take their children for their well-child visits.

Other examples of Title V partnership activities include:

Agreements

- CSHNB/Early Intervention Services (EIS) worked with MQD to update the MQD-DOH MOA related to Medicaid payment for early intervention (EI) services. The MOA includes appropriate coding and rates and adds the collaboration that will occur between the EIS Care Coordinator and MQD Health Plan Service Coordinator to ensure a smooth transition of clients from EIS to the next setting. The MOA covers the period from January 1, 2021, through December 31, 2026.
- CSHNB/EIS collaborated with MQD on guidelines and role delineation for collaboration between EIS and QUEST Integration (QI) health plans. A March 2017 MQD memo specifies a simple workflow outlining how and when information will be exchanged and a detailed side-by-side role delineation of the EIS Care Coordinator and QI Health Plan Service Coordinator.
- MQD clarified in its May 2017 memo that EIS may provide Intensive Behavioral Therapy (IBT) services to EI Medicaid children and will transition them to QI health plans to cover Applied Behavior Analysis (ABA) services for Autism Spectrum Disorder (ASD). The memo also details that an EI Care Coordinator and QI Health Plan Service Coordinator will collaborate on the transition.

Enrollment & Service Utilization

- Title V programs continue supporting Medicaid eligibility redetermination efforts by updating addresses for Medicaid enrollees in Title V direct service programs. Med-QUEST continues to provide updates on the Public Health Unwinding, and presentations include training on Medicaid eligibility, the enrollment process (both online and in-person resources), a review of benefits, and the Medicaid process for transitioning youth to adult health care plans. Ongoing communications and updates continue.
- Most Title V health service programs and contracts promote enrollment in Medicaid.
- During the aftermath of the Lahaina Wildfires, Medicaid halted the Public Health Unwinding for families on Maui and continues to provide outreach to families impacted by the fires.

Title V Priorities

- MQD also provides data for the Title V annual report for Form 6 and updates on Medicaid enrollment numbers. They will make monthly enrollment data available through the redetermination period.
- The Medicaid Quality/Member Relations RN serves on the Early Childhood Comprehensive Systems (ECCS) Advisory Board to help improve the system of maternal/infant care.
- Medicaid supports the HRSA Pediatric Mental Health Access grant and is exploring possible funding for the mental health consultation warmline since the estimated costs for the service exceed the grant award. The Medical Director participates in the PMHCA planning. He is regularly updated on the progress, especially as it relates to pediatric providers on Maui, where a pilot warmline is being developed because of the impact of the wildfires.
- In January 2023, the state Medicaid program convened regular bi-monthly meetings with Medicaid health insurance plan EPSDT coordinators and community partners. Several CSHNB staff attend these meetings, and FHSD staff are regularly asked to present updates on behavioral health and developmental screening programs and services.

Other Activities

- 2023 Legislation Act 127 SB2857 created the Hawaii Child Wellness Incentive Program (HCWIP), overseen by the Med-QUEST Division's Policy and Program Development Office. This law was created to incentivize well-care examinations for Hawaii's keiki whose parents are active Medicaid/QUEST recipients. In March 2024, DHS presented program information to DOH staff serving Medicaid parents and children, such as Home Visiting, Early Intervention Section, WIC, and CYSHN. As part of this program, Medicaid parents may receive a $50 gift card, one per child in a 12-month period when their child completes a well-child examination. The card can be used to buy items such as healthy food and other household necessities. Eligibility is limited to a parent who is actively receiving Medicaid/QUEST with an unmarried child(ren), including adopted and stepchildren, below 18 years of age. The child does not have to be receiving Medicaid.
- FHSD continues to partner with DHS to support infant and early childhood mental health. The MQD Quality/Member Relations RN participates in the Hawaii ZERO TO THREE® Technical Assistance (TA) project on Infant and Early Childhood Mental Health Financing and policy to help advance policies that contribute to the healthy development of young children. Both the Med-QUEST Director and Medical Director were able to attend the national meeting, where Hawaii's efforts on financing were featured.
- During the legislative session, FHSD and MQD routinely coordinate to develop policy briefs and testimony.

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

State Action Plan Introduction

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

With the new Title V grant guidance, NPM numbers were replaced with abbreviations. SPM continue to be numbered.

Three Universal Measures were added to this year's report:

- Postpartum care
- Medical Home for children
- Medical Home for CSHN

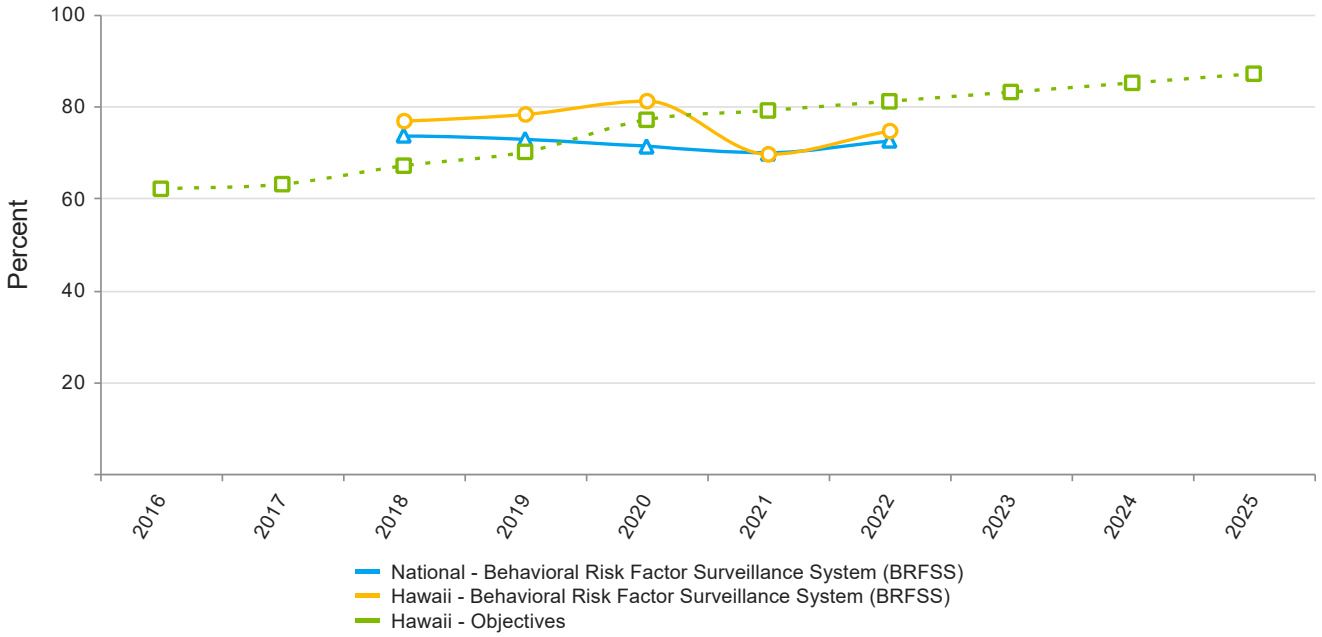
As directed by the MCH Bureau only plans are required for the new Universal measures.

Domain	PM Label	Subject
Women's/Maternal Health	NPM WWV	Women's Wellness Visits
	NPM PPV	Postpartum Care
Perinatal/Infant Health	SPM 2	Food Security
	NPM SS	Safe Sleep
Child Health	NPM DS	Developmental Screening
	NPM MH	Medical Home
	SPM 1	Child Abuse & Neglect Prevention
Adolescent Health	NPM AWV	Adolescent Wellness Visits
Children with Special Health Care Needs	NPM TR	Transition to Adult Health Care
	NPM MH	Medical Home
Cross Cutting	SPM 3	Child Mental Health Services

Women/Maternal Health

National Performance Measures

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		77	79	81	83
Annual Indicator	76.6	78.1	81.1	69.5	74.6
Numerator	184,106	185,323	191,337	167,306	179,419
Denominator	240,287	237,398	235,933	240,808	240,472
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	85.0	87.0

Evidence-Based or –Informed Strategy Measures

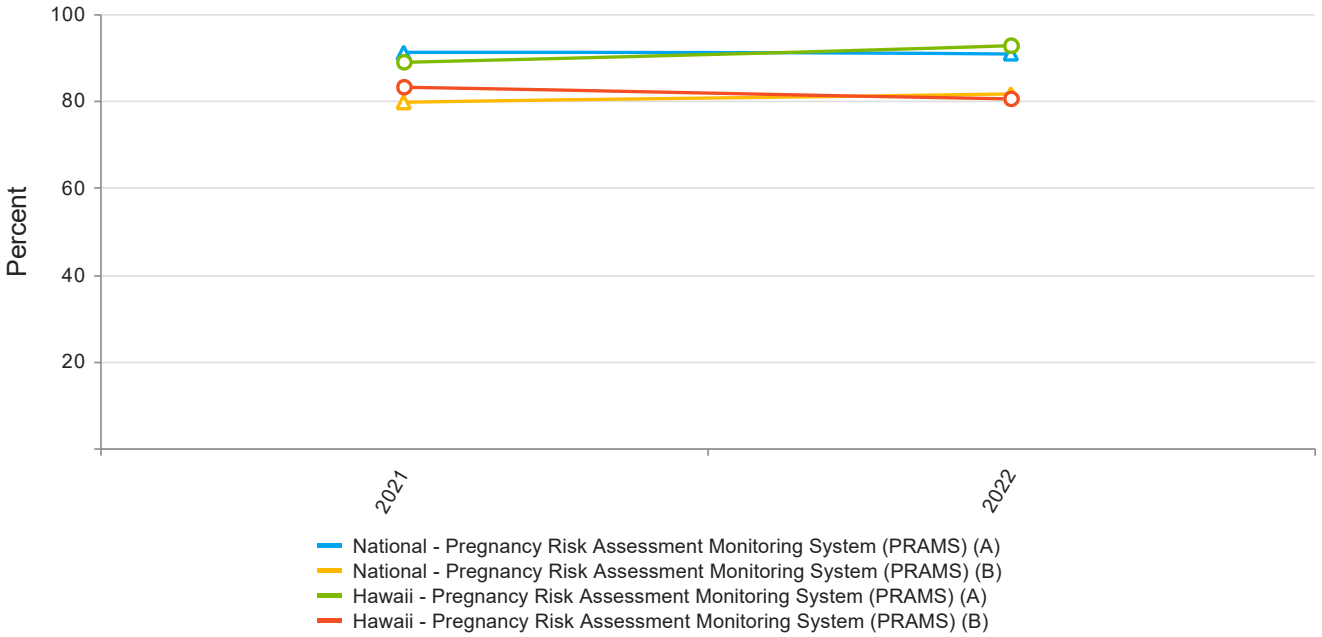
ESM WWV.2 - The number of women aged 18-44 years served through the state MCH reproductive health and wellness program.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	3,681	2,698
Numerator		
Denominator		
Data Source	Family Planning and Reproductive Health program	Family Planning and Reproductive Health program
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

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

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	92.4
Numerator	13,947
Denominator	15,098
Data Source	PRAMS
Data Source Year	2022

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	80.3
Numerator	11,089
Denominator	13,802
Data Source	PRAMS
Data Source Year	2022

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Hawaii) - Women/Maternal Health - Entry 1	
Priority Need	
Promote reproductive life planning with a focus on underserved populations	
NPM	
NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	
Five-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	
Provide reproductive health services for areas with limited access and/or shortage of care, including rural communities	
ESMs	Status
ESM WWV.1 - Percent of births with less than 18 months spacing between birth and next conception	Inactive
ESM WWV.2 - The number of women aged 18-44 years served through the state MCH reproductive health and wellness program.	Active

NOMs

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

State Action Plan Table (Hawaii) - Women/Maternal Health - Entry 2

Priority Need

Improving maternal care including postpartum care for pregnant people

NPM

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Five-Year Objectives

• By July 2025, increase the percent of women who attended a postpartum checkup within 12 weeks after giving birth to 94%. • By July 2025, increase the percent of women who attended a postpartum checkup and received recommended care components to 82%.

Strategies

Define the maternal care health issue by completing a mixed method review of relevant data, with a specific focus on disparities that include race/ethnicity data and geographic location.

Review the evidence-based literature, emerging best practices, and expert opinion resources on current postpartum care practices, in order to identify specific strategies to improve postpartum health outcomes and maternal well-being.

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

NPM WWV - 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 WWV, Well-Women Visits, based on the 2020 five-year Title V needs assessment results. By July 2025, the state seeks to increase the percentage of women who have a preventive medical visit to 87%.

Data: The FY 2023 indicator (2022 data) shows that 74.6% of women in Hawaii received a preventive medical visit, which did not meet the annual objective and was not significantly higher than the previous year. The 2022 data may still reflect COVID isolation, shutdowns, and healthcare service disruptions. Hawaii's rate was similar to the national estimate of 72.5%. The BRFSS preventive checkup survey measure was revised in 2018 and is not comparable to previous survey years. There were no significant differences in reported subgroups by race/ethnicity, maternal age, household income, health insurance, or marital status based on 2022 (one-year of) data.

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

Title V Lead/funding: Several key personnel work on this priority.

- The Women's and Reproductive Health Section (WRHS) Supervisor in the Maternal and Child Health Branch (MCHB) provides key leadership for this issue and is Title V funded. The WRHS Adolescent Health Supervisor filled this supervisory position in September 2023 after it was vacant for over a year.
- The Adolescent Health Supervisor position now remains vacant.
- The state-funded Family Planning supervisor position also provides support for this health issue.
- Based on MMR findings, the state-funded MMR/CDR nurse position works on women's preventive health initiatives and participates in the Hawaii Perinatal Collaborative and the Hawaii Maternal and Infant Health Collaborative (HMIHC).

Strategies/Evidence: The strategies for this priority include the work of HMIHC, which has provided leadership for women's health and perinatal issues in the state for over 15 years. Title V helped establish 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 inter-conception healthcare visits
- Provide reproductive health services for areas with limited access and/or shortage of care, including rural communities.

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

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

The 2016 MCH Bureau Infant Mortality Collaborative Innovation and the Improvement Network (CoIIN) promoted the two approaches as best practices. Recently, OKQ efforts have been expanded to include other evidence-based reproductive health screening approaches. Additionally, many of the Evidence Center's best practices are utilized by community service contractors, including FQHC, who employ trained medical interpreters and regular patient

reminders.

Progress on the strategies is described below.

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

This strategy recognizes that public health issues are best addressed by developing and sustaining partnerships between multi-sector partners, including community organizations, academic institutions, and government. These partnerships provide opportunities to improve women's health before, after, and between pregnancies through planning, policy development, and system changes. In Hawaii, women's wellness is currently integrated into four major state plans and collaboratives:

- The Hawaii Early Childhood State Plan
- The Early Childhood Action Strategy (ECAS) Plans
- The HMIHC Strategic Plan
- Early Childhood Comprehensive Systems Grant Strategic Plan

The plans guide developing and implementing collaborative action strategies and policy development. All state plans embrace a life course approach that acknowledges the importance of women's wellness as a foundation for healthy women and the health and well-being of their infants, children, and families.

Hawaii Maternal and Infant Health Collaborative (HMIHC): The HMIHC is a collaborative group focusing on improving birth outcomes, reducing infant mortality, and promoting intended pregnancies. The HMIHC strategic plan recognizes and supports women's health as critical to its goals. Over 120 individuals participate in HMIHC, including physicians, clinicians, public health professionals, community service providers, and health plan/healthcare administrators. Several MCH Branch staff sit on the HMIHC steering body and sub-committees.

Medicaid Policies: HMIHC was instrumental in the issuance of Hawaii Medicaid provider policies in 2016 to support the use of OKQ and expand contraceptive coverage. The policy promoted the OKQ screening process and eliminated prior authorization for contraceptive procedures, methods, or devices, allowing for reimbursement for a 12-month supply of oral contraceptives. The policy also unbundled LARC reimbursement from the global fee for inpatient delivery services, supported stocking of LARC in hospital pharmacies, and listed new billing codes for providers. The policy was disseminated to all Medicaid health plans, hospitals, pharmacies, and healthcare providers. HMIHC efforts have focused on ensuring implementation of the policies to address the needs of low-income women, who are often underserved.

In 2021, DHS updated its provider policy, which clarified outpatient coverage of LARC devices with new billing codes. It also encouraged healthcare providers to adopt a reliable, evidenced-based pregnancy intention screening tool to support individual reproductive life plans. The memo specified that OKQ is one of several evidence-based pregnancy intention screening tools available. OKQ must be used by the eight new MCH Branch Reproductive Health Service contractors (described in Strategy 3).

Extension of Postpartum Care. In 2022, Hawaii extended Medicaid postpartum care from 2 to 12 months with federal approval, funding, and a State appropriation of $2.4 million to the Hawaii Medicaid budget. Well-women visits are particularly important postpartum, given the risk of pregnancy-related deaths and severe maternal mortality, which data indicates is rising in Hawaii.

The extension of postpartum care will ensure continued insurance coverage through Medicaid enrollee

redeterminations, which began in May 2023 (although the Maui Fires temporarily halted Hawaii's redeterminations from September to December 2023).

Maternal Health Innovation Grant. A meeting of Hawaii maternal health (MH) grantees was convened by the Healthcare Association of Hawaii (HAH), which represents all the facilities-based healthcare services in the state, including hospitals, skilled nursing facilities, residential care homes, and assisted living sites. HAH administers Hawaii's Alliance for Innovation on Maternal Health (AIM) grant, convenes the state Perinatal Quality Collaborative, and was awarded HRSA's Maternal Health Innovation (MHI) grant in 2023. In addition to Title V, MH grantees included ECCS, the Maternal Health Research Network (MH-RN), a National Institute of Health grant for Native Hawaiian/Pacific Island Maternal Outcomes, and the Centers for Disease Control (CDC) MMR grant. The purpose of the meeting was to learn about the various MH grants and identify opportunities to coordinate efforts. Collaboration areas include assessment, research, planning, funding, engaging those with lived experience, and addressing health equity and the MH disparities unique to Hawaii.

Maternal Mortality Review (MMR). MCH Branch established Hawaii's MMR in 2016. The purpose of the MMR is to determine the causes of maternal mortality and identify public health and clinical interventions to improve systems of care and prevent future maternal deaths. MCHB applied for and received a CDC MMR grant to improve data quality by identifying and characterizing pregnancy-related deaths and addressing health inequities. The grant runs through September 2024, and there are opportunities to apply for ongoing CDC funding to improve maternal health.

Abortion Protections: In response to the overturning of Roe v Wade by the U.S. Supreme Court, Hawaii policymakers quickly adopted statutory protections for a woman's right to choose, including:

- protecting out-of-state visitors who obtain abortions in Hawaii, as well as anyone who assists them, from civil and criminal penalties that their home states may impose
- protecting Hawaii healthcare providers who perform surgical abortions or provide abortion medications to non-Hawaii residents
- expanding abortion access by allowing physician assistants to perform abortions
- updating laws to allow for non-surgical abortions

HMIHC leaders were instrumental in drafting and supporting these policy protections for women and their providers.

Strategy 2: Promote pre/inter-conception healthcare visits

This strategy focused on the efforts of the HMIHC Pre/Inter-Conception Workgroup and the promotion of reproductive health screening and LARC strategies.

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

The State Medicaid program and a family practice physician currently co-chair the workgroup, which includes representatives from the Hawaii American College of OB-GYNs (ACOG); University of Hawaii John A. Burns School of Medicine (JABSOM) Department of Obstetrics, Gynecology and Women's Health; Queen's Physicians Network; Hawaii Healthy Mothers, Healthy Babies Coalition (HMHB); Planned Parenthood; and several federally qualified health centers (FQHC), among others. The involvement of Medicaid and FQHCs helps to focus and deliver services to more lower-income, at-risk women of reproductive age. The workgroup continued to meet regularly and remotely throughout 2023.

Reproductive health screening: After many years of promoting reproductive health screening using the OKQ approach, the Pre/Inter-Conception Workgroup reduced efforts around OKQ promotion and training. OKQ is a simple tool to engage women in discussing their pregnancy intentions by asking, "Would you like to become pregnant in the next year?" Follow-up is based on a woman's response, leading to desired reproductive planning and follow-up for preventive healthcare. Many healthcare/family organizations continue screening but utilize other evidence-based approaches. This change gives clinicians and counselors more options and flexibility in reproductive counseling approaches.

LARC: Hawaii chose LARC as an evidence-informed approach to help reduce rates of unintended pregnancy. LARC placement occurs in a single provider visit/encounter and does not require additional medication or follow-up visits. Although LARC is considered a "highly effective" form of contraception, practitioners are instructed to provide non-directive counseling and respect clients' decisions about LARC.

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

Despite the updated Medicaid contraception policy, HMIHC continues working with hospitals, clinics, and physician offices to assure same-day access to LARC. Other issues include pharmacy barriers to filling 12-month contraception prescriptions, parity in coverage/reimbursements between public and private insurance, and issues with claims processing, billing, and reimbursement that create barriers to stocking LARC devices.

Strategy 3: Providing reproductive health services for areas with limited access and/or shortage of care, including rural communities

This strategy focused on increasing access to reproductive health services and ensuring the provision of reproductive life planning services through contracted community-based services to promote health equity.

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

- Services to uninsured and underinsured participants seeking reproductive health care and related preventive health services statewide and assist the uninsured in applying for healthcare insurance upon initial visit
- Supplies that are not covered by health insurance plans or are occasionally difficult to obtain to maintain good health and promote healthy birth outcomes
- Subsidized transportation and child/respite care costs for participants who may have challenges (e.g., reside in rural areas and/or experiencing poverty) with attending medical appointments that are not covered by health insurance plans or occasionally difficult to obtain
- Collaboration with community programs to reach underserved populations to provide educational activities and presentations that are age and culturally respectful of the history, traditions, and values of different ethnic groups to help increase positive parenting and family support
- Provide medically accurate and cultural perspective information, education, awareness, reproductive health screening (using OKQ), family support, violence prevention, and ensuring the promotion of voluntary family planning clinical services throughout Hawaii.
- Enhance and increase outreach activities/strategies by utilizing media sources.

Eight community providers statewide were selected to deliver reproductive health services to most counties through FQHCs and neighbor island college health centers.

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

ESM WWV 2 - The number of women aged 18-44 years served through the state MCH reproductive health and wellness program.

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective								3800	4000	4200
Annual Indicator							3681	2698		

The Evidence-Informed Strategy Measure (ESM) reflects the number of women aged 18-44 served by the state's reproductive health and wellness program. The ESM relates to evidence-based strategies, including working with FQHC and other community providers who employ trained medical interpreters and regular patient reminders. The FFY 2023 data collected indicates that 2,698 women were served, a decline from the previous year. The reason for the drop is being explored.

Mobile Reproductive Care. To further outreach to pregnant people in rural areas in the state with poor birth outcomes, MCHB partnered with Healthy Mothers Health Babies' mobile clinical reproductive care program, Mana Mama. The program uses a community-based midwifery model for prenatal care and education for pregnancy, labor, birth, postpartum, lactation, and well-baby care for the newborn. Clinical services are provided by licensed midwives, lactation consultants, and a nurse practitioner. Services also include comprehensive phone support and referrals to resources, family planning services, pregnancy testing and counseling, basic infertility services, preconception and interconception health care, and sexually transmitted disease services. Additionally, primary care for the entire family is available. The MCHB contract helped launch a new mobile van on Hawai'i island, where transportation often hampers access to regular in-person clinic visits.

Current Year Highlights for FY 2024 (10/1/2023 – 6/30/2024)

Maui Mobile Reproductive Health Services. In response to the Maui wildfires, the MCH Branch partnered with the HMHB Mana Mama program to support services on the island. The O'ahu mobile unit was already in the process of moving to Maui to help address a shortage of ob-gyn providers on-island. After the fires, the mobile unit was able to be located in strategic areas to provide easy access to services for displaced Lahaina/Upcountry residents affected by the fires. Services included reproductive health services (including prenatal care and distribution of contraception/Plan B) as well as on-site first aid to families as they were permitted to return to the 'burn zone' to recover any remaining belongings. Challenges included the clients' difficulty accessing delivery services and tracking families constantly moving to temporary hotels/housing. The HMHB contract continues through FY 2024

Maui Community College clinic. The Maui Community College Health Center clinic is the MCHB reproductive health services contractor for Maui. In response to the urgent need for medical care due to the wildfires, the clinic expanded outreach and health care to those in need from the Lahaina community and the West side of Maui, including dispensing free birth control options.

Maternal Mental Health. Supported by an MCHB contract, HMHB will facilitate and lead a perinatal behavioral health initiative to prevent maternal deaths related to perinatal mood, anxiety disorders, and substance use disorders among women residing in Hawaii. HMHB will begin developing a more coordinated system of statewide perinatal and inter-conception services to identify mental health needs, coordinate service delivery, and maintain partnerships for collaborative action. A final report is due September 2024.

CDC MMR Grant: The MCH Branch used the one-year CDC MMR grant to implement recommendations from the MMR Council to support the HMMB mobile reproductive service contracts to underserved areas and support the coordination of maternal mental health programs and resources. The grant also supported regular state MMR meetings, MMR Council members' travel to a national CDC MMR data users meeting, and the development of a maternal health media campaign to launch later this year. Based on MMR findings, MCHB also submitted a CDC Maternal Mortality.5-year grant application to improve data quality, reporting, training, and prevention efforts.

Contraception Barriers: To support the HMIHC Pre/Inter-Conception Workgroup, MCHB contracted with the Hawaii Children's Action Network (HCAN) to investigate and resolve barriers to same-day access to contraception in multiple settings, including hospitals, community health centers, rural health clinics, and private practices. A final report is due December 2024.

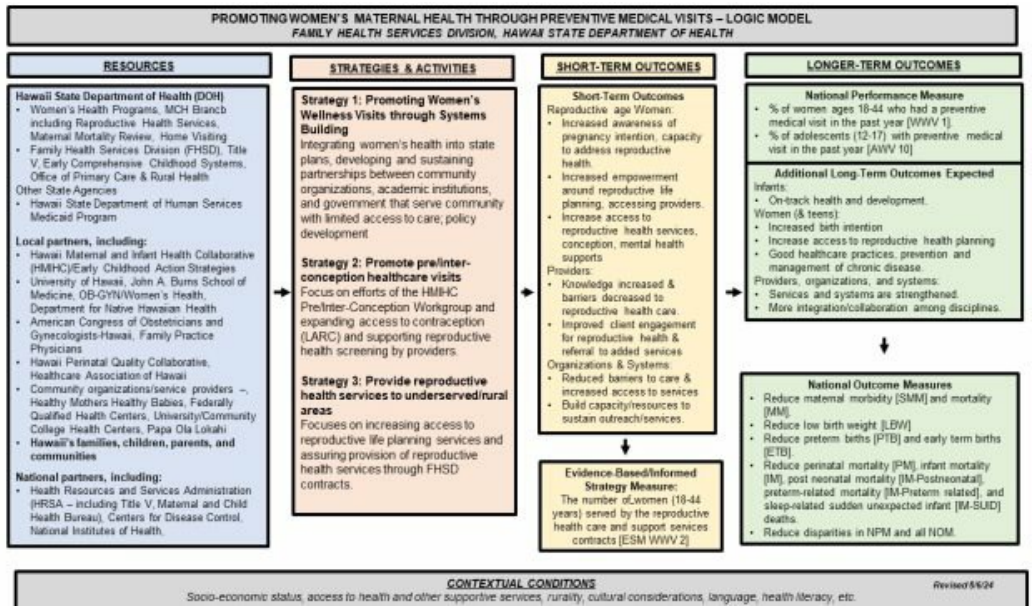
Maternal Health Steering Committee. The HMIHC received a technical assistance (TA) grant in December 2023 to help establish a state maternal health steering committee and develop a state plan to improve maternal health for the MHI grant. The CDC Foundation Strategies to Repair Equity and Transform Community Health (STRETCH) 2.0 Initiative TA grant was used to conduct two initial kick-off meetings for the MH Steering Committee in April, which included a draft charter and membership agreement. Title V is collaborating with the MHI grant on needs assessment: conducted a focus group with the Hawaii PQC, working on an MH secondary data review, and collecting qualitative data from key populations and those with lived experience.

Researching Transportation Barriers. FHSD's Rural Health program funded the University of Hawai'i Rural Health Research & Policy Center (RHRPC) to conduct a policy study on "The Impacts of Transportation and Travel Access on Rural Health: Focus on Maternal Health." Access to equitable transportation options for the maternal population residing on Molokai and Lanai's small, rural neighbor islands has been an ongoing issue. Many women relocate to islands with hospital care several weeks before their delivery date. The RHRPC advisory committee selected this issue as one of its top priorities as the impetus for this project.

Maternal Care Target Areas. The FHSD Office of Primary Care is contracting to conduct a survey of maternal health providers to generate data for Hawaii's MCTA designation. Additionally, vital statistics and Medicaid data are being requested to identify patterns in access to birthing facilities. MCTA scores reflect areas experiencing a shortage of maternity health care professionals and range from 0-25. The maximum score of 25 indicates the greatest need for maternity care services within the health professional shortage area. Currently, Hawaii has one of the ten highest MCTA ratings (15.65) in the nation. This research will provide a more accurate assessment of maternal care providers in the state.

Review of the Action Plan

A logic model developed for WWV 1 aligns strategies and activities with performance measures and desired outcomes. This logic model was updated to reflect changes in women's health and wellness activities since last year, including new measure abbreviations.



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

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

Challenges Encountered

Maui Fires. The impact of the Maui fires on families and maternal care is still unclear, particularly since Maui was already facing a shortage of OB-GYNs and family practice providers. Several Maui needs assessments are currently in the process to monitor the impacts on access to care and health outcomes.

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

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

Overall Impact

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

- Integration and continued efforts to improve maternal health as part of four key state plans.
- Successful partnership building in the formation of HMIHC with Title V's support and participation with Medicaid, physicians, and safety net providers in Pre/Inter-Conception Workgroup. The diverse HMIHC

membership assures support to maintain and sustain the ongoing collaboration to address populations who are underserved and experience poor health outcomes.

- Collaborative partnerships among maternal health grantees, organizations, and programs to coordinate efforts for assessment and planning to reduce duplication and ensure alignment across the state.
- Progress in advancing policies/legislation, including Medicaid provider policies to support reproductive health screening/planning, expanded access to contraceptive use (elimination of prior authorization for contraception, reimbursement for a year's supply of oral contraceptives, unbundled LARC reimbursement from delivery fees, stocking of LARC in hospital pharmacies), and continued protections to access abortion services for both pregnant people and their providers.
- LARC is now stocked in more of the state’s birthing hospital pharmacies.

Women/Maternal Health - Application Year

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

For the Women/Maternal Health domain, NPM 1 Well-Women Visit will continue as a priority through FY 2025 then will be discontinued for the next five year project period and replaced by the universal maternal measure on postpartum care.

By July 2025, the state seeks to increase the number of women who have a preventive medical visit to 87%, including pre/interconception care. Plans to address this objective and NPM are summarized below.

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

This strategy recognizes that public health issues are best addressed by developing and sustaining partnerships between and within community organizations, academic institutions, and government.

State Maternal Health Steering Committee. The State MH Steering Committee should be established and meet to complete a maternal health needs assessment in partnership with Title V and complete drafting a maternal health strategic plan.

CDC MMR Grant: MCHB will be informed whether the 5-year CDC Maternal Mortality.5-year grant was awarded. The grant will improve data quality, reporting, training, and prevention efforts based on MMR findings.

The University of Hawai'i Rural Health Research & Policy Center (RHRPC) will complete its policy study on "The Impacts of Transportation and Travel Access on Rural Health: Focus on Maternal Health." Findings will be shared with maternal health stakeholders for consideration and action.

Maternal Care Target Areas. Results from the FHSD Office of Primary study for MCTA designation will be released by late 2024. MCTA scores reflect areas experiencing a shortage of maternity health care professionals. This research will provide a more accurate assessment of maternal care providers in the state.

Strategy 2: Promote Pre/Inter-Conception Healthcare Visits

The HMIHC Pre/Inter-Conception Workgroup plans will continue to focus on improving access to contraception options, including LARC, via multiple healthcare settings.

Addressing Contraception Barriers: The final report to investigate and resolve barriers to same-day access to contraception of choice (including LARC) will be released in December 2024 in conjunction with the HMIHC Pre/Inter-Conception Workgroup. Follow-up plans and recommendations will be considered and adopted as appropriate.

Strategy 3: Providing reproductive health services for areas with limited access and/or shortage of care, including rural communities

Title V MCHB will continue to work towards increasing access to reproductive health services to reach uninsured, underinsured populations and those who have challenges accessing healthcare.

Maui Mana Mama Mobile Van. A final report on reproductive health services for the island of Maui will be completed in December 2024, and follow-up support will be considered based on identified needs, success of the service model, and available funding.

Reproductive Health Services: MCHB will continue to provide ongoing reproductive health care and support services through eight community-based providers across the state, except in Kauai County and the island of Molokai.

NPM – PPV A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth
B) Percent of women who attended a postpartum checkup and received recommended care components

For the Women/Maternal Health domain, the new Title V grant guidance added postpartum care as a new universal performance measure that all states are now required to address. Objectives were set through FY 2025 are as follows:

- By July 2025, increase the percent of women who attended a postpartum checkup within 12 weeks after giving birth, to 94%.
- By July 2025, increase the percent of women who attended a postpartum checkup and received recommended care components, to 82%.

Data: The data for this measure is from the Hawaii Pregnancy Risk Assessment Monitoring Survey (PRAMS). Note: There was no PRAMS data collection in Hawaii from 2017-2018 for both PPV A and B. For PPV-B there was no data for this measure before 2016.

NPM PPV-A The latest 2022 PRAMS data indicates that, in Hawaii, about 92.4% of women attended a postpartum checkup within 12 weeks after giving birth, which was similar to the national estimate of 90.8%. There has been a 4% increase in the percent of women that attended postpartum checkup since 2013 (88.2%). Based on the 2019-2022 aggregated PRAMS data, Other Pacific Islander mothers (74.8%) were less likely to attend a postpartum checkup, when compared to White mothers (93.1%). Mothers under 20 years of age (77.8%) were less likely to attend a postpartum checkup, when compared to those who were 20-34 years of age (90.7%), or those women who were 35 or more years of age (93.0%). Mothers whose incomes were at or below 100% of the FPL (85.2%) were less likely to attend a postpartum checkup, when compared to those mothers at 186-300% (93.9%) of the FPL, or those women at or above 301% of the FPL (95.2%).

NPM PPV-B The 2022 PRAMS data indicates that, in Hawaii, about 80.3% of women who attended a postpartum checkup received the recommended follow-up care components, which was similar to the national estimate (81.5%). The increase in estimate from 2019 (75.8%) was non-significant. Based on the 2019-2022 aggregated PRAMS data, Japanese mothers (72.0%) were less likely to receive recommended care components, when compared to White mothers (84.1%). Mothers who were 35 or more years of age (71.6%) who attended a postpartum checkup, were less likely to receive recommended care components, when compared to those mothers 20-34 years of age (84.2%), or mothers under 20 years of age (93.4%).

Objectives: The state objectives reflect a projected annual increase of two percentage points over two years.

Strategies: The strategies for this priority are:

- Define the maternal care health issue, by completing a mixed method review of relevant data, with a specific focus on disparities that include race/ethnicity data and geographic location.
- Review the evidence-based literature, emerging best practices, and expert opinion resources on current postpartum care practices, in order to identify specific strategies to improve postpartum health outcomes and maternal well-being.

Plans to address this objective and NPM are summarized below:

Strategy 1: Define the maternal care health issue, by completing a mixed method review of relevant data, with a specific focus on disparities.

This strategy recognizes that both quantitative and qualitative data for this measure needs to be collected, reviewed, and analyzed. The work on the Title V needs assessment will be reviewed and applied in order to develop a better

understanding of evolving postpartum and maternal health care in Hawaii.

Strategy 2: Review the evidence based literature, emerging best practices, and expert opinion resources on current postpartum care practices, in order to identify specific strategies to improve postpartum health outcomes and maternal well-being

Strategies and activities to address this issue will be developed, based on relevant data findings, along with a review of evidence-based research and input gathered from community MCH partners and providers, including the Hawaii Maternal Infant Health Collaborative (HMIHC) and the state Maternal Health state strategic plan that is currently HRSA-funded and under development.

Title V Women's Health Programs

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

Reproductive Health Care & Support Services: Reduces risk factors that contribute to poor birth outcomes and maternal mortality/morbidity, by providing a variety of targeted interventions contractual services to community-based providers, for uninsured and underinsured pregnant women throughout pregnancy, and up to six months postpartum.

Women Infants and Children (WIC): The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a longstanding federally funded program that provides income-eligible Hawaii women and their infants and small children with nourishing supplemental foods, nutritional education, breastfeeding promotion and support, as well as health and social service referrals. WIC participants are required to be either pregnant, breastfeeding, or postpartum women, with infants and/or children under the age of five, who meet income eligibility guidelines and who also have an identified medical or nutritional risk factor.

Adolescent Health Services: Adolescent Health Services focuses on adolescents and young adults ages 10-24 years, to comprehensively address the physical, mental, social-emotional, sexual health, positive youth development, as well as transition into adulthood aspects for this population. The WRHS Adolescent Health Services Unit is supported by the Personal Responsibility Education Program grant, administering the Evidence-Based Prevention Teen Outreach Program, which is a program that focuses on reducing teenage pregnancy, school failure, and school suspension rates.

Hawaii Home Visiting: The Hawaii Home Visiting Program provides comprehensive early identification services to at-risk families, including expectant families and families of newborns. Program clients are those who may benefit from home visitation services in order to help reduce health disparities, by improving birth, health, and development outcomes. The program works within a systems approach, through collaboration with, and referral from, birthing hospitals, health care providers, WIC clinics, and community health centers.

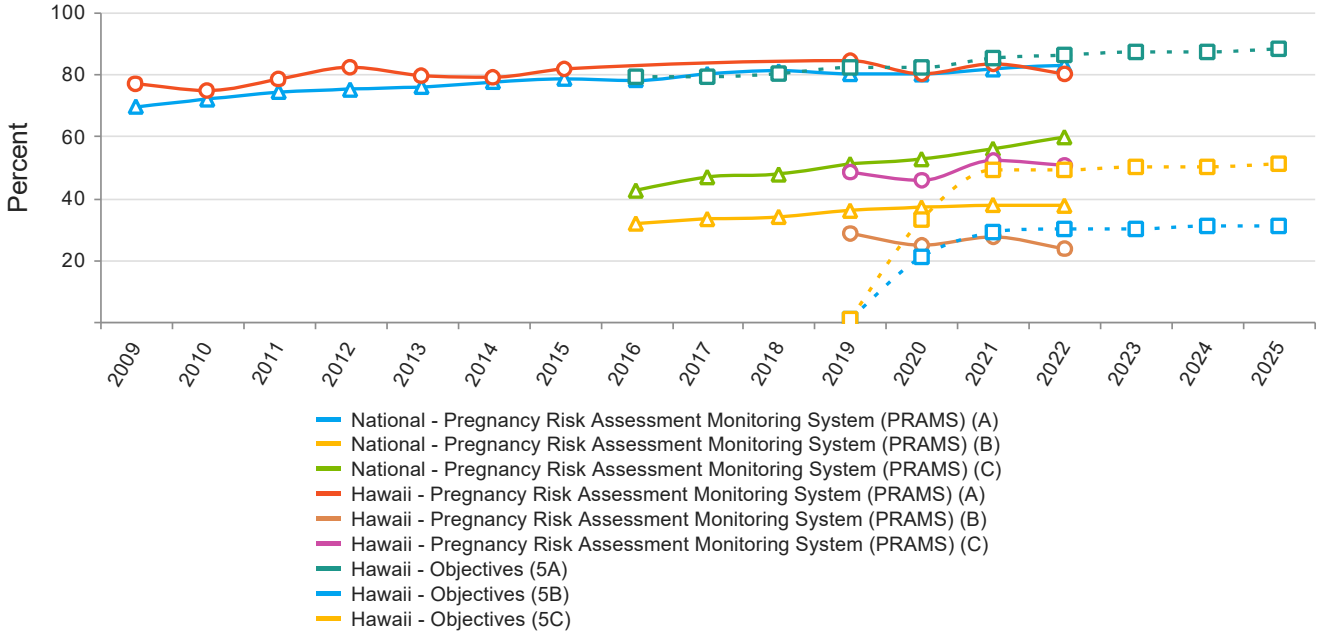
Pregnancy Risk Assessment Monitoring System: The PRAMS surveillance system collects and analyzes population-based data in order to Identify and monitor maternal health experiences, attitudes, and behaviors, that occur from preconception on through pregnancy, and into the interconception period. It provides the most comprehensive data available in Hawaii at this time on the experiences and outcomes for maternal health.

Maternal Mortality Review: The MMR systematically reviews causes of all maternal deaths in Hawaii that occur during pregnancy, and up through one year of giving birth. MMR seeks to identify appropriate public health, safety and clinical interventions that will reduce preventable deaths, as well as improve systems of MCH care. . The MMR team is currently composed of representatives from a wide range of disciplines and agencies that provides a multi-perspectives and expertise approach to the review process.

Domestic Violence Fatality Review: The DVFR conducts multidisciplinary and multiagency reviews of child, maternal, and domestic violence fatalities; near-deaths; and suicides, in order to reduce the incidence of preventable deaths in the MCH community. The DVFR process reviews and analyzes systemic responses to domestic/partner violence, with participation and input from community agencies and other related organizations.

National Performance Measures

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS
Indicators and Annual Objectives



NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	82	82	85	86	87
Annual Indicator	81.5	84.0	80.1	83.0	80.0
Numerator	14,376	6,895	12,016	12,363	11,938
Denominator	17,634	8,212	15,003	14,891	14,928
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2019	2020	2021	2022

Annual Objectives		
	2024	2025
Annual Objective	87.0	88.0

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2020	**2021**	**2022**	**2023**
Annual Objective	21	29	30	30
Annual Indicator	28.7	24.7	27.7	23.5
Numerator	2,245	3,565	4,047	3,383
Denominator	7,829	14,455	14,591	14,412
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	1	21	29	30	30
Annual Indicator	20.3	28.7			
Numerator	3,306	2,245			
Denominator	16,296	7,829			
Data Source	PRAMS	PRAMS			
Data Source Year	2016	2019			
Provisional or Final ?	Final	Final			

Annual Objectives		
	2024	**2025**
Annual Objective	31.0	31.0

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2020	**2021**	**2022**	**2023**
Annual Objective	33	49.0	49	50
Annual Indicator	48.1	45.9	52.0	50.4
Numerator	3,755	6,633	7,507	7,256
Denominator	7,801	14,477	14,422	14,405
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	1	33	49	49	50
Annual Indicator	46.2	48.1			
Numerator	5,186	3,755			
Denominator	11,228	7,801			
Data Source	PRAMS	PRAMS			
Data Source Year	2016	2019			
Provisional or Final ?	Final	Final			

Annual Objectives		
	2024	**2025**
Annual Objective	50.0	51.0

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

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

Evidence-Based or –Informed Strategy Measures

ESM SS.2 - The number of translated Safe Sleep Guides for Parents that were provided to the agencies, organizations and individuals, on request

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	7,839	1,464
Numerator		
Denominator		
Data Source	Hawaii Title V Safe Sleep program	Hawaii Title V Safe Sleep program
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

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

State Performance Measures

SPM 2 - Reduce the rate of food insecurity for pregnant women and infants through the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) services

Measure Status:	Active			
State Provided Data				
	2020	**2021**	**2022**	**2023**
Annual Objective			27,000	28,000
Annual Indicator	25,584	25,907	25,855	26,116
Numerator				
Denominator				
Data Source	Hawaii WIC Services	Hawaii WIC Services	Hawaii WIC Services	Hawaii WIC Services
Data Source Year	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	29,000.0	30,000.0

State Action Plan Table

State Action Plan Table (Hawaii) - Perinatal/Infant Health - Entry 1	
Priority Need	
Increase the rate of infants sleeping in safe conditions	
NPM	
NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	
Five-Year 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	
Build diversity and reach of Safe Sleep Hawaii through increased community partnerships to promote health equity	
Increase awareness of the importance of Safe Sleep and provide safe sleep education, including public service announcements and digital media	
ESMs	**Status**
ESM SS.1 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.	Inactive
ESM SS.2 - The number of translated Safe Sleep Guides for Parents that were provided to the agencies, organizations and individuals, on request	Active
NOMs	
NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM	
NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal	
NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID	

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

Priority Need

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

SPM

SPM 2 - Reduce the rate of food insecurity for pregnant women and infants through the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) services

Five-Year Objectives

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

Strategies

Partner with agency and community programs to to improve WIC enrollment and utilization

Improve data collection and analysis to identify key barriers to WIC benefit utilization and enrollments

NPM SS-A - Percent of infants placed to sleep on their backs
NPM SSB - 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 SS based on the 2020 Title V needs assessment. By July 2025, the state seeks to increase the percentage of infants placed to sleep on their backs to 88.0%

Data: NPM SS-A: The latest data from the 2022 PRAMS survey (80.0%) indicates that Hawaii did not meet the 2023 state objective or the Healthy People 2030 objective of 88.9% but was similar to the 2022 national estimate (82.7%). The increase from the 2016 Hawaii estimate was not statistically significant. The state objectives through 2025 reflect an approximate 5% projected improvement.

Analysis of Hawaii PRAMS 2019-2022 aggregated data indicated that Native Hawaiian (77.3%), Samoan (61.3%), and other Pacific Islander (65.9%) mothers were significantly less likely to place their infants to sleep on their backs when compared to White (87.1%) or Japanese (88.1%) mothers. Mothers under 20 years of age (60.9%) were less likely to place their infants on their backs to sleep when compared to mothers 20-34 years of age (80.8%) or 35 or more years of age (85.9%). Mothers whose income fell below 100% of the FPL (74.3%) were less likely to place their infants on their back to sleep when compared to those mothers at 186-300% of the FPL (83.5%) or those who were at or above 301% of the FPL (89.7%).

NPM SS-B: The latest data from the 2022 PRAMS survey (23.5%) indicated that Hawaii did not meet the 2023 state objective (30.0%) and was significantly lower than the 2022 national estimate (38.0%). The decrease from 2022 (27.7%) and the increase from 2016 (20.3%) was not statistically significant. The state objectives from 2021 through 2025 reflect a projected 5% improvement.

Based on the 2019-2022 data, Native Hawaiian (23.8%), Filipino (16.4%), Black (20.6%), and other Pacific Islander (21.7%) mothers were less likely to place their infant to sleep on an approved surface, when compared to White (35.7%) mothers. Mothers who were under 20 years of age (14.9%) were less likely to place their infants to sleep on an approved surface, when compared to mothers 20-34 years of age (26.8%). Mothers with incomes below 100% of the FPL (21.1%), at 101-185% of the FPL (22.5%), or at 186-300% of the FPL (22.7%), were less likely to place their infants on an approved surface to sleep when compared to those mothers who were at or above 301% of the FPL (32.1%).

NPM SS-C: The latest data from the 2022 PRAMS survey (50.4%) indicates that the 2022 state objective of 49.0% was exceeded but was significantly lower than the 2022 national estimate (59.9%). The decrease in the estimate from 2022 (52.0%) was not statistically significant, but the increase was significant when compared to the 2016 estimate (31.6%). The state objectives from 2021 through 2025 reflect an approximately 5% projected improvement.

Based on the 2019-2022 data, Native Hawaiian (34.8%), Filipino (48.0%), and other Pacific Islander (25.7%) mothers were less likely to place their infant to sleep without soft objects or loose bedding when compared to White (64.7%) mothers. Mothers who were under 20 years of age (24.8%) or those 20-34 years of age (48.1%) were less likely to place their infants to sleep without soft objects or loose bedding compared to mothers who were 35 or more years of age (55.5%). Mothers at or below 100% of the FPL (37.2%), those at 101-185% of the FPL (42.8%), or those mothers at 186-300% of the FPL (47.4%) were less likely to place their infants to sleep without soft objects or

loose bedding when compared to those mothers at or above 301% of the FPL (62.9%).

PRAMS data: There was no PRAMS data collection in Hawaii from 2017 to 2018 due to statutory privacy concerns that were being addressed regarding using vital records for public health research. The Title V 2019 NPM SS indicators are derived from the 2016 PRAMS survey, and the 2020 indicators are from the 2019 PRAMS survey. Note: The 2019 dataset includes only six months of weighted data. Full 12 months of yearly data was available thereafter.

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

Child Death Review: Total number of child deaths for 2022 was 155, which in the average range of pre-COVID deaths per year. There were a reported 62 non-natural deaths and 93 natural deaths in the total number. Infant sleeping conditions were considered as possible contributing or causal factors in several of the natural death cases reviewed by the 2022 Hawaii Child Death Review.

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

Strategies: The strategies for safe sleep were updated and revised:

- Build diversity and reach of Safe Sleep Hawaii through increased community partnerships to promote health equity
- Increase awareness of the importance of Safe Sleep and provide safe sleep education, including public service announcements and digital media

Evidence: A recent review of the AMCHP and MCH Evidence Center research indicates moderate evidence of effectiveness in targeting caregivers with safe sleep education. National campaigns have focused on vulnerable subgroups as having the most significant impact on advancing health equity. Hawaii is focusing on addressing disparities in safe sleep behaviors by targeting key ethnic groups and developing multilingual educational outreach for limited English-speaking families. The strategy was also supported by input from local service providers who work regularly with underserved, multicultural families. The new ESM SS 3 measures progress to distribute translated safe sleep educational materials to these key ethnic groups.

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

Strategy 1: Build diversity and reach of Safe Sleep Hawaii through increased community partnerships to promote health equity

This strategy reflects a new direction developed by the Safe Sleep Hawaii (SSH) Coalition, which is to expand community connections that can address health disparities.

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

SSH has a diverse membership that represents government, nonprofits, for-profits, grassroots organizations, individuals, and families committed to preventing infant mortality through safe sleep practices. SSH meets remotely every quarter with steady participation. SSH reviews trainings and public messaging campaigns on an ongoing basis to ensure that information remains updated and consistent with current AAP guidelines.

SSH identified several implementation activities which align with the Title V strategies:

- Foster collaboration and partnership among community programs and stakeholders on safe sleep efforts and other maternal and child health issues.
- Increase interaction with providers and families via the SSH Coalition Instagram account and SSH Facebook page.
- Increase community awareness of the availability of translated Safe Sleep guides in all offered languages.
- Create new resources and messaging for Safe Sleep education that are locally designed and tailored for Hawaii populations.

SSH Staffing/Coalition. To ensure ongoing support for the SSH Coalition activities, a children's law and policy consultant, Karen Worthington, was contracted to coordinate the activities, including scheduling meetings; maintaining and building membership/partnerships; conducting planning and policy development; working with advocates and families; and organizing trainings, presentations, social media, and other outreach efforts for safe sleep. Ms. Worthington is an attorney offering SSH years of local and national experience in CAN prevention.

Safe Sleep Assessment: The FSVPU, in partnership with SSH, contracted for a needs assessment to identify all current efforts and partnerships, the impact of these efforts, gaps, where there is a need, and an action plan for promoting Safe Sleep in Hawaii. The assessment collected data through research, surveys, key informant interviews, stakeholder listening sessions, and birthing hospitals. Numerous state reports were reviewed, and input was collected from 78 people working in the field, including 16 caregivers. A report and proposed Action Plan was provided to SSH in April 2023 for consideration.

Diversifying Membership. SSH reached out to additional partners, including prenatal and maternity care providers at hospitals and doulas and lactation consultants, with an invitation to join the SSH Coalition. While all those contacted were pleased to learn about the Coalition and SS resources, to date, none of those invited have opted for active participation.

Strategy 2: Increase awareness of the importance of Safe Sleep and provide safe sleep education, including public service announcements and digital media.

Strategies include providing public health information on safe sleep and referring families to resources for more information and support.

Media Campaign: During COVID, Title V used mass media efforts to promote public safe sleep messaging, given statewide shutdowns and social isolation for most households. In 2022, a Safe Sleep media campaign was again launched to educate parents and caregivers as part of October's *Safe Sleep and SIDS Awareness Month.* The

media campaign ran through December, including a governor's proclamation signing and press release. Television and digital spots promoting safe sleep were developed, using the ABC messaging (Alone, on their Backs, in a Crib), which were evidence-based recommendations from AAP. The media spots mirrored the content of a widely used *Hawaii Safe Sleep Guide for Parents,* previously developed by SSH. The call-to-action for the campaign directed the public to the Safe Sleep information available via The Parent Line (www.theparentline.org), the primary Title V warmline for family support.

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

Safe Sleep webpage: In September 2023, DOH launched the SSH Coalition landing page, https://health.hawaii.gov/safesleep/. This webpage features the video used in the 2022 campaign television spots, several social media ads and posts, and the Safe Sleep Guide in 12 languages/dialects (including English). The social media posts are included in the E-Toolkit and were translated into 11 of the most commonly used non-English languages/dialects spoken in Hawaii households. Since the webpage was launched in late 2023, 388 users have viewed the site 714 times. Viewers stayed on the site for an average of 45 seconds. Documents were clicked on and/or downloaded 160 times.

The launch of the webpage marked a significant accomplishment of the SSH Coalition's long-time goal of having one Hawaii-specific safe sleep online site, where DOH-approved information would be available for anyone interested in learning more about safe sleeping environments for infants.

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

The Parent Line distributed 18,338 hard copies of the Safe Sleep Guide for Parents, with 16,874 in English and 1,464 in other languages/dialects.

Translated SS Materials. Hawaii has a large immigrant and multi-ethnic population, including many households that use English as a second language (ESL). These populations subscribe to a range of diverse traditional and cultural practices for infant sleep, including co-sleeping practices.

To expand outreach to these groups, MCHB partnered with the Department of Human Services (DHS) and the Office of Language Access (OLA) to translate the *Hawaii Safe Sleep Guide for Parents* into 11 of the most common non-English languages/dialects currently spoken in Hawaii households: Chuukese, Ilocano, Japanese, Korean, Marshallese, Samoan, Spanish, Simplified Chinese, Tagalog, Traditional Chinese, and Vietnamese.

The Safe Sleep Guide's translated text and design layouts were thoroughly reviewed and cross-checked by focus groups of native speakers to ensure accuracy and that all information and graphics were appropriately displayed in a culturally sensitive, readable, and understandable manner. The guide is also used by all licensed childcare providers and other early child programs statewide.

The Hawaii Parent Line was contracted to distribute the Safe Sleep Guide to ensure broad public access statewide.

Printed versions of the guide were mailed out upon request, and electronic copies were located on The Parent Line website. The media campaign spots were designed to promote broader dissemination of the newly translated Safe Sleep Guides.

In FFY2023, social media posts were created from the images in the translated Safe Sleep Guides to allow providers of Safe Sleep education to share this information across their social media platforms in languages appropriate to the families they serve. These social media posts are available in the SSH Coalition E-Toolkit, which is posted on the DOH Safe Sleep home page.

ESM SS 3 was developed to track progress on dissemination efforts to reach diverse populations with the translated Safe Sleep information in conjunction with the SSH media campaign launched in FY 2023. ESM SS 3 measures the extent to which translated informational materials were requested and distributed to limited and non-English-speaking populations.

ESM SS 3 The number of translated Safe Sleep Guides for Parents that were provided to the agencies, organizations, and individuals on request

	2022	2023	2024	2025
Annual Objective	7000	8000	9000	10,000
Annual Indicator	7839	1,464		

These are the number of printed safe sleep guides distributed by Parent Line by language for the reporting period:
Chinese Simplified: 102
Chinese Traditional: 102
Chuukese: 162
Ilocano: 162
Japanese: 104
Korean: 102
Marshallese: 162
Samoan: 102
Spanish: 202
Tagalog: 162
Vietnamese: 102
An SS guide in Chuukese is shown to the right.

The number of guides distributed dropped significantly in year two of their availability. An evaluation may explain whether the cost of printing more copies is helpful to family service providers for limited and non-English-speaking families. The translated guides remain available for online download and distribution from the Parent Line website.

Cribs for Kids: The Family Strengthening and Violence Prevention Unit contracted with the Healthy Mothers, Healthy Babies Coalition (HMHB) in 2022 to provide Safe Sleep education and distribute safety-tested infant cribs. HMHB's Cribs For Kids (CFK) Program is accessible remotely via email, video, or phone to help parents and caregivers reduce the incidence of sleep-related deaths. Parent participants were provided safe sleep information and a *Graco Pack N Play* crib so that each infant in the program was provided a safe place to sleep. The program also works closely with Hawaii's birthing hospitals to ensure that parents, upon discharge, can provide their infants with safe sleeping conditions at home. As of May 2023, HMHB has provided safe sleep education and cribs to over 450 parents and caregivers statewide. HMHB has also coordinated with the Department of Human Services' Temporary

Assistance to Needy Families (TANF) program and their contracted service providers, who work with homeless families or those at risk for homelessness. HMHB is working to translate the CFK program materials to reach those with limited/non-English proficiency and is also working with DOH to develop a program evaluation tool.

Safe Sleep Professional Development. The Hawaii Children's Action Network (HCAN) was contracted to provide professional development on Safe Sleep education for perinatal/postpartum service providers, including doulas, midwives, and lactation consultants. In May 2023, the SSH Coalition created a subcommittee to collect information about professional development needs and goals. The committee gathered input at Safe Sleep Coalition meetings and created a provider survey for the Coalition. In response to the results of those activities, the Coalition, in partnership with HCAN, created an electronic Safe Sleep Hawai'i Toolkit to accomplish the SSH Coalition's professional development and public education goals. The toolkit includes a guide for using the toolkit, activities for educating families, instructions for providers, information about professional development opportunities, safe sleep-related data and statistics, planning tools, and other resources.

Current Year Highlights to FY 2024 (10/1/2023 – 6/30/2024)

Safe Sleep Summit. The SSH Coalition continued to meet, focusing on planning for a June statewide SS Summit and supporting ongoing professional development activities. The Safe Sleep Hawai'i Virtual Summit is scheduled for June 2024. The keynote speaker is Dr. Rachel Y Moon, MD, the Harrison distinguished teaching professor of pediatrics at the University of Virginia School of Medicine. Summit agenda items include a review of current AAP safe infant sleep guidelines, the importance of social norms and networks in communicating safe sleep practices, and Hawaii-specific updates on safe sleep activities and community resources.

Media Campaign Repeated: A follow-up Safe Sleep television and digital media campaign was launched in October 2023, highlighting the October national Safe Sleep and SIDS Awareness Month. The media campaign ran through December, with activities that included a Governor's proclamation signing and press release. The *Safe Sleep Guide for Parents* and The Parent Line remain the central means of sharing information on the AAP guidelines. The campaign also coordinated with community-based programs supporting safe sleep efforts, such as HMHB's *Cribs for Kids*.

Safe Sleep webpage: After eight months (September-April) of the SSH Coalition homepage launch, https://health.hawaii.gov/safesleep/, 388 users had viewed the website 714 times. Viewers stayed on the site for an average of 45 seconds. Documents were clicked on and/or downloaded 160 times.

SSH. The Native Hawaiian Keiki O Ka 'Āina Preschools and Infant/Toddler Centers joined SSH in 2023. This early childhood program integrates a Hawaiian culturally based curriculum with Montessori activities, utilizing Hawaiian language, values, and cultural principles. The organization led efforts to have the Mayors of Kauai and Hawaii Island both issue SS proclamations for October 2023. Because of the Maui County administration's focus on recovery from the August 2023 wildfires, the SSH Coalition did not seek a proclamation for Maui County.

Cribs for Kids (CFK): HMHB provided safe sleep education and cribs to over 180 parents and caregivers statewide as of May 2024. HMHB is working to translate the CFK program materials to reach those in non-English-speaking households. The program evaluation for 2023 reported the following client self-reported outcomes after three months:

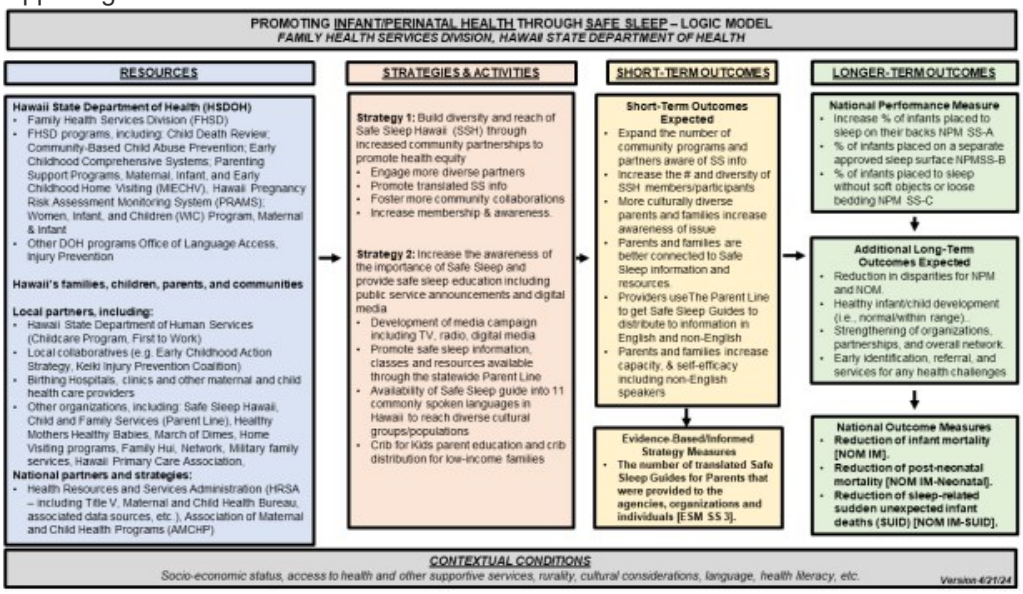
- 85% of clients continue to use a provided crib for their baby
- 98% of clients continue to place baby on their back when going to sleep
- 80% of clients continue to not place any blankets, pillows, or toys in the crib with baby
- 45% of clients continue to exclusively breastfeed
- 93% of clients continue to allow supervised tummy time

- 90% of clients did not allow family members in the household to smoke around the baby.

The follow-up contacts also provided an opportunity to reiterate SS and other health information and assist families with referrals if needed. HMHB, through its extensive partnerships, continues to assist families with referrals to needed support services, including SNAP, WIC, Medicaid, childcare, and referrals for other health-related needs. The CFK program aims to build a trusting relationship with clients so that the staff can identify and assist families with their health-related needs during the challenging postpartum period.

Review of the Action Plan

A logic model was developed for NPM SS to review alignment among the SS strategies, activities, measures, and desired outcomes. The program focuses on two primary strategic areas: engaging and diversifying community partners, expanding educational outreach, utilizing new media modalities, and targeting limited and non-English speaking families. Theseticipated to help reduce disparities, with improved outcomes reflected in future PRAMS data. The activities associated with the two strategies directly correlate with short-term outcomes and will also impact longer-term outcomes, including infant mortality. A copy of the Safe Sleep logic model is included in the Supporting Documents.



Challenges Encountered

Key staff changes: The supervisor for the Family Strengthening and Violence Prevention Unit (FSVPU) under the MCH Branch (MCHB), who served as the Title V program lead for safe sleep, left this position in October 2022. The FSVPU position was filled in September 2023, but the gap in staffing for the year created more work for the existing staff.

Housing Insecurity. Soaring housing costs, limited affordable housing options for residents, and inflation contribute to increasingly overcrowded households and housing insecurity in Hawaii. This translates to a greater likelihood of less safe sleep conditions, especially for vulnerable younger and lower-income families.

Maui Wildfires. Stresses after the August 2023 natural disaster significantly stressed Maui families, especially the overcrowding of families housed in temporary hotel rooms, relocating constantly to new FEMA housing/hotel options, and/or having to move in with family/friends. This level of displacement, unemployment, uncertainty, and stress increases the likelihood of unsafe sleeping conditions for families with infants.

Cribs for Kids (CFK) Remote Outreach The CFK program provides services to families virtually following COVID; however, there are plans to re-establish in-person classes, since some families have had difficulty accessing their online services.

Addressing Co-Sleeping: Hawaii PRAMS data confirms that co-sleeping is a common family/cultural practice in Hawaii. Initiatives such as Pack and Play crib distribution and education through the *Cribs for Kids Program* have proven effective nationally and locally with at-risk populations. However, addressing local/cultural beliefs and a general acceptance of co-sleeping continues to be challenging. The practice may be attributed to the state's ethnic/cultural diversity, with exacerbation due to household overcrowding, housing insecurity, multi-family living arrangements, and high housing costs. Data indicates that certain ethnic groups, young mothers, and low-income families are more likely to engage in infant co-sleeping practices. Working with cultural leaders and other community organizations is key to the success of targeted outreach to these at-risk populations.

Both the 2022 and 2024 Safe Sleep Summits address this critical challenge with culturally sensitive approaches, including 'The First Candle Straight Talk for Infant Safe Sleep.' The program's focus is on recognizing and addressing personal bias and improving communication skills to effectively engage with families.

Media Effectiveness: The Safe Sleep media campaign, *Safe Sleep Guide for Parents and Caregivers* (both in English and translated languages), and The Parent Line are primary vehicles for public health messaging. It is currently unknown to what extent the SS messaging has changed family attitudes and behavior around safe sleep practices. It is also unclear as to what extent service providers have utilized the translated SS information with their client populations. The safe sleep environmental scan currently underway will collect and document additional data to better determine the effectiveness of these efforts.

Overall Impact

Expansion of Media Outreach. COVID-related challenges fundamentally changed outreach efforts on safe sleep practices, with the program relying more on electronic/digital methods, which have increased virtual access to key information statewide. The *Safe Sleep Guide for Parents and Caregivers* was previously primarily distributed through printed posters to provider offices and is now widely available in electronic form via The Parent Line website. The website also provides virtual safe sleep parent and caregiver workshops at no cost to families. Written information on safe sleep guidelines and resources is available via regular mail by request.

The newly created DOH Title V safe sleep website and social media posts (Instagram and Facebook) are now available for service providers to share with their patients/clients and the general public. The home page was created at the request of the SSH Coalition.

Title V MCHB has worked on increasing statewide awareness of safe sleep education by promoting The Parent Line through public service announcements aired on TV and digital media, press releases, and television/morning show provider interviews. This brought more awareness of the issue to the general public, and also highlighted the available SS resources. Subsequent media posts will also include the new DOH website.

Service Supports. The statewide crib distribution programs offered by community-based organizations were paired effectively with safe sleep education to help families and providers needing support. This program is primarily geared toward lower SES families who were most affected by COVID restrictions, escalating economic challenges, and overcrowded living conditions. These community and social media-driven initiatives have strengthened widespread dissemination of evidence-based AAP safe sleep guidelines for infants.

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

Introduction: Food Insecurity Priority

For the Perinatal/Infant Health domain, Hawaii added a new state priority in FY 2021, to address Hawaii food insecurity based on the results of ongoing needs assessment. Expanding the use of WIC and other governmental food support programs continues to be a crucial step towards helping women, children, and families, during the economic difficulties exacerbated by COVID, along with Hawaii's escalating cost of living. This priority focuses on increasing enrollment and utilization of the FHSD's Supplemental Nutrition Program for Women, Infants, and Children (WIC), emphasizing outreach to families and populations that may not be aware of or accessing WIC's many benefits.

Data: The data for this measure comes from the U.S. Department of Agriculture's WIC user participation reports, which reflects12-month user averages. The national data indicates that participation for Hawaii WIC increased slightly through 2023, with 26,116 women, infants, and children total served by the program. WIC total enrollments are nearly 12% higher than in 2019, which reverses a pre-COVID trend of declining WIC enrollments since 2016, with a similar decline trend reflected nationally in many WIC programs.

The steady decline could be attributable to the state (and nation's) growing economy prior to COVID, the continued decline in births, as well as out-migration of Hawaii families due to the state's ongoing high cost of living.

There are several factors that could account for the recent enrollment increase, including Hawaii's escalating cost of living, improved collaboration with entitlement agencies and community service programs to promote enrollment in WIC, as well as WIC programmatic operational changes that include the continuation of remote online services.

Objective: By 2025, increase the total number of WIC participants in Hawaii to 28,000 pregnant women, infants, and children.

Title V Lead/Funding: The Hawaii WIC Services Branch is the lead program for this food insecurity priority, as WIC remains the largest public food security program in the state and nation that specifically serves pregnant and parenting women and their infants and young children with an array of health education and support. Although WIC services are not directly funded by Title V, WIC benefits from Title V-funded administrative supports and programmatic services, such as media, contracting, data analytics, and IT services.

Key Partners: WIC's many community partners include a wide range of programs and agencies which also serve low-income children and their families. These partners include: Federal entitlements programs (Medicaid, SNAP, and TANF); State offices (Hawaii Head Start Collaboration Office, Executive Office on Early Learning); the University of Hawaii's Center on the Family, Department of Health partners (Chronic Disease Nutrition programs helping to establish WIC Farmer's Market, Early Childhood, Women's Health, MIECHV), as well as a number of private sector community based organizations (Head Start, Hawaii Children's Action Network).

Evidence: There is strong national longitudinal evidence that demonstrates the effectiveness of the WIC program in addressing family food insecurity. For more than four decades, local and national researchers have investigated WIC's effects on key measures of maternal and child health, including birth weight; infant mortality; diet quality and nutrient intake; initiation and duration of breastfeeding; cognitive development and learning; acceptance of immunizations; use of health services; and childhood anemia. These findings strongly support WIC's demonstrated capacity to help significantly improve maternal, infant, and child health outcomes (Center on Budget and Policy Priorities, 2021).

Strategies: The new key food insecurity strategies for Hawaii are the findings of a Hawaii WIC workgroup that met monthly, from October 2021 through June 2022, to identify specific barriers and challenges, with the goal of increasing Hawaii's WIC enrollments and utilization. This work was supported by a Partnership for America's Children 2020 grant that was received by the Hawaii Children's Action Network (HCAN). HCAN convened the workgroup, in partnership with WIC and invited community, agency and family representatives. The group utilized the Federal Food Research and Action Center's (FRAC) May 2019 report, "Making WIC Work Better," as a guide for its process. Although there were several recommendations relating to barriers, challenges and improving access to WIC services, the key Title V WIC strategies identified were:

- Partner with agency and community programs to improve WIC enrollment and utilization
- Improve data collection and analysis to identify key barriers to WIC benefit utilization and enrollments.

A report on WIC food insecurity strategies and activities is discussed below.

Strategy 1: Partner with agency and community programs to improve WIC enrollment and utilization.
This grant strategy focused on maintaining and building on WIC's many community partnerships, in order to expand and improve on WIC enrollment and utilization.

WIC Data Sharing. One of the two key WIC Work Group recommendations was initiated in May 2022, when WIC executed a data-sharing agreement with the SNAP program, in order to align the enrollment process for clients, who are deemed eligible for both programs. Efforts were initiated to test migrating the referral data from SNAP to WIC; however, the data exchange was delayed to allow time for the WIC data contractor to modify the WIC data system in order to effectively link the two client datasets. The WIC system modifications are scheduled to be released in Spring 2025. While this work is occurring, promotional efforts were prioritized. A social media campaign to inform the public about dual eligibility for SNAP and WIC enrollment was developed and released in late summer of 2023. The FHSD and DHS communications staff collaborated on the development of images to be used for the social media campaign, as well as agency websites updates and a joint press release.

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

Although WIC does not currently share its program data with Medicaid, staff from both agencies share program eligibility and enrollment information with their clients.

WIC Farmer's Market & Food Hubs. As part of the implementation of the DOH Chronic Disease program's nutrition plan, WIC is working with community partners to increase WIC client access to nutritious locally grown produce, by authorizing WIC benefits for fruits and vegetables that are redeemable at community farmer's markets and food hubs. The pilot cohort for this project includes two farmer's markets and two food hubs, which are located in rural, predominantly Native Hawaiian communities. These projects are expected to increase access to fresh produce, while supporting local farmers, and promoting WIC with greater community visibility.

WIC Innovation Grant. Another WIC Work Group recommendation was completed, when HCAN submitted a successful WIC Community Innovation and Outreach Project (WIC CIAO) grant application. In May 2023, HCAN received an award of $530,312, which was one of 36 awards received nationally. The grant will be used to

implement added Work Group recommendations designed to develop and implement innovative outreach strategies, to increase WIC participation, improve benefit redemption and reduce factors leading to disparities in WIC program delivery. WIC and other partners met to finalize the work plans for this new WIC CIAO grant.

Strategy 2: Improve data collection and analysis to identify key barriers to WIC benefit utilization and enrollment

This strategy focuses on the primary data and research work in identifying and addressing key barriers to WIC benefit utilization and enrollment.

WIC Workgroup Assessment: HCAN completed a needs assessment of the Hawaii WIC program, which included examining census data and other local and national sources of information relating to child food insecurity, researching policies and systems in other states across the country that successfully maximize WIC utilization, as well as analyzing trends in Hawaii WIC program usage in recent years.

Utilizing 2019 Federal U.S. Department of Agriculture data, some of the key findings relating to Hawaii WIC participation rate were:

- In Hawaii, 83.8% of WIC-eligible pregnant and postpartum women, and 100% of eligible infants, participated in the WIC program.
- Only 42.5% of Hawaii's children (ages 1 to 4) eligible for WIC services participated in the program.
- A major limitation of the national WIC dataset was there is no disaggregated racial/ethnicity data, that was based on Hawaii's multi-ethnic populations. This made it difficult to determine which Hawaii sub-populations were less likely to be receiving access to WIC's services.

WIC Data Analysis: WIC finalized a data-sharing agreement with the University of Hawaii's Center on the Family (COF) in November 2022, and the WIC program datasets were provided to COF for analysis. COF found that, while the required data fields were complete for most clients, many of the optional fields had very high proportions of missing data, rendering them of little use for an analysis. In May 2022, COF presented a preliminary analysis of the WIC dataset, with initial drafts of the demographic client profiles for each county and its regional areas. The analysis revealed that the WIC population was predominantly of Native Hawaiian (34%), White (15%), Mixed (13%), Pacific Islander (11%), Filipino (10%), and Other Asian (10%) ancestry. This breakdown is not consistent with Hawaii state population ethnic data analysis, and there were some variations found by county. Other characteristics identified in the WIC population included:

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

The COF data analysis confirmed that the largest drop-off in WIC participants occurred after age one, which is a

similar pattern among most WIC programs nationally. Factors associated with longer participation with the WIC program included: Native Hawaiian ancestry, mothers who were also enrolled in WIC, the child or family members were enrolled in other entitlement programs, smaller household size, and older mothers. A final COF data analysis report and completion of the county profiles were due in July 2023.

Current Year Highlights for FY 2024 (10/1/2023 – 6/30/2024)

Maui Wildfires. In response to the August 2023 Maui wildfires that decimated Lahaina, WIC expedited the certification of new Maui retailers, expanded WIC food package options, and partnered with national manufactures to ship infant formula specifically for Maui WIC clients, as well as the Maui Food Bank. Maui WIC staff were engaged in immediate aftermath outreach, providing WIC enrollment information, and assisting with replacement of eWIC cards at emergency shelters for wildfire-displaced families. Maui WIC staff reported that WIC families who were displaced by the wildfires and located in emergency shelters were focused on using benefit to secure infant formula since there was no access to cooking facilities. This trend continued as families were relocated to temporary hotel rooms.

Relief efforts for Lahaina families focused on free distribution of ready-made meals. These services continued for many months. Additionally, Hawaii SNAP benefits were expanded for Maui SNAP enrollees to access hot foods/meals.

WIC Data Fact Sheets. The WIC fact sheets are expected to be released by summer 2024. Another contract is being executed with UH-COF to continue the WIC data analysis, with analysis of an additional year of data.

WIC/SNAP Collaboration. This DOH and DHS collaboration on dual eligibility and sharing of data continues, with the completion of the WIC MIS Spring 2025 software update.

WIC Farmer's Market & Food Hubs The four WIC Farmer's Market and Food Hub distribution pilot projects were successfully implemented in FY 2024. This pilot project will be evaluated, with programmatic modifications made, as needed. Additional WIC Farmer's Market and Food Hub project sites are in the process of being identified. One new farmer's market and two food hubs have recently been authorized on the islands of Oahu and Maui.

WIC Innovation Grant. HCAN recently hired a grant coordinator, who has "lived experience" as a former WIC client. New proposed activities include: the creation of a new colorful program logo, partnering with social media influencers to promote WIC services via engaging videos, sharing easy family recipes that utilize WIC-eligible foods, and sharing of family stories. HCAN has also worked with WIC local agencies, to further customize WIC outreach efforts for each agency's clients. The grant coordinator attends monthly WIC clinic site meetings, in order to ensure program coordination and collaboration occurs with all WIC locations.

Title V measure. The new 2024 Title V grant guidance includes a national performance measure (NPM) on child food insecurity. Hawaii may consider changing this state performance measure to the new NPM. The WIC program is being increasingly considered as a source of potential source of 'lived experience' input from families for other Title V and FHSD services.

Challenges Encountered

The WIC Working Group identified several barriers to accessing services, along with new opportunities to improve WIC enrollment, benefit utilization, and retention. This was accomplished by drawing upon the WIC Working Group's unique diverse perspectives and experiences with the WIC program.

The Working Group identified several potential opportunities for WIC program improvement in outreach and recruitment:

- Provide a technically-updated approach to communication with WIC clients, utilizing commonly-utilized and preferred methods for client contacts, including texting, email, and/or messaging directly to WIC staff. This included the delivery of timely e-reminders to clients, when they have an appointment due, or when their WIC benefits are about to expire
- Emphasize more cultural competence skill building in WIC clinic workers, and readily provide materials available in languages that are commonly used by potential WIC applicants and participants
- Partner with agencies that work closely with the Pacific Islander communities, such as We Are Oceania (WAO), the City and County of Honolulu's Resilience Resource Center, and the Big Island's Micronesians United (MU-BI)
- Conduct routine assessments and evaluations of the appropriateness and effectiveness of the WIC Program and its services in meeting the food security needs of its WIC participants

Overall Impact

Prior to the convening of the WIC Working Group, the WIC program had limited opportunity or capacity to dedicate significant resources towards improving the WIC program. Despite WIC's large budget, most of the staffing/resources go toward WIC operations, with few resources available for program enhancements. This unique private-public partnership brought sorely-needed resources, staffing, and supports to the state's largest and most significant maternal and child health program.

The WIC Working Group provided invaluable feedback from entities with different perspectives of the WIC program. The diverse composition of the Working Group – academics, advocates, WIC clinic staff, WIC state office staff, and WIC clients – enabled these diverse viewpoints to come together to work to better address WIC clients' needs.

The importance of the "lived experiences" of participating family voices also proved invaluable to the workgroup. WIC clients provided clear and candid input about their WIC services experience, as well as the significant challenges facing young families, given current socio-economic conditions. There will be a greater focus on collecting more of this experiential input in future programmatic research and planning.

COVID forced more of a focus on the impacts of food insecurity in Hawaii, as well as the importance of food/nutrition programs like WIC and SNAP. With the assistance of both private and public funding, there is greater collaboration and communication between the two Hawaii federal food assistance programs, in order to improve awareness and access to needed services.

Additional partnerships with the DOH Chronic Disease Nutrition program, as well as working with community partners, has enabled WIC to pilot four new farmer's markets and food hubs, as innovative and accessible options in expanding access to local fresh produce for WIC enrollees.

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

For the Perinatal/Infant Health domain, Hawaii selected NPM SS Safe Sleep based on the 2020 Title V needs assessment findings. The 2025 Title V state objective is to increase the proportion of infants placed to sleep on their backs to 86.0%. Objectives were also set for NPMs SS-B and SS-C. The work plan highlights the two safe sleep strategies listed below.

Strategy 1: Build diversity and reach of Safe Sleep Hawaii through increased community partnerships to promote health equity

This strategy emerged from Safe Sleep Hawaii (SSH). The implementation activities for this strategy include the following:

- Foster collaboration and partnership among community programs and stakeholders on safe sleep efforts, as well as other maternal and child health issues.
- Increase interaction with the SSH Coalition Instagram account and Facebook page.
- Increase awareness of the availability of translated Safe Sleep guides in all offered languages/dialects.
- Create new resources and messaging for Safe Sleep education that have been locally designed and tailored for a Hawaii audience.

A contract will continue with the SS consultant to ensure the Coalition's ongoing work.

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

Safe Sleep Summit. The SSH plans to hold an annual statewide Safe Sleep Summit in FY 2025, which will further examine the evaluation findings received at the 2024 Safe Sleep Summit. Normally, the event hosts national speakers, presents the latest data and evidence-based practices, and offers breakout groups to share local resources and identify/address key challenges.

Cribs for Kids. Based on the CFK evaluation results, funding for the program will continue, and areas for expanded support will be explored.

Strategy 2: Increase awareness of the importance of Safe Sleep and provide safe sleep education, including public service announcements and digital media

Media Campaign: Another Safe Sleep television and digital media campaign is anticipated for FY 2025. The campaign will be relaunched during October Safe Sleep and SIDS Awareness Month. Activities are expected to include a proclamation signing and a press release by the Governor and County Mayors. The Safe Sleep Guide for Parents and The Parent Line will be highlighted to share information on AAP guidelines and links to the new DOH SS website. The campaign will also coordinate with community-based programs that continue to support and educate on safe sleep efforts for Hawaii’s families.

Translation of Media Messaging: The television and digital media spots used in the campaign will be translated into several languages/dialects to reach limited and non-English speaking populations. The spots will be strategically aired and presented via venues to best reach more limited and non-English-speaking households.

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

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

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

The two strategies and plans presented below emerged from a Partnership for Children (PFC) grant, which ended in 2022. Although there were several recommendations, the two key Title V WIC strategies were:

- Partner with agency and community programs to improve WIC enrollment and utilization
- Improve data collection and analysis to identify key barriers to WIC benefit utilization and enrollments.

Strategy 1: Partner with agency and community programs to improve WIC enrollment and utilization

This grant strategy focuses on continuing and building on WIC's many partnerships to improve WIC enrollment and utilization. Future plans include:

- Work on the WIC/SNAP data-sharing MOA will continue through monthly meetings between DOH and DHS.
- The WIC four Farmer's Market and Food Hub distribution pilot projects will be implemented in FY 2024. This pilot project will be evaluated, with program modifications made, as needed. Additional project sites are being identified for phase 2.
- The Federal FRAC has announced an additional round of funding for WIC innovation grants. Community based partners and contracted WIC clinics are considering applying for this additional funding.

Strategy 2: Improve data collection and analysis to identify barriers to WIC benefit utilization and enrollments

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

- The University of Hawaii's Center on the Family will continue and expand its data analysis of the WIC dataset, with the 2020 calendar year data added to the 4-year dataset that was previously analyzed.
- Additional qualitative data collection will be carried out with WIC families, including the use of focus groups and key informant interviews, is planned in order to assess program retention issues, and targeting key sub-population groups: Native Hawaiians, Pacific Islanders (Micronesians and other COFA residents), as well as Filipinos.

Title V Perinatal/Infant Health Programs

The list of programs below focuses on infant/early childhood health programs administered by Hawaii Title V.

Newborn Hearing Screening: provides newborn hearing screening for babies as required by Hawaii state law to identify hearing loss early so that children can receive timely early intervention services.

Newborn Metabolic Screening: provides newborn blood spot testing for babies as required by Hawaii state law. The tests help detect rare disorders that can cause serious health, developmental problems and even death if not treated early.

Early Intervention Services (EIS): provides early intervention services for eligible children from birth to three years old with developmental delay or at biological risk, as mandated by Part C of the Individuals with Disabilities Education Act (IDEA). Services include care coordination; family training, counseling, home visiting; occupational therapy; physical therapy; psychology; social work; special instruction; and speech therapy. Parents/caregivers are coached on how to support the child's development within the child's daily routines and activities.

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

Birth Defects Surveillance: provides population-based surveillance and education for birth defects in Hawaii and monitors major structural and genetic birth defects that adversely affect health and development.

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

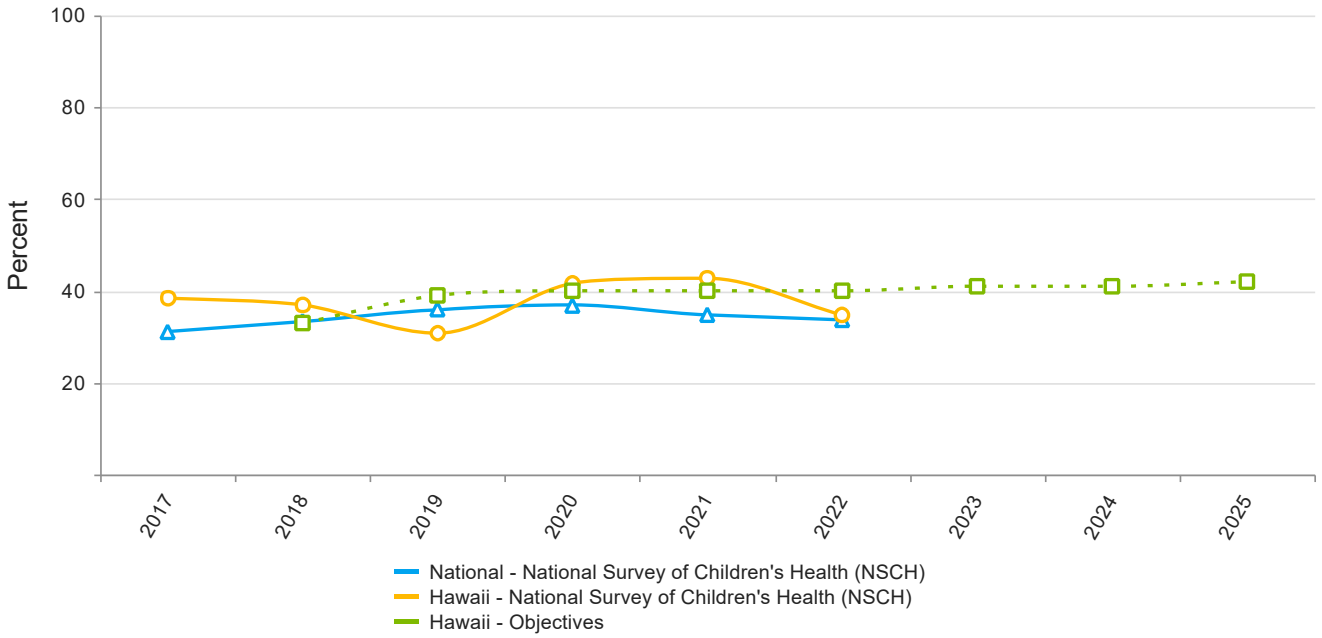
Hawaii Home Visiting: Through the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant, the Home Visiting Unit provides comprehensive early identification of high-risk families, including expectant families and families of newborns who may benefit from home visitation services to reduce health disparities by improving birth, health, and development outcomes through collaboration with and referral from birthing hospitals, physicians, WIC clinics, and community health centers.

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

Child Health

National Performance Measures

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



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	39	40	40	40	41
Annual Indicator	36.5	31.6	41.2	41.0	34.6
Numerator	13,201	12,899	16,334	15,213	12,730
Denominator	36,145	40,832	39,621	37,098	36,781
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	41.0	42.0

Evidence-Based or –Informed Strategy Measures

ESM DS.1 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations

Measure Status:	Inactive - Completed				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	12	18	24	27	30
Annual Indicator					
Numerator	23	26	26	28	30
Denominator	30	30	30	30	30
Data Source	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

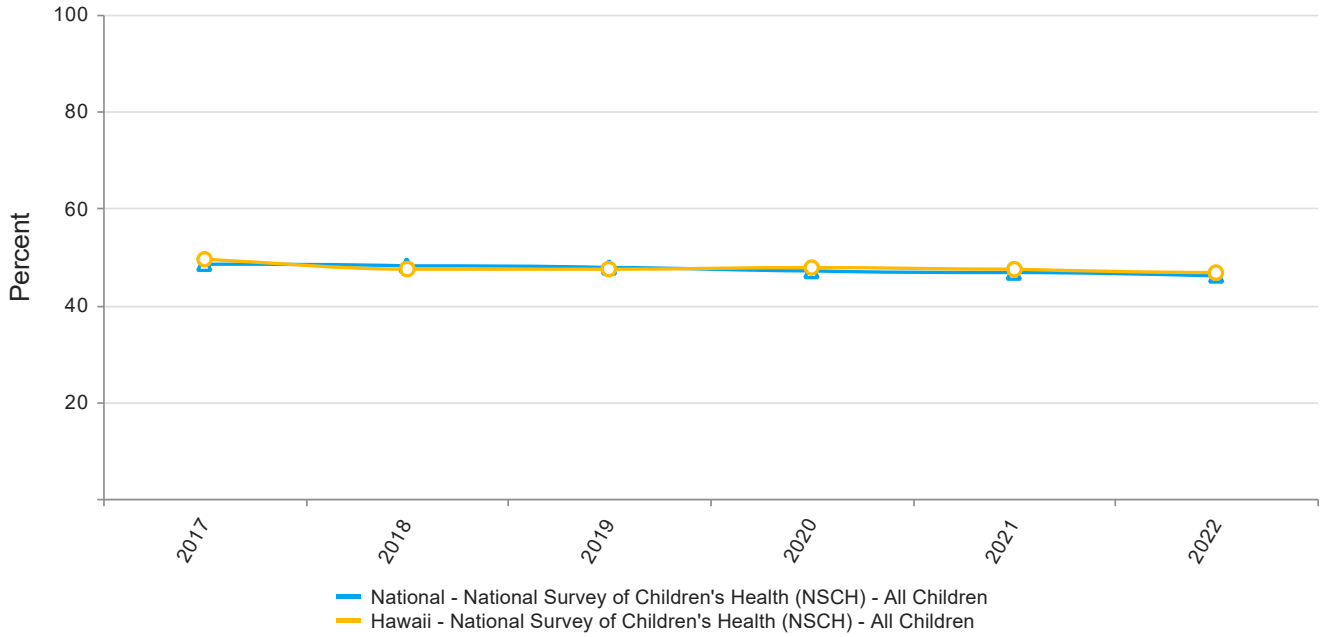
ESM DS.2 - The number of children screened through the Hi'ilei Developmental Screening Program using a standardized screening tool.

Measure Status:	Active

State Provided Data	
	2023
Annual Objective	
Annual Indicator	30
Numerator	
Denominator	
Data Source	Title V CSHN Branch H'ilei program
Data Source Year	2023
Provisional or Final ?	Final

Annual Objectives	
	2025
Annual Objective	50.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	46.6
Numerator	138,882
Denominator	297,934
Data Source	NSCH-All Children
Data Source Year	2021_2022

Evidence-Based or –Informed Strategy Measures

None

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					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	5.9	5.5	5.4	5	4.9
Annual Indicator	5.5	5.7	5	5.8	5.9
Numerator	584	591	508	587	565
Denominator	105,815	104,141	101,271	100,421	96,580
Data Source	DHS CAN annual report	DHS CAN annual report	DHS CAN annual report	DHS CAN annual report	FY 2022 DHS Databook
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	4.9	4.8

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

Measure Status:	Inactive - The Title V COVID child-wellness workgroup disbanded. The State Medicaid program is now convening regular EPSDT meetings to address service concerns.

State Provided Data				
	2020	2021	2022	2023
Annual Objective			75	76
Annual Indicator	73.2	63.8	63.8	64.8
Numerator				
Denominator				
Data Source	Hawaii Med-QUEST	Hawaii Med-QUEST	Hawaii Med-QUEST	Hawaii Med-QUEST
Data Source Year	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final

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 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	
Five-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 42.0%	
Strategies	
Develop and improve services infrastructure to better coordinate developmental screening efforts	
Improve developmental screening data	
Build the capacity of the Hi'ilei program to increase developmental screening and referral efforts for young children	
ESMs	**Status**
ESM DS.1 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations	Inactive
ESM DS.2 - The number of children screened through the Hi'ilei Developmental Screening Program using a standardized screening tool.	Active
NOMs	
NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR	
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS	

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

Priority Need

Improving access to medical homes for all children including children with special health care needs.

NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Five-Year Objectives

By July 2025, increase the percent of all children, ages 0-17, who have a medical home to 46.6%.

Strategies

Define the issues around the pediatric medical home by implementing a mixed method review of all available data on this population, with a focus on disparities including race/ethnicity.

Review the evidence based literature, emerging best practices, and expert opinion to identify pediatric medical home care strategies to improve medical home establishment and related care.

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

State Action Plan Table (Hawaii) - Child Health - Entry 3

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.

Five-Year Objectives

By July 2025, reduce the rate of confirmed child abuse and neglect cases per 1,000 for children to 4.8 per 1,000

Strategies

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

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

Promote health equity by addressing disparities in confirmed CAN cases

NPM DS – 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 DS Developmental Screening as a priority based on the 2020 five-year needs assessment. By July 2025, the State sought to increase the proportion of children ages 9 through 35 months receiving a developmental screening to 42.0%.

Data: Aggregated data from 2021-2022 indicated that the estimate for Hawaii (34.6%) did not meet the 2023 state objective (41.0%) but was not significantly different from the 2022 indicator (41.0%) and the national estimate of 33.7%. Due to the small sample size, results for this measure should be used with caution. The related Healthy People 2030 Objective for developmental screening (35.8%) was almost met. There were no significant differences in reported subgroups by health insurance status, household income, or gender, possibly due to the small sample size.

Objectives: Considering the baseline data, data limitations, and the HP 2030 objective, we set the state objectives to reflect an incremental increase in screenings completed at 42% through 2025.

Title V Lead/Funding: Developmental screening has remained a priority since 2010 for the Family Health Services Division (FHSD) 2010. The FHSD coordinates federal, state, and local efforts in Hawaii for developmental screening, referrals, and related services. The lead for this priority activity falls to the Children with Special Health Needs Branch's (CSHNB) Early Childhood Coordinator, a state-funded position. New CSHNB staff will be involved in building future program capacity for this priority. Title V does not directly fund developmental screening program staff and activities but does support management, epidemiology, data, and administrative positions, which contribute significantly to the work done on this NPM.

Partnerships: There is a broad collaboration among state agencies and community stakeholders working towards a statewide systematic approach to developmental screening. This collaboration includes medical partners, early childhood providers, and community-based nonprofits who conduct developmental screenings and ensure that children are appropriately referred to needed services or supports if a concern is identified. Development screening is also identified as a priority area in several key state plans, including:

- Executive Office on Early Learning (EOEL) Early Childhood State Plan for 2019-2024 and the Strategic Implementation Plan focusing on "Early Childhood Health and Family Wellness."
- Early Childhood Action Strategy (ECAS), Hawaii Community Foundation (HCF), and DOH's Infant and Early Childhood Behavioral Health Plan
- Maui County plan for the early childhood collective impact team, *Kākou for Keiki (Hawaiian translation: All of us [together] for children)*, which was formerly supported by the HRSA Early Childhood Comprehensive Systems (ECCS) grant.

Strategies/Evidence: Hawaii focuses on three developmental screening strategies utilizing systems-level approaches following the guidance:

- The American Academy of Pediatrics (AAP), in its January 2020 "Developmental Surveillance and Screening Recommendations and Guidelines," recommends incorporating developmental surveillance into regular health visits. Any concerns raised during surveillance should be addressed with standardized developmental screening tests, which should be administered regularly at the 9-, 18-, and 24—or 30-month visits.
- The Centers for Disease Control and Prevention (CDC) developmental surveillance checklists for the CDC

Learn the Signs. Act Early. Program that identifies evidence-informed milestones when most children are expected to reach a developmental milestone and supports clinical judgment regarding screening between recommended ages.

- The federal Administration for Children and Families (ACF) Child Care and Development Block Grant Act of 2014 encourages lead agencies to adopt policies to promote developmental screenings in childcare programs as an integral part of their Child Care and Development Fund (CCDF) state plans.

Hawaii recently revised its developmental screening strategies based on new grant funding and available staffing resources, along with the completion of several strategy activities. The current three developmental screening strategies are:

- Develop and improve services infrastructure to better coordinate developmental screening efforts
- Improve developmental screening data
- Build the capacity of the Hi'ilei program to increase developmental screening and referral efforts for young children

To align with these changes in strategies, ESM DS 1 was inactivated, and a new ESM DS 2 was added to reflect the new focus to establish
and build a new comprehensive CSHN Branch developmental screening service.

Hawaii works with both early childhood and healthcare programs to ensure that the national developmental screening standards are implemented. Recent research compiled by AMCHP and the MCH Evidence Center indicates that there is evidence-based support for training healthcare providers on developmental screening and screening through home visiting programs. Following these promising practices, Hawaii continues to provide community-based trainings on the Ages and Stages Questionnaires (ASQ) and CDC milestones to healthcare providers, early childhood providers, and families through the DOH Hi'ilei Developmental Screening Program and other initiatives.

Updates for FY 2023 on the three strategies follow.

Strategy 1: Develop and improve services infrastructure to better coordinate developmental screening efforts

The activities for this strategy focused on systems and policy development to better support increased levels of child developmental screening. Hawaii's healthcare and early childhood sectors are crucial partners in ensuring the four stages of developmental screening, which include screening, referral, service, and support, are implemented. Some of these key partners are highlighted below.

Project LAUNCH: In September 2023, Hawaii received a Substance Abuse and Mental Health Services Administration (SAMHSA) Project Linking Actions for Unmet Needs in Children's Health (LAUNCH) grant. The grant component of Screening and Assessments, designed to identify concerns and coordinate and collaborate with Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) programs, addresses developmental screening.

The overall goal of Project LAUNCH is to build capacity of adult caregivers of young children to promote healthy social and emotional development; prevent mental, emotional, and behavioral disorders; and identify and address behavioral concerns, before they develop into serious emotional disorders (SED).

Part of LAUNCH's efforts is to ensure that adequate infrastructure is in place for a functional communications and

referral system that provides for the documentation of screenings, referrals, and treatment. This will help ensure timely follow-up and treatment of children screened and identified who need more support to promote their optimal development.

As part of this grant, Hawaii focuses on the ASQ for developmental screening and ASQ Social Emotional (ASQ SE) for behavioral screenings. Project LAUNCH works closely with families, pediatric providers, and childcare providers to promote children's healthy social and emotional development.

Medicaid EPSDT Coordinators: Med-QUEST and DOH continue to share a strong collaborative partnership. Since COVID has subsided, Med-QUEST has reconvened regular EPSDT Coordinator meetings, where health plans and state departments share updates on programs and services that serve to augment Medicaid's health services. DOH programs that serve families and young children are often present at these meetings. CSHNB has provided participants with updates on resources related to developmental screenings and young children's mental health/social-emotional development.

The Survey of Well-being of Young Children (SWYC): DOH and Med-QUEST are currently partnering to promote the use of the SWYC since it was added to the national AAP list of validated screening tools. SWYC is a free tool that helps to assess behavioral and family well-being, including social determinants of health. Referrals stemming from SWYC may be more extensive than those covered by IDEA Part C (EI services) or Department of Education developmental services. Hawaii continues to work with partners on the adoption and full utilization of this tool, which can improve identification of young children and their families' socio-economic needs and reference cross-sector support that can effectively and efficiently meet their needs.

CSHNB developed a SWYC Resource List for sharing information statewide and by county for those who use the SWYC tool. It is also available on the DOH and Med-QUEST websites. Helpful resources are available for each question asked on the SWYC, and CSHNB continues to update the list as needed: https://health.hawaii.gov/cshcn/resourcelists/.

ECCS HIPP Grant: The HRSA ECCS HIPP strategic plan includes one of the performance measures that assess child development support through developmental screening. ASQ training for community providers continues to be conducted to support and enhance this outcome. ECCS HIPP received a complementary grant, Early Childhood Developmental Health Systems: Evidence to Impact grant (ECDHS), designed to assist with implementation of evidence-informed and equity-focused strategies from ECCS HIPP. ECCS HIPP piloted the online ASQ Enterprise System, which allows multiple programs to enter data on a web-based system to consolidate data management and reporting abilities. The pilot online ASQ Enterprise System is still being tested.

Child Care Development Fund (CCDF): The Administration for Children and Families (ACF) oversees the CCDF, which provides funding to states to help low-income families better access needed child care. Developmental

screening is essential to the CCDF's goals to support early childhood development and improve the overall quality of child care. CCDF also encourages the integration of developmental screenings into quality improvement initiatives within all childcare settings. DHS administers CCDF and is partnering with DOH to develop materials for childcare providers and families on Hi‘ilei services and other developmental screening resources, trainings, and activities.

Strategy 2: Improve developmental screening data

This strategy focused on acquiring better population-based developmental screening data to identify at-risk populations and underserved communities.

NSCH Data. Initially, Hawaii sought to work with the National Survey of Children's Health (NSCH) on data; however, the data sets did not align with Hawaii’s Title V efforts, which specifically focus on childcare and healthcare providers. The NSCH survey question focuses only on screenings conducted in healthcare settings. The NSCH data also has limited utility for Hawaii since it does not collect race/ethnicity data sets that reflect Hawaii’s Asian, Native Hawaiian, and Pacific Islander populations. It needs to provide county-level details needed to better focus program efforts. Subgroup data based on social drivers is also limited due to Hawaii’s small state sample size. As a result, Hawaii chose instead to focus on more useful state data available through the DHS Medicaid program.

Medicaid EPSDT Data: Although the State Medicaid program (Med-QUEST) reports on the Centers on Medicaid and Medicare (CMS) developmental screening quality measure, Med-QUEST staff expressed concerns about the data accuracy, given the mixed sampling method used for the measure. Therefore, they recommended utilizing CMS 416 EPSDT reporting data, as shown below.

Table 1. Data from CMS 416 FFY 2023

		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
7. SCREENING RATIO	CN:	0.80	1.00	1.00	0.94	0.65	0.69	0.62	0.24
Hawaii %	Total:	80%	100%	100%	94%	65%	69%	62%	24%

While Medicaid developmental screening data focuses on low-income children, the data for subgroups, including county level or race/ethnicity, remains inaccessible at this time. However, Med-QUEST is requesting child providers complete a more detailed EPSDT visit form, specifically inquiring about the completion of developmental and other preventive screens. Med-QUEST is working on preparing the dataset for analysis and plans to share this expanded data with DOH in the future.

CSHN Branch will continue to work with partners, including Medicaid EPSDT insurance plan coordinators, to explore other sources of information to identify developmental services/screening gaps and to better target screening efforts.

Strategy 3: Build the capacity of the Hi’ilei program to increase developmental screening and referral efforts for young children

This strategy focuses on expanding the CSHNB development screening program called Hi’ilei. A new Program Coordinator was hired for the Hi‘ilei Developmental Screening in 2023 to better support the program’s developmental screening and referrals. Hi‘ilei is a free resource for children ages birth to five years old and provides ASQ-3 developmental screens and information for interested families. The new Coordinator recently conducted a program assessment of previous Hi‘ilei program efforts and has since been working to re-establish and form new

connections with state and community partners to increase awareness of and improve access to the program.

Hawaii created a new ESM DS 2 to focus more on the Hi‘ilei Developmental Screening Program. This measure is preliminary as the program expands outreach efforts and develops a program workplan that reflects the current number of children screened, given past limited promotional efforts.

ESM DS 2 - ESM DS 2 - The number of children screened through the Hi’ilei Developmental Screening Program using a standardized screening tool

		2023	2024	2025	2026	2027	2028
Annual Objective		30.0	40.0	50.0	60.0	70.0	80.0
Annual Indicator		30.0					

Current Year Highlights for FY 2024 (10/1/2023 – 6/30/2024)

Maui Wildfires Response. Following the August 2023 Maui wildfires that burned downtown Lahaina, CSHNB has been hosting monthly meetings with Maui programs affected by the Maui Wildfires. The CSHNB Early Childhood Coordinator meets weekly with the Maui Early Childhood Resources Coordinator to discuss the needs of children in childcare programs and other programs affected by the wildfires. DOH staff have attended resource fairs to share information on available programs and services that support early childhood, as well as with Maui’s healthcare providers who are caring for young children and their families who may have experienced trauma. CSHNB continues to promote the Hi‘ilei program to children whose development may have been adversely affected by this event, as they are deemed a vulnerable population due to the significant disruption of lives and its impact on families.

Hi‘ilei Program: The Hi’ilei program assesses the various screening efforts in the community to identify areas of need and to determine how the Hi‘ilei Program might be expanded to help meet community needs. The intent is to increase collaboration with state and community partners to maximize resources; streamline access; and improve equitable access to screening, referral, service, and support systems for families. Hi‘ilei continues to meet with partners, such as Med-QUEST EPSDT Coordinators, DOE IDEA Part B 619 Coordinators, and MIECHV and EIS programs to share information and better address gaps in developmental screening referrals and services.

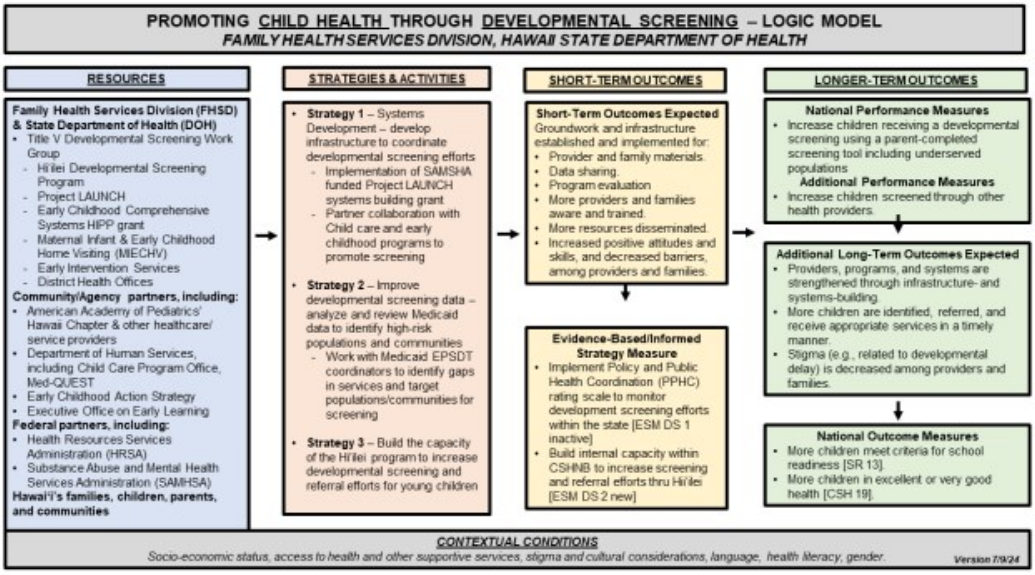
Project LAUNCH grant: In January 2024, a LAUNCH Kick-Off was conducted to orient the community on LAUNCH's planned activities. While DOH is still working on establishing new project positions, contracts for training on trauma-informed care and establishing community hubs in underserved communities in Kalihi and Kauai were procured.

Preschool Development Grant Birth through Five (PDG B-5): The University of Hawaii P-20 and the Executive Office on Early Learning (EOEL) manage the PDG B-5 to support efforts to enhance the early childhood system as well as improve children’s access to high-quality early care and education. One of the activities of the grant is to promote developmental, behavioral, hearing, and vision screening for 3- and 4-year-old children in the EOEL Pre-Kindergarten Program. Developmental screening is one of the quality benchmarks in the National Institute for Early Education Research (NIEER). It was included in the PDG B-5 to help optimize children's learning and development. The contract for the screenings is being finalized, and screenings are anticipated to begin in the Fall of 2024 school year.

Review of Action Plan

The logic model for Title V NPM DS was updated with revised strategies, including the new focus on expanding the Hi’ilei developmental screening program's capacity to help identify and fill in system gaps. The strategies reflect

community, local, statewide, and national initiatives. By working on these three strategies, Hawaii intends to increase the number of children receiving developmental screening statewide by addressing systemic issues and challenges.



Challenges Encountered

Challenges relating to developmental screening continue in several key areas.

Impact of the Maui Wildfires. Following the August 2023 Maui wildfires, priority attention was focused on families' immediate health, social, safety, and housing needs. This redirected many usual programmatic activities, slowly returning to the program routine as of early 2024. Hawaii had planned to participate in the MCH Workforce Development Center Cohort, but because of the lack of capacity and the change of date, Hawaii was not able to participate at the time but hopes to attend a future event

Lack of Coordination. While there is some improvement in referral and intake coordination, more infrastructure development is needed to better integrate services. With EIS's strict confidentiality standards in conferring with referring providers, the referral process is impeded when signed consents are difficult to attain. Hi'ilei and EIS are working to address the challenges from HIPAA and FERPA to see how to expedite support to families while working within the law. Project LAUNCH is also working with partners on a universal parental consent form, so parents would need only one form to complete. More interest in a coordinated intake and referral cross-sector system has largely stemmed from this statewide challenge.

Low Utilization of Hi'ilei: While the program was developed in 2013 to support children who might not be eligible for the DOH Early Intervention Section and to provide a reliable and accessible source of information for parents who may have concerns about their child's development, there has been a relatively low utilization rate of these services. Efforts to promote the program through various outlets and community outreach have been ineffective in reaching and motivating parents to enroll. For children transitioning out of EIS, Hi'ilei is offered as a key resource for families to help them keep track of their child's development, but only some families participate. This is an evaluative concern for DOH, which recognizes the importance of keeping this service available to parents despite the low utilization rate.

Overall Impact

Statewide Partnerships: The Early Childhood State Plan and other early childhood coalitions continue to identify developmental screening as a key health priority. Providers and partners are working collaboratively to stress the

importance of developmental screening via a validated screening tool. Providers understand this includes a services referral process, including timely and consistent communication with the child's medical home provider. The ongoing collaboration to promote a more seamless developmental screening and referral system continues.

Pediatric Providers/Early Childhood Partnership: Over the years, Title V has developed some key partnerships that continue to the present. These include pediatric providers in the AAP-Hawaii Chapter, particularly the Hawaii CDC Act Early Ambassador, Dr. Jeffrey Okamoto. Title V also continues to work with the Medicaid program to better reach and support this underserved population. Committed efforts by programs like MIECHV and other early childhood programs conducting developmental screenings contribute to collective statewide efforts. Working with early childhood providers, systemic efforts are continuing to promote developmental screening and sharing of information with the child's medical home provider. Standardizing the completion of developmental screening in early childhood services and well-child visits will help to ensure that universal developmental monitoring and follow-up occur.

Data: Title V will continue to work with the Hawaii Medicaid program to secure disaggregated developmental screening data to help inform strategies and activities that will increase screenings. Approximately 40% of Hawaii's children are insured through Medicaid, but Hawaii's efforts must also address the 60% of children on private or without health insurance. When available, detailed EPSDT office visit data currently reported by pediatric providers will provide vital insights into child health status and provider performance.

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

Introduction: Child Abuse and Neglect Prevention

The 2020 Title V needs assessment confirmed that Child Abuse and Neglect (CAN) prevention should be continued as a priority, under the Child Domain. Child maltreatment continues to be an important concern for the state. Community needs relating to child abuse and neglect span the spectrum, from primary prevention services to support at-risk families, as well as improvements to the child welfare service system, to promote family unification and to prevent children from unnecessarily entering or remaining in foster care for longer than necessary.

Data: The latest data for confirmed child abuse cases is from a different agency report. The annual State Child Abuse and Neglect Report was not published this year; thus, the normally reported *unduplicated* CAN case count data is not available. Instead, the numerator is reported from the annual Department of Human Services (DHS) Databook which only reports total confirmed cases. Thus, the data is not comparable to data reported in previous years. Characteristics for FY 2022 total cases reflect:

- Cases for ages 0-5 years represents 40.9% of all reported confirmed cases.
- Hawaiian/Part Hawaiian (38.9%) children continued to be overrepresented among confirmed CAN cases for all age groups, largely attributed to historical, systemic racism, socio-economic factors, historical discrimination policies and practices, and poverty.
- The second largest group represented in this data were white (21.0%) children.

There was a broad array of reported types of child abuse & neglect reflected in 2022 data: threatened harm remained the most common type of reported mistreatment, followed by maltreatment, physical abuse and sexual abuse.

In 2022, the most highly-reported **precipitating factors** of abuse or neglect of children of all ages were:

- inability to cope with parenting responsibility (69.6%), and
- unacceptable child-rearing methods (66.9%),followed by

- drug abuse (34.5%).

More than one precipitating factor could have been reported for each case.

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

Title V Lead/Funding: The Title V Child Abuse and Neglect Prevention Program (CANP-P) is administratively located in the Maternal and Child Health Branch (MCHB) within the Family Support and Violence Prevention Section (FSVPS). The section includes other programs: Sexual Violence Prevention, Domestic Violence, Parenting Support, and Maternal Infant and Early Childhood Home Visiting (MIECHV). The CANP-P is funded by the Administration for Children and Families (ACF) Community-Based Child Abuse Prevention (CBCAP) formula grant. Filling the CANP-P coordinator position with reliable, qualified staffing has been an issue, since October 2022. While Title V does not directly fund CAN prevention activities, it does fund key staff positions related to the support of the program, including MCH Branch support staff, such as the Branch research statistician.

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

- Community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs, and activities to help prevent and address CAN
- Support the coordination of resources and activities to strengthen and support at-risk families, to reduce the likelihood of CAN occurring
- Foster greater understanding, appreciation, and knowledge of diverse populations, in order to effectively prevent and treat CAN in at-risk families

Strategies: Child abuse and neglect (CAN) are complex problems rooted in social and health inequities, unhealthy relationships, and unstable environments. Preventing CAN requires simultaneously addressing multiple levels of individual, relational, community, and societal factors. Hawaii's CAN strategies were selected to reflect a public health systems approach:

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

Evidence: While CAN Prevention is not a Title V national priority, recent research presented by the MCH Evidence Center that was derived from the Child Safety Network, supports Hawaii cross-cutting strategies that leverage partnerships to better establish and support increased evidence-based/informed CAN programs and practices.

Updates for 2023 on the three strategies follow. Because program staffing remains a persistent issue, planned activities be delayed or postponed.

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

This strategy focuses on the key system partnerships CAN-P supports to ensure that a coordinated statewide system of services exists to prevent and address CAN. This partnership approach is based on State, local, and community programs having specific responsibilities, strengths and expertise in reducing CAN, while building safe and resilient families and communities. Interagency collaborations across family and child-services systems

include: public health, child welfare, education, early childhood service providers, law enforcement, and health providers, as well as other public and private agencies and organizations. Collectively, these diverse partners help to strengthen and support families, by addressing the specific needs of children and their parents/caregivers. A list of the key CAN agencies/programs follow.

Department of Human Services (DHS). DHS is a key partner for DOH in Hawaii to provide leadership on CAN, since it houses Child Welfare Services (CWS) and core family entitlement programs, such as SNAP, Medicaid, and affordable housing support. The 2018 Federal Family First Prevention Services Act (FFPSA) shifted the focus of the child welfare system toward maintaining children's safety within their families, via family-strengthening services and supports.

The CANP-P has partnered with DHS and others to develop and implement the State Child and Family Services Plan (CFSP). Efforts under this plan focuses on improving connections to family strengthening resources, including identifying service gaps and piloting new family support programs, such as the Zero to Three Family Court and the ‘Ohana Visitation Time System of Care model (‘Ohana means family in Hawaiian).

Family Resource Centers (FRC). FRC utilize an evidence-based approach to provide coordinated, accessible program supports that target at-risk communities/populations.
In 2022 a 5-year FRC program was established by the State Legislature that was tasked to coordinate statewide efforts to develop FRCs. This FRC program is located within DHS, and it coordinates partners across state departments as well as private providers.

FRCs are a critical way to prevent CAN, while strengthening families. They effectively connect families to a range of needed services, create opportunities for community-level coordination and connections to CAN resources and support systems, and work diligently to enhance family engagement. National research has shown that FRCs have lowered rates of CAN cases, reduced the number of children needing to enter foster care, and decreasing parental unemployment, which is a risk factor for CAN.

The FRC program ensures that community and school-based FRCs coordinate as a statewide network, establishing practice/training standards and developing appropriate referral/data protocols to better serve families. CAN-P assisted in this effort, by providing training/technical assistance for the four DOE school-based FRCs established on Oahu, and is also part of the statewide FRC organization, called the Hawaii Family Ohana Support Network: https://www.hawaiiohanasupportnetwork.org/

In 2023, the state FRC Coordinator was hired, and subsequently convened a cohort of public-private agencies in an intensive team-building process, which was facilitated by One Shared Future (OSF). OSF is a unique organization that was created by a former state Department of Human Services director, which is designed to support public professionals and their community partners to initiate effective organizational and community change, by fostering collaboration and innovation. Following the 10-session training, the CAN collaborative cohort established stronger cross-sector relationships as well as ideas to lay a foundation to drive future FRC work. Title V staff actively participated in this cohort.

Department of Education (DOE): The Hawaii DOE, with over 167,000 students, is a key agency partner, in statewide efforts to identify, report, treat, and prevent CAN. The DOE Trauma Recovery Project ensures that income-eligible students who have experienced trauma, receive trauma-specific mental health services. This Project expands the capacity of DOE counselors and other staff by training them on the use and implementation of Trauma-Informed Care (TIC) as the standard across the entire DOE school system. TIC practices emphasize that agencies and programs serving children and families who experience any form of violence, understand the impact

of trauma on child development, and understand how to minimize its effects when providing TIC services. Hawaii DOE staff are regularly invited to participate in CANP-P-sponsored training events.

Office of Wellness & Resilience. Another CANP-related state legislative bill that passed in 2022, created the U.S.'s first statewide Office of Wellness & Resilience. This state administration-housed office focuses on promoting wellness and resilience efforts across all affected state departments to develop a comprehensive trauma-informed services system that better supports Hawaii families, while improving overall community health. CANP-P and several Title V programs are actively involved in this collaborative effort.

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

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

The CANP program continued to sponsor and support trainings and conference attendance, sponsorships for staff and community partners.

National Alliance for Children's Trust Funds (NACTF): CBCAP funds were used to support attendance of six community partners, who serve as HCTF community advisors, to attend the NACTF conference in November 2023, titled "Celebrating the Stories that Strengthen and Connect Us." Lessons learned from the Conference underscored the need to connect components of child welfare to macroeconomic supports, which empower and uplift families in need. There was timely discussion at the conference on how to better de-link neglect from child abuse cases, clarify mandated reporting vs mandated supporting, confirm the positive impact of family resource centers, and related CAN priority policy issues.

Institute on Violence, Abuse and Trauma (IVAT). CBCAP also helped sponsor the IVAT conference held in Honolulu in November 2023, which addressed an array of topics, from violence prevention to child welfare initiatives. Funding to support the attendance for both staff and community partners was provided via CANP.

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

Parent Leadership Training. The CBCAP actively supports parent leadership and participation in both the planning and implementation of grant-funded CANP initiatives. In 2023, CANP-P funded a hybrid Parent Leadership Training Institute (PLTI) cohort. PLTI is an evidence-based model that provides participating parents with core technical and practical skills/knowledge, in order to be effective advocates with their own children, as well as change agents in their own communities. Participating parents attended a total of 20 evening sessions, culminating in the completion of a community project, that demonstrated their capacity to apply their learned skills into practice. Several PLTI community projects addressed CANP issues, such as creating a women's peer-peer support group for pregnant women who were abused as children, and an indigenous-focused leadership program for mothers and daughters.

Conferences. The FSVPS and MCHB Home Visiting Unit collaborated on a two-day virtual Summit in April 2023, that focused on personal and professional wellness and resilience for providers who are serving children ages 0-5 years and their families.

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

Based on existing CAN disparities-related data, CBCAP funds were awarded, under the American Rescue Plan Act (ARPA), and distributed to community-based providers who are serving primarily at-risk communities and populations, including Native Hawaiians and Micronesians, as well as families with lower incomes.

Community Based Services. Over $600,000 in ARPA CBCAP funds were contracted out with community organizations statewide, in order to provide services to help prevent family violence, while supporting and enhancing family strengthening and resiliency. These contracts included support for the Maui CAN Prevention Coalition and the Hoʻoikaika Partnership.

These community service programs offered:

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

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

Nā Kama a Hāloa (NKAH). A group of Native Hawaiian organizations and service providers, known as Nā Kama a Hāloa, has been meeting since 2018 to address and improve outcomes for Native Hawaiian children and families involved in CWS. Native Hawaiians are historically over-represented in the CWS program. The network's recent achievement includes:

- Creation of an advisory council of parents with experience in the CWS system, to provide experiential input on how to improve child welfare services.
- Creation of a peer support program for parents currently in the CWS system, as well as pregnant women experiencing substance use disorders.
- Development of a new training on Native Hawaiian history and cultural training module for CWS new hires, existing staff and contracted providers.
- Made CWS practice changes to better support sibling connections for children who are in foster care.

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

Native Hawaiian Perspective Training. Through a contract with HCAN, CBCAP funded the development of a training series in partnership with NKAH that focuses on Native Hawaiian perspectives for CAN prevention. The training series involves an initial, foundational presentation that is open to a wide audience, followed by four

focused more intensive training sessions with a smaller cohort. The foundational presentation is virtual, and open to members of the HCTF and other individuals and organizations working at the intersections of CANP, domestic violence prevention, legal advocacy, and economic justice. The 4-5 smaller training sessions (1 hour per session) are virtual, and culminate in a field trip to a traditional taro farm, emphasizing traditional practices and values, in the final session.

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

Current Year Highlights for FY 2024 (10/1/2023 – 6/30/2024)

Maui Wildfire Response. Several purchase of service contracts were issued to support community based services efforts to meet the immediate needs of Lahaina families that were displaced by the August 2023 inferno. Many families were compelled to evacuate with little warning, leaving their homes or workplaces without any supplies, daily medications, or clothing.

Maternal, Infant, and Early Childhood Home Visiting (MIECHV). In response to the Maui wildfires, the MIECHV Maui service area was expanded to include Lahaina families, focusing on supporting community linkages and networks as an immediate need and protective factor. MIECHV continued the practice of gatherings for enrolled families to meet each other and participate in program activities. After the fires, many displaced families were temporality relocated from emergency shelters into empty hotel rooms. Because MIECHV families were confined by the small hotel spaces, meetings were held outside the hotel. Lahaina lost many of its meeting places during the fire, making community convenings difficult, so people often met on the beach. With more flexible funding, the program was also able to provide families with needed basic daily necessities and resources. MIECHV providers also expressed concerns about witnessing increases in interpersonal violence (IPV), due to the post-fire stresses, uncertain futures and the added impact on children of witnessing IPV.

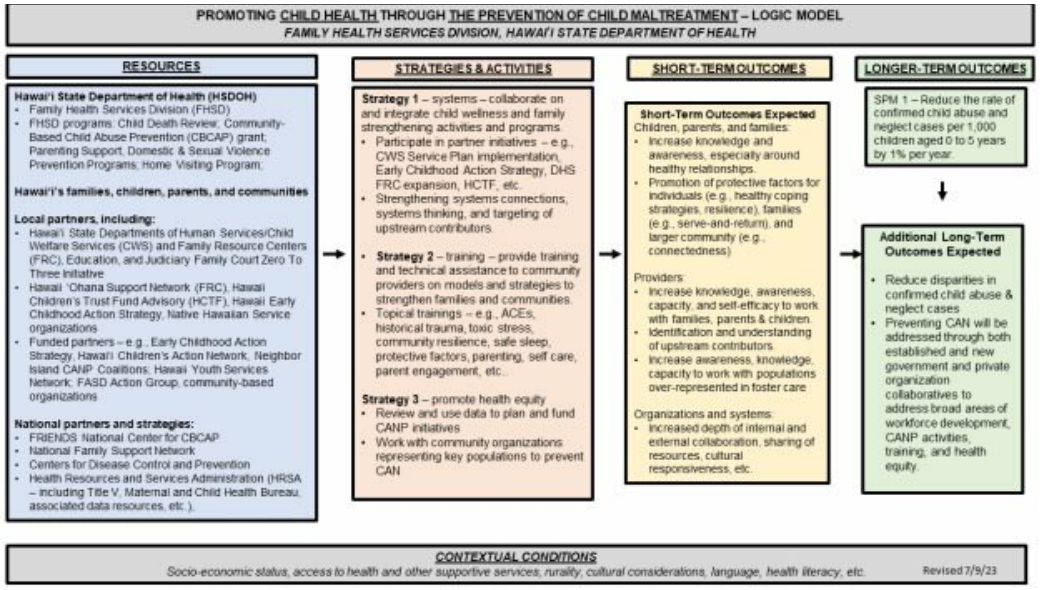
Community Based Services. CBCAP funds continue to support community organizations statewide to provide services to help prevent family violence, while supporting family strengthening/resiliency. The services also help to promote specific protective factor strategies to help prevent CAN.

Mālama Ohana Working Group Listening Sessions. The working group is conducting statewide listening sessions with families who have experience with the child welfare/foster care system, with a strong focus on the Native Hawaiian community. The information collected will help to plan for and implement improvements to the CW service system, including more prevention/diversion program supports.

Conferences/Trainings. CAN-P is assisting in co-sponsoring the 2024 Safe Sleep Summit in June, as an integral aspect of protective parenting practices.

Review of Action Plan

The revised CANP logic model provides an overview of the strategic approach to prevent CAN. The effort cannot be addressed as a standalone public health concern, instead incorporating a diverse array of public partners/resources to address CAN in Hawaii. The logic model also confirms the importance of acknowledging and addressing contextual conditions that impact and influence CAN negatively or positively, in tandem with programs that specifically target family violence prevention.



Challenges and Barriers

Social contributors to family stress: The socio-economic consequences of COVID continue to impact Hawaii families, primarily reflected by inflationary economic stressors. The social signs and consequences are typically associated with family stress and violence, due to under- and unemployment, lack of affordable childcare, unaffordable housing, and increased financial insecurity, due to Hawaii's increasingly-high cost of living.

Workforce Shortages: The MCHB continues to grapple with recruiting and maintaining qualified and committed staff to lead the CAN-P program and manage the CBCAP grant. Staffing shortages are a pervasive problem through the state services system. The Hawaii Children's Trust Fund Coalition members recently participated in a workforce development/training survey. The survey findings confirmed common staff-related recruitment and retention challenges, including;

- Job applicants often lacked the necessary position-related credentials.
- Low salary levels did not attract more qualified applicants.
- Staff workload stress grew, due to the number of agency's staff vacancies.
- Required use of hybrid virtual work scheduling did not always support staff needs.
- There was a lack of professional development and career pathways for current staff.

In response to the challenges, some organizations have expanded professional development trainings, and widely co-share position recruitment announcements. The DHS/CWS recently expanded online learning opportunities for their staff. The CANP is planning to issue a contract to expand on online CAN educational modules for service providers and families.

Reaching Families Remotely: Since COVID, many family support services to communities and families have moved to online/virtual platforms. Clients residing in rural areas of the state often lack access to broadband, digital devices, and skills to use software programs. In response, federal relief funds were deployed during COVID to support the purchase of IT equipment for selected community providers and families, including CBCAP funds. Federal infrastructure funds continue to expand/improve broadband access statewide. Lack of direct family/child contact by providers has also made it more difficult to assess family dynamics and needs for intervention services.

Overall Impact

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

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

Child Health - Application Year

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

For the Child Health domain, Hawaii has selected NPM-DS, Developmental Screening as a continuing priority, based on the Title V 2020 five-year needs assessment. By July 2025, the state seeks to increase the percentage of children ages 9 through 35 months receiving a developmental screening to 45.0%.

Hawaii will focus on the new strategy measure by utilizing the Hi'ilei Program as the primary DOH entity to conduct developmental screening at no cost to parents, as well as a complement to screenings conducted via the child's medical home. This model is similar to what other states use with Help Me Grow®, which is a system of supports for pregnant women, caregivers with new babies, and families with young children who have developmental delays and disabilities.

Strategy 1: Develop and improve services infrastructure to better coordinate developmental screening efforts

Hawaii will continue to work with partners to strengthen and implement the statewide system for developmental screening, referral, and services. These efforts are part of the State Plan for Early Childhood, which developed from the strategic plan for the federal Preschool Development Grant Birth through Five (PDG B-5) and the Child Care Development Fund (CCDF) State Plan.

Project LAUNCH grant: CSHNB will work on implementing the LAUNCH grant to promote developmental screening and other screens to identify children who may have developmental or behavioral concerns and to refer their families to appropriate mental health services to help address and mitigate severe emotional disturbances (SED).

Maui Early Childhood Wellness Campaign: CSHNB will continue to offer and assess screening activities for families of young children who may have been affected by the 2023 Maui wildfires. CSHNB is seeking to partner with Maui County to develop a wellness campaign targeted to parents and childcare providers, with services and supports on how to best support a young child's development.

Strategy 2: Improve Developmental Screening Data

The existing Hawaii Medicaid program data for the developmental screening CMS quality measure will be reviewed and assessed. A request for further disaggregation of the data will be submitted, although the state Medicaid program is currently focused on eligibility redeterminations that were delayed due to the Maui wildfires. Medicaid progress on the EPSDT-related office visit data collected from pediatric providers will also be reviewed and assessed once the dataset is cleaned and prepared for analysis and findings generated for review.

While the CMS 416 data indicates that nearly all children on Medicaid are meeting EPSDT screenings via their well-child visits, DOH will also focus on children being served by community health centers (FQHCs) to support universal screening efforts further.

Strategy 3: Build the capacity of the Hi'ilei program to increase developmental screening and referral efforts for young children

Hi'ilei Developmental Screening Program: CSHNB plans to focus more on program evaluation and re-envision the

program scope of services to better address the statewide challenges and needs for developmental screening, especially considering ongoing changes in healthcare delivery. Purchase of an ASQ Enterprise license that can be used more broadly programmatically will also be explored. Results of the Enterprise license piloted in Maui County are being reviewed to assess the challenges and benefits of expanding developmental screening there.

Training on ASQ for Staff Working with WIC Programs: CSHNB and public health nurses will conduct training on the administration and interpretation of the ASQ:3 and ASQ:SE2 screening tools, which will potentially increase the number of developmental screenings conducted for clients in WIC waiting rooms.

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

For the Child Health domain, Hawaii selected Child Abuse and Neglect (CAN) prevention as a continuing state priority, based on the 2020 Title V 5-year needs assessment. By July 2025, the state seeks to reduce the rate of confirmed child abuse and neglect cases per 1,000 children, ages 0 to 5 years, from 5.9 to 5.2. Plans to address this objective and SPM are discussed below.

The CAN strategies reflect a broader public health systems approach:

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

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

Preventing CAN will be addressed through continued public and private collaborative initiatives that address broad areas of workforce development, CANP activities, training, and health equity.

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

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

The goal is to develop an integrated CAN prevention continuum of services, policies, and practices across the state and with county government offices and programs. This will include strengthening the current collaborations and establishing new partnerships with state offices and programs that address CANP, including the Hawaii State Departments of the Attorney General and Public Safety, the Fatherhood Commission, and the Executive Office on Early Learning. This includes new collaborations efforts that incorporates the Family Resource Centers and the State Office of Wellness and Resiliency, to further support and strengthen the child welfare system.

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

Public and private collaboration and integration will be supported through statewide CANP activities and training/workforce opportunities. The HCTF Coalition and the individual neighbor island coalitions represent diverse and broad membership that is involved in the execution of CANP activities, to be supported by CANP program funds.

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

The CANP Program will continue to support training, as needed, throughout the CAN service system. Content is expected to include building individual and community resilience, trauma-informed and trauma-responsive systems of care, protective factors, and Standards of Quality for Family Strengthening and Support. Trainings offered will utilize a range of modalities: virtual, on-demand/online, as well as in-person.

The CANP Program will also partner with internal and external partners on other related CAN training topics such as: safe sleep, safe and effective discipline, and domestic violence. Improved collaboration with the MIECHV and the Home-Visiting Network will be an important focus over the next year.

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

The CANP Program will continue to support training that focuses on historical and cultural trauma experienced by Native Hawaiians and Pacific Islanders, as well as the effects of trauma on special populations (military, children with disabilities, children and families experiencing incarceration or homelessness).

Many of the service contracts supported by CBCAP funds were disbursed to community-based organizations that are addressing disparities associated with living in an underserved rural area, as well as race/ethnicity. The CANP will monitor implementation of these contracts, in order to ensure identified projected outcomes. Based on individual program evaluations, these efforts are expected to eventually develop into useful models for emerging evidence-based interventions and practices.

NPM Medical Home (MH): Percent of all children, ages 0-17, who have a medical home

For the Child Health domain, the new Title V grant guidance added a new universal performance measure that all states are now required to address: children who have a medical home for CSHN, and all children. Objectives for this measure have been set through FY 2025:

- By July 2025, increase the percent of all children, ages 0-17, who have a medical home, to 46.6%.

Data: The data for this measure is from the National Survey on Children's Health (NSCH). Aggregated NSCH data from 2021-2022 indicates that the estimated percentage of children ages 0-17 with medical homes in Hawaii (46.6%), was similar to the national estimate of 46.1% for all children ages 0-17. No significant change in the estimate was reflected, when compared to the 2019-2020 NSCH estimate. Based on the 2021-2022 NSCH aggregated data, those children who were below 100% of the FPL (31.5%) were significantly less likely to have a medical home, when compared to those children who were at 200-399% of the FPL (48.4%), or those who were at, or above, 400% of the FPL (55.8%). Children whose parents were high school graduates (39.2%), or whose parents reported having some college education (37.8%), were less likely to have a medical home, when compared to those children whose parents were reported to be college graduates (53.5%).

Objectives: The state objectives through 2025 remain the same as the baseline data over the next 2 years since programmatic initiatives have yet to be implemented.

Strategies: The strategies for this priority are:

- Define the issues around the pediatric medical home by implementing a mixed method review of all available data on this population, with a focus on disparities including race/ethnicity.
- Review existing evidence-based literature, emerging best practices, and expert opinion resources to identify pediatric medical home care strategies to improve medical home establishment and related care.

Plans to address this objective and NPM are summarized below.

Strategy 1: Define the issues around the pediatric medical home by implementing a mixed method review of all relevant data, with a specific focus on disparities.

This strategy recognizes that both quantitative and qualitative data for this measure needs to be collected, reviewed, and analyzed. The work on the Title V needs assessment will be used to develop a better understanding of access to a medical home for children since this measure is a composite of 5 separate questions regarding:

- care coordination
- family centered-care
- having a personal doctor or nurse practitioner
- accessing referrals, as needed
- having a usual source of care.

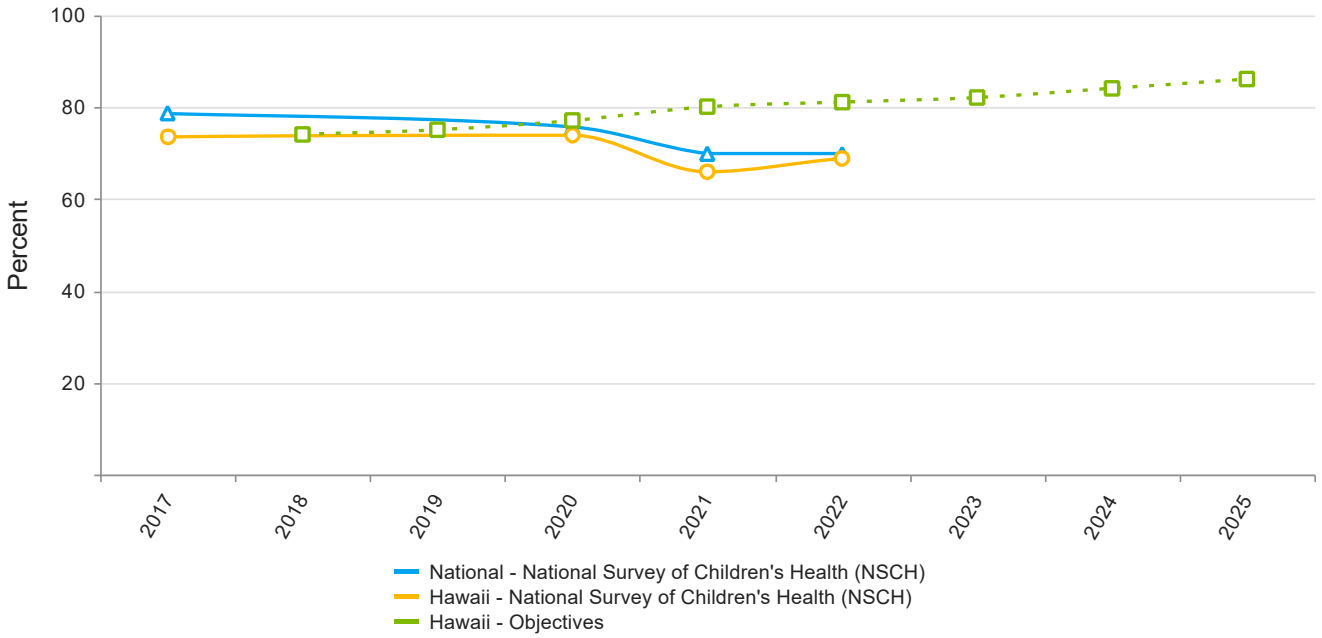
Strategy 2: Review the evidence based literature, emerging best practices, and expert opinion on pediatric and adolescent medical home care to identify strategies to improve medical home establishment and related care.

Strategies and activities to address the issue of increasing the percentage of pediatric and adolescent medical homes will be developed, based on the 2024-25 needs assessment findings and recommendations, a review of the evidence based research, as well as recommendations and input from medical home care providers, as well as families, and programs.

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	75	77	80	81	82
Annual Indicator	74.6	77.7	73.4	66.3	68.9
Numerator	74,226	76,702	71,318	63,067	65,633
Denominator	99,470	98,664	97,099	95,187	95,192
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	84.0	86.0

Evidence-Based or –Informed Strategy Measures

ESM AWV.1 - Develop and disseminate a teen-centered Adolescent Informational Resource (AIR) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective		18	23	25	28
Annual Indicator					
Numerator	13	20	26	27	27
Denominator	30	30	30	30	30
Data Source	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	
Five-Year Objectives	
By July 2025, increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 86%	
Strategies	
Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits	
Engagement. Work with adolescents and youth service providers to develop and disseminate informational resources to promote access to adolescent preventive health services	
Workforce Development. Provide resources, training, and learning opportunities for youth service providers and community health workers to promote adolescent health and wellness visits	
ESMs	**Status**
ESM AWV.1 - Develop and disseminate a teen-centered Adolescent Informational Resource (AIR) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits	Active

NOMs

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

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

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

NPM AWV - 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 AWV (preventive medical visits) based on the 2020 Title V five-year needs assessment findings. The 2025 Title V state objective for NPM AWV is to increase the percentage of adolescents who have had a preventive medical visit in the past year to 86.0%.

Data: Aggregated data from the 2021-22 National Survey on Child Health (NSCH) indicates that Hawaii (68.9%) did not meet the 2023 state objective (82.0%), but it was similar to the national estimate of 69.7%. The increase from 2020-2021 (66.3%) and the decline from the 2019 estimate (77.7%) were both non-significant when compared to the 2021-2022 estimate (68.9%). The Hawaii estimate did not meet the related Healthy People 2030 Objective to increase the proportion of adolescents who had a preventive health care visit in the past year (82.6%).

Based on 2021-2022 aggregated data, adolescents of parents who were high school graduates (49.6%) or who had some college education (62.1%) were less likely to have preventive medical visits than those whose parents were college graduates (79.9%). Adolescents whose parents were unmarried (45.7%) were less likely to have preventive medical visits than those whose parents were married (75.5%). Adolescents with Special Health Care Needs (SHCN) were more likely to have preventive medical visits than non-SHCN (85.5 vs 65.7%).

The 2021 Hawaii Youth Risk Behavior Survey (YRBS) reported a 1.0% decrease in preventive medical visits for high school teens. For teens in 2019 who reported seeing a doctor for a check-up or a preventive physical exam, visits declined slightly, from 64.0% in 2019 to 63.0% in 2021. These numbers may be inflated if adolescent respondents reported their sports physicals as a wellness visit.

Neighbor island disparities remain, with Kauai County high school youth reporting the lowest percentages of adolescent wellness visits, followed by Hawaii County and Maui County youth. High school students of other Pacific Islands ancestry reported the lowest percentage of preventive medical visits, followed by Filipino and Native Hawaiian students.

Objectives: After reviewing the baseline data and the HP 2030 objective, the state objectives through 2025 were updated to reflect approximately a 10% improvement over five years.

Title V Lead/Funding: The Title V Adolescent Health Unit (AHU) in the Maternal and Child Health Branch (MCHB) is the lead for the AWV measure. The AHU administers the federal Personal Responsibility Education Program (PREP) grant and assists with managing state-funded contracts that support women's reproductive health. The AHU coordinator is partially Title V funded. At this time, the two AHU positions remain vacant, pending recruitment and hiring.

Strategies/Evidence: The four strategies for this measure are based on guidelines from the national Office of Adolescent Health's *Think, Act, Grow (TAG) Call to Action,* designed to promote adolescent health via a comprehensive approach that focuses on working with varied stakeholders. The strategies are:

- Collaboration. Develop partnerships with community health and youth service providers to promote adolescent wellness visits.
- Engagement. Work with adolescents/youth service providers to develop and disseminate informational resources.
- Workforce Development. To promote adolescent wellness visits and provide resources, training, and learning

opportunities for adolescent caregivers, community health workers, and other service providers.
- Health Equity. Develop self-help resources, tools, and services to address health disparities for teens and young adults of Pacific Islands ancestry and all other young adults in Hawaii.

Research compiled by AMCHP and the MCH Evidence Center was reviewed to identify any recent additional evidence for Hawaii's strategies. AHU uses several strategies that the National Adolescent and Young Adult Health Information Center recommends, which are also cited in the evidence-based literature. These include building collaborative networks with agencies and institutions at the systems level and building capacity in communities to reach youth-serving professionals, parents, guardians, and other caring adults to engage adolescents to share their voice and to better structure how teens access and receive information of interest and of concern to them. The MCH Evidence Center identifies this ESM as an 'innovative tool' to track AWV efforts and notes that it "is a strong measure of an evidence-based strategy."

Strategies to address the NPM for adolescent preventive visits are discussed below.

Strategy 1: Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits.

The Title V AHU continues to build community partnerships with teens, youth service providers, parents, and other community organizations that are working to promote adolescent health and wellness visits.

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

PREP: AHU PREP contracts serve the most high-risk incarcerated youth, or those in residential facilities, to provide them with information on adolescent wellness, collect youth input to develop relevant resources, and provide workforce training to the PREP providers on the evidence-based Teen Outreach Program® (TOP®) curriculum. Information on AWV was also integrated into the TOP curriculum and program evaluation. The PREP programs provide information on a wide range of adolescent wellness topics, including active promotion of wellness visits. The CSHN Branch's "*Footsteps to Transition*" infographic was also incorporated to help initiate conversations about AWV and the importance of scheduling a regular health wellness appointment.

PREP services are contracted out via youth-serving organizations. Recent changes in PREP contractors, primarily due to administrative and staffing shortage issues, have presented barriers to fidelity in implementing the TOP curriculum. The current contractors are the Hawaii Youth Correctional Facility, known as the Kawailoa Family and Youth Wellness Center (KFYWC), Parents and Children Together (PACT), and Hawaii Friends of Restorative Justice (HFRJ).

The KYFWC is administered by the state Department of Human Services, Office of Youth Services (OYS). The program is a "last resort" residential facility for more than 30 court-involved youth, 16 to 18 years of age, from across the state. The youth corrections officer (YCO) training coordinator reported positive changes in the climate/culture of the facility and the adolescent resident due to TOP, as well as other staff development training offered through AHU. Each teen resident receives a medical assessment from the facility physician upon entry. AHU continues to work with the YCO training coordinator to provide more resources to the healthcare services currently being provided to the facility's average daily census of 30 KFYWC teens.

KYFWC takes a restorative justice approach, rather than a punitive focus, in its work with youth residents receiving services from the multiple organizations on its campus. KYFWC has leveraged its campus facilities to house multiple community organizations that help to address identified gaps in health care for its residents. These gaps include shelters for homeless youth (RYSE), a residential workforce and skills development program (Kinai Eha), and an agriculture program (Farm to Table) that focuses on learning traditional Hawaiian values and agricultural practices.

Parents And Children Together (PACT)—PACT provides afterschool drop-in centers for youth ages 7-18 to help promote the development of healthy youth, families, and communities with abundant positive experiences, including educational, recreational, community-building, and support services. PACT collaborates with the AHU in capacity-building activities and has identified four certified staff members who are TOP facilitators.

Hawaii Friends of Restorative Justice (HFRJ)—The mission of HFRJ is to train, advocate, develop programs, research, and provide education on evidence-based practices that help to rehabilitate, heal, and give hope to youth in the urban, low-income community of Kalihi. HFRJ has participated in capacity-building activities to certify four HFRJ staff members to serve as TOP facilitators.

Palama Settlement Partnering with the MCH Branch Child Abuse and Neglect program, AHU sponsored a youth program at Palama Settlement (PS), an established local community center in Honolulu serving the nearby urban low-income and immigrant community. PS is adjacent to a large state public housing development, with nearly 80% of tenants who moved from Pacific Island jurisdictions. The funds assisted PS in developing evidence-based youth summer programs that support school engagement, health/well-being, and career/personal aspirations. The Career Camp program hosted a series of business, university, and public sector leaders to encourage and sometimes mentor youth regarding potential academic, personal, and career options.

Other Community-Based Organizations AHU continued to expand and strengthen connections with the state's youth-serving organizations to promote healthy relationships, adolescent health, wellness visits, and connections with caregiving adults through virtual meetings and webinars. Partners include the Hawaii Youth Services Network; Office of Youth Services; Hawaii Partnership to Prevent Underage Drinking; Youth Tobacco Prevention Coalition; DOH Chronic Disease School Health program; Prevent Suicide Hawaii Taskforce (PSHT); Mental Health America of Hawaii; After School Program Alliance; Weed & Seed Hawaii; Atherton YMCA; Department of Education; Boys & Girls Club; Na Leo Kane; Big Brothers Big Sisters Hawaii; Hawaii Alliance of Nonprofit Organizations; Partners in Development; KUPU; Family Programs Hawaii; Catholic Charities; EPIC Ohana Inc.; We Are Oceania; The Salvation Army Hawaiian and Pacific Islands Division; Kokua Kalihi Valley Comprehensive Family Services; University of Hawaii Health Centers; and P.A.R.E.N.T.S., Inc.

YRBS: AHU participates on the Hawaii Health Survey committee, which consists of representatives from the Department of Education, University of Hawaii, Office of Hawaiian Affairs, and DOH Chronic Disease School Health program. The Committee provides oversight for the Youth Risk Behavioral Survey (YRBS), which is administered in odd-numbered years, currently including an AWV-specific question, "*When was the last time you saw a doctor or nurse for a check-up or physical exam when you were not sick or injured?"*

Strategy 2: Engagement. Work with adolescents and youth service providers to develop and disseminate informational resources to promote access to adolescent preventive health services.

This strategy focuses on developing online adolescent informational resources (AIR) to build knowledge, promote healthy behaviors, and improve skills that enable youth to better access healthcare and community resources. These online resources are also advertised and readily available to health educators and outreach staff so that they can share/connect teens to needed services and/or healthcare.

Youth Input: Since 2020, AHU has worked with teens and young adults from the Coalition for a Drug-Free Hawaii's (CDFH) *TeenLink Hawaii* (TLH) program to conduct health and wellness surveys designed to assess their knowledge, attitudes, and concerns about their health.

Surveys have validated that many youth did not initially believe an AWV was important but later recognized the benefits of knowing your health status and learning ways to improve health. Teens typically cited doctors as the best source of health information, but most identified their parents as more immediate and accessible sources for reliable health advice, as well as the internet and social media sources. Based on these results, TLH youth staff have developed resource materials on the TLH website that address health-related topics of highest concern and/or that appear in a timely manner.

Website: The TLH youth leadership groups continue to maintain and update the TLH website regularly. The website continues to receive approximately 2,500 site visits on average each month. In 2023, 24,418 TLH website visits were reported, with 20,478 being unique visits and 33,973 page views. The top topics/pages that are visited are: Volunteer Opportunities; TeenLink Hawaii Home page; Suicide; Self-Care; Mental Health; Sleep; Health and Wellness Toolkit; Dealing with Anger, Stress, Youth Leadership, Nutrition and Health Eating; Emergency Contacts; Mushrooms; Runaways; Depression; Marijuana; and Romantic Relationships.

Social Media: The TLH Instagram site remains active, with posts and stories highlighting prevention messages on a variety of topics. As of the end of 2023, the Instagram page had 1,041 followers.

Presentations: TLH's outreach and educational activities for youth have included 26 presentations that reached 912 youth and teens, focusing on drug prevention, health and wellness, and TLH resources. Presentations are conducted primarily for elementary and middle school students who contacted TLH for a presentation or are part of CDFH prevention programs. TLK also participated in 23 resource fairs in 2023, sharing a wide range of prevention information and health and wellness resources.

PREP Youth Input: Youth involved in PREP service sites provide valuable information on their knowledge of AWV, health topics of interest, and their preferred methods for receiving key health information. While most teens possess health insurance, most reported that they did not know their specific health insurer's name, did not carry their health insurance card, and did not have any experience making a doctor's appointment for themselves.

Youth Summit: To engage more diverse and underserved youth populations within the state, the AHU began conducting annual youth summits in 2020. The in-person summits were halted during COVID-19 and restored in 2022. A new approach to the Summit design was developed with the Hilopa'a Family to Family Information Center to be more youth-driven and utilize a retreat-style gathering while incorporating healthy youth development principles. PS Summer Career Camp (CC) youth were used as the pilot group in the 1-day meeting. Youth partnered with mentors to identify an issue or need in their community and then developed ideas for actionable plans to address the identified issue. Following the summit, these participants regularly met to work with their adult mentors on a plan of action with plan implementation following.

The Evidence-Based/Informed Strategy Measure (ESM) selected for adolescent wellness is ESM AWV 2: Develop and disseminate a teen-centered Adolescent Informational Resource (AIR), collaborating with community health and youth service providers to promote adolescent health and annual wellness visits. The measure uses a scale to track

progress in the development and dissemination of AIR. Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 30. Scoring is completed by Title V AHU staff, with input from key stakeholders.

The 2023 indicator scored 27 out of 30 points, a 90% completion rate. This is credited to significant progress made by working directly with youth to assess, revise, and promote the AIR via *TeenLink*. The most current data collection form is below.

Needs Assessment. AHU is using the Title V needs assessment to collaborate with community partners and closely listen to youth voices to identify Title V adolescent health priorities and strategies.

A few revisions were made to the ESM checklist, reflecting the strategy activities' evolution over the past five years. This priority, strategies, and measure will be evaluated and reconsidered as part of the 2025 needs assessment process.

ESM AWV 2 – Develop and disseminate a teen-centered Adolescent Informational Resource (AIR) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective			N/A	N/A	20.0	23.0	27.0	28.0	29.0	30.0
Annual Indicator			9	13	20	26	27	27		

Element	0 Not met	1 Partially met	2 Mostly met	3 Completely met
Strategy 1: Collaboration				
1. Utilize/maintain partnerships with youth servicing programs to promote AWV and adolescent health, including AHU service contractors and other Title V and DOH programs, community coalitions, and organizations.				X
2. Introduce CSHN's "Footsteps to Transition" to contractors and outreach staff to utilize the infographic to show participants where they are in their transition to adulthood and to direct the warm handout conversation to the topic area needed.				X
3. Maintain listserv of adolescent health stakeholders and, if available, collect adolescent-developed information for incorporation into the AIR/TeenLink.				X
4. Develop a local resource list of speakers on issues affecting adolescent behaviors.			X	
Strategy 2: Engagement: Adolescent Informational Resource (AIR)				
5. Promote the TeenLink Hawaii website as the “teen and young adult go-to site” for teen-centered resources, tools, and services, which includes the Footsteps to Transition and other AIR materials developed by teens and young adults.				X
6. Conduct assessments to determine adolescent awareness of the AWV and the perceived barriers to accessing an AWV.				X
7. Assess service provider and informant information to ensure the AIR/TeenLink provides useful health and resource information that meets the needs of adolescents.				X
Strategy 3: Workforce Development Training for Community Stakeholders				
8. Maximize opportunities to inform internal direct service providers and community stakeholders regarding AWV visits through the AIR.			X	
9. Utilize the listserv to inform the work of lead adolescent health advocates regarding webinars, in-person training opportunities, and other adolescent resources, including positive youth development, teen pregnancy prevention, mental health first aid, gender orientation, and the benefits of AWVs.				X
10. Assess stakeholders for increased knowledge and comfort level post-training.			X	
Total Points	27			

Strategy 3: Workforce Development. Provide resources, training, and learning opportunities for youth service providers and community health workers to promote adolescent health and wellness visits.

AHU provides training and technical assistance (TA) on adolescent health and positive youth development to youth and other service providers and continues training on positive youth development and protective factors as part of the PREP program. During 2022-23, AHU continued to provide staff development webinars and online training opportunities.

TeenLink Hawaii (TLH) is one of the "go-to" websites for adolescent health and wellness tools and resources, with Instagram Posts, IGTV, TikTok and YouTube videos, print resources, infographics, and more. The site was developed by teens for teens, their parents and caregivers, and youth service providers. AHU sends the recorded introduction to *the TeenLink Hawaii* workshop every quarter to neighbor island agencies serving families. In 2022, additional informational resources were added on self-care and wellness, how to use telehealth services, and mental health resources, which were also shared on social media posts. CSHN’s neighbor island staff routinely utilize TLH as their transition to adult healthcare information website.

Current Year Highlights for FY 2024 (10/1/2023 – 6/30/2024)

Here are some highlights of current adolescent health activities for FY 2024, including continued impacts and changes.

Maui wildfire response AHU/PREP supported HYCF's service learning project, which involved youth assembling 'go bags' for displaced Lahaina children and teens housed at emergency shelters due to the August 2023 Maui wildfires.

Needs Assessment. AHU is using the Title V needs assessment to collaborate with community partners and listen to youth concerns to better identify future Title V adolescent health priorities and strategies.

PREP: PREP contractors continue to offer youth development services to underserved and incarcerated youth. The PREP curriculum continues to include information on adolescent wellness and actively promotes wellness visits. While the HRFJ contract will end in December 2024, services will continue through PACT, a program that addresses the same urban geographic location.

PREP Expanded Curriculum. To further disseminate PREP evidence-based program options to more youth service programs, AHU solicited feedback from youth service organizations to help identify program formats that would best fit their existing youth services settings. Afterschool programs were identified as youth service providers' most prevalent activity setting. A UH public health graduate intern assisted AHU by sharing research on PREP evidence-based programs that work more effectively in an afterschool setting. The *Making Proud Choices* program was selected after securing additional feedback from youth providers and will be included in future PREP service contract solicitations.

Service Provider Training Hilopa'a was awarded a contract to promote and provide training on the Positive Youth Development and Pregnancy Prevention curriculum to youth service programs statewide. Hilopa'a will also pre-test the *Making Proud Choices* curriculum at the Palama Settlement youth program and host a training session with youth service providers on the TOPS curriculum.

New PREP Partners In addition, Hilopaa will assist in capacity-building activities intended to increase the number of and access to Hawaii's PREP program contractors. In current development is a collaboration with a residential Substance Abuse Rehabilitation program, the State Judiciary (diversionary programs, Drug Court, Girls Court, probationary youth), and Catholic Charities youth programs.

Youth Career Camp. Based on the success of the 2023 youth summer 'Career Camp' program, Palama Settlement is expanding the program in 2024 to include more sessions, including an introductory session and another, as well as one for 'returning' youth from 2023. Staff from the FHSD's Pediatric Mental Health Access grant are also assisting with these youth programs.

MCH AHU staff vacancies. The MCH Branch is currently recruiting to fill both vacant AHU positions. It is anticipated both positions will be filled by FY 2025. AHU is being overseen by the Women's Health Supervisor, who formally worked as the AHU coordinator.

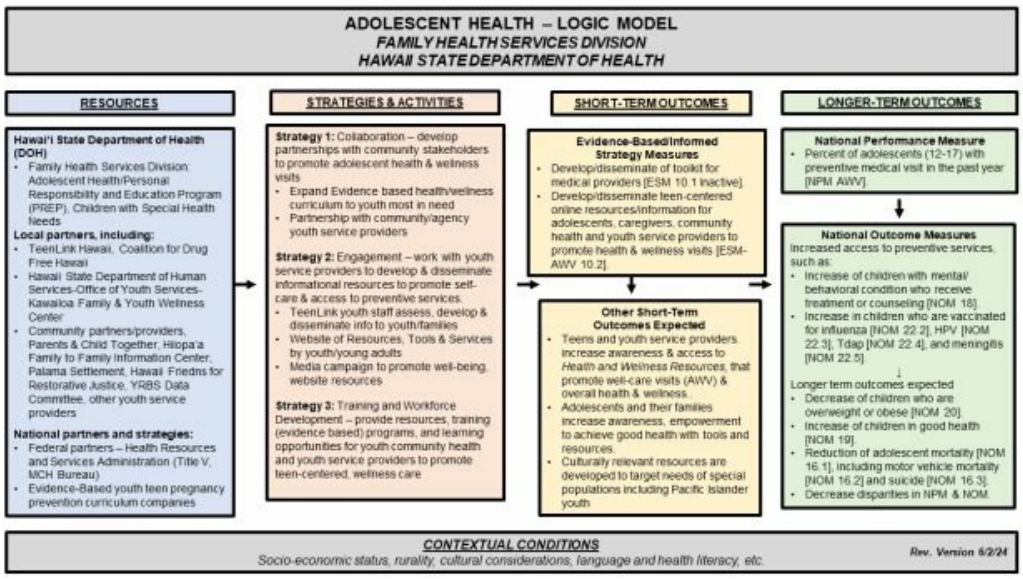
TeenLink updates: The *TeenLink* youth leadership groups continue to regularly maintain and update the TLH website, social media messaging, and presentations.

Medicaid The MCH Branch's EPSDT coordinators continue to attend EPSDT coordinators meetings to share

information on their and other child/youth services and collaborate on multi-agency efforts to promote and increase adolescent wellness visits.

Review of the Action Plan for 10/1/2022 - 9/30/2023

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



Challenges and Barriers

AHU's AIR continues to promote positive health behaviors, including self-care and lifestyle factors; encourage youth to take greater responsibility for their health decisions; provide teens with essential information that they need to connect with their healthcare providers; develop the teen's ability to schedule well-visits; and link youth to needed health services (e.g., AWVs) and resources.

Data on AWVs remains low, likely due to several factors, including the lack of regular healthcare access, the state's lack of primary care physicians, and competing family priorities that may lead to delayed or missed medical visits. Ongoing misconceptions persist that doctor visits are for illnesses only, that preventive visits require unaffordable out-of-pocket costs, and that annual required school sports physicals are the same as an AWV. New players in the healthcare market, such as 'minute clinics' and urgent care centers, also pose tracking challenges to AWVs. Busy families sometimes use these convenient, community-based options as a primary but temporary source of acute care, which can undermine the benefits of the more comprehensive AWV provided by a long-term regular medical home.

Working with specific populations to address health disparities has been challenging. However, new partnerships with community centers, such as Palama Settlement, along with expanded PREP curriculum options, are expected to extend the reach of adolescent wellness efforts while addressing healthcare access disparities among youth.

Operationally, AHU continues to contend with critical staffing shortages within the Unit, Section, and Branch, including both AHU positions. Efforts to recruit and fill these essential positions are ongoing.

Overall Impact

AHU's greatest success has been with youth engagement. AHU's commitment to engaging youth in assessing their health concerns and development and disseminating health education and messaging has culminated in youth-designed information offered via the statewide *TeenLink* website and social media.

Another significant success is the partnership with CSHNB to coordinate AWV and transition messaging, including participation in an MCH ad hoc cohort.

PREP has successfully partnered with agencies that are working with some of the state's most underserved youth to promote health and wellness and its commitment to address significant health equity issues. State youth correctional program directors have been receptive to new approaches to their health curriculum since their internal program resources were limited. Partnering with programs that state agencies administer also simplified contracting, as these residential programs were deemed essential services and were therefore largely unaffected by the 2020-22 COVID lockdowns/restrictions.

Adolescent Health - Application Year

NPM AWV - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

For the Adolescent Health domain, Hawaii selected NPM AWV: Adolescent Preventive medical visits as a continuing priority, based on the 2020 Title V five-year needs assessment. By July 2025, the state seeks to increase the percentage of adolescents, ages 12 through 17, completing a preventive medical visit in the past year to 84%. Plans to address this objective are discussed below.

Moving forward, the Adolescent Health Unit (AHU) strategies will continue with:

- Collaboration. Develop more partnerships with youth service providers to promote adolescent health and annual wellness visits (AWV) to reach diverse populations.
- Engagement. Establish more working relationships with service providers with access to adolescents and young adult groups to develop relevant information tools, services, and resources; provide insight on how health-related information is sought and received; assist in promoting self-care; and provide assistance in better accessing adolescent preventive health services.
- Workforce Development. Provide further resources, training, and learning opportunities for youth service providers and community health workers to promote greater access to 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 AHU will continue to build partnerships with community health and youth service providers that routinely work with groups of teens and/or young adults to promote adolescent health and wellness visits.

PREP Expansion. AHU will continue to work with youth service providers to promote PREP evidence-based curricula that address AWV and other adolescent wellness topics via school and community venues. Existing staff position vacancies may, however, temporarily constrain these PREP outreach activities.

Collaboration will continue with other youth-serving programs, including the Title V CSHN and other community-based organizations working with children and families in low-income, under-resourced communities statewide.

Update the listserv of adolescent health stakeholders to share staff development training opportunities and new resource materials to be incorporated into the *TeenLink* Hawaii one-stop website and to continue supporting and promoting adolescent resources and tools statewide.

Strategy 2: Engagement. Work with adolescents and youth service providers to develop and disseminate to promote access to preventive health services.

The Title V AHU will continue to partner with adolescent-serving organizations to develop innovative outreach methods, with regular guidance from teens and young adults. The *TeenLink Hawaii* (TLH) teen leadership groups will utilize their peer survey research findings to develop further resources and materials, update and maintain the teen-driven TLH website, and develop more effective media platforms, designs, and tools designed to engage their peers on health matters and promote adolescent AWVs.

The teen groups will also assist in co-presenting TLH information to peers, families, and other youth organizations and conducting educational presentations in local middle and high schools. Content will include national and local online information, local services resources, and various teen-centered health and wellness materials.

Other activities planned for the coming fiscal year include:

- Engaging other youth groups to utilize and share the TLH materials through other community-based agencies

and organizations, including the PREP program sites. PREP program surveys will also be expanded to collect additional essential input on health matters for the Title V needs assessment and to further refine *TeenLink* resources.

- Palama Settlement youth programs will also use a new software application to capture youth voices and expand needs assessment data collection efforts, which could also be used at neighbor island youth summits.

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

AHU will continue working with the CSHN Branch to engage Youth with Special Health Needs clients and their families. It will also develop informational resources specific to this population's needs on the TLH website.

Strategy 3: Workforce Development. Provide resources, training, and learning opportunities for youth service providers and community health workers to promote adolescent health and wellness visits.

AHU will continue providing adolescent health training and other technical assistance to PREP grant contractors and other youth service organizations. Training will be provided on both TOPS and Making Proud Choice curriculums, the latter tailored for afterschool settings. AHU will continue to solicit diverse stakeholder input on topics of interest and as new methods for training delivery.

Title V Adolescent Health Programs

Adolescent Health programs under the Hawaii Title V program include:

Adolescent Wellness: Spans across the physical, mental, and social-emotional aspects of adolescents and young adults 10 to 24 years. Concentration on high school graduation, sexual health, positive youth development, and transitioning into adulthood.

Personal Responsibility Education Program (PREP): The grant aims to fund the implementation of evidence-based positive youth development programs that broaden the cognitive context of abstinence and contraception for the prevention of pregnancy, sexually transmitted infections, and HIV/AIDS. This includes decision-making, self-regulation, and other adulthood preparation subject areas. This program targets services to high-risk, vulnerable, and culturally underrepresented youth populations between the ages of 10 and 24. Hawaii funds are used to implement the Teen Outreach Program (TOP) curriculum at the Youth Challenge Academy residential facilities on Oahu and Hawaii Island and the Kawailoa Youth and Family Wellness Center (formerly known as the Hawaii Youth Correctional Facility). Both facilities focus on high-risk youth.

Child Abuse and Neglect, Domestic and Sexual Violence Prevention: These programs are committed to the primary prevention of all forms of violence and stopping violence before it begins so that all people, families, and communities are safe, healthy, and free of violence. Together known as the Family Strengthening & Violence Prevention Unit, staff and partners provide programs statewide to prevent child abuse and neglect, sexual violence, and domestic violence. Activities also include support for parents and provision of education targeted at teens to prevent sexual violence.

Child Death Review: Statewide surveillance system for deaths among children ages 0-18 years. Aims to reduce preventable deaths of infants, children, and youth through multidisciplinary interagency

reviews.

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

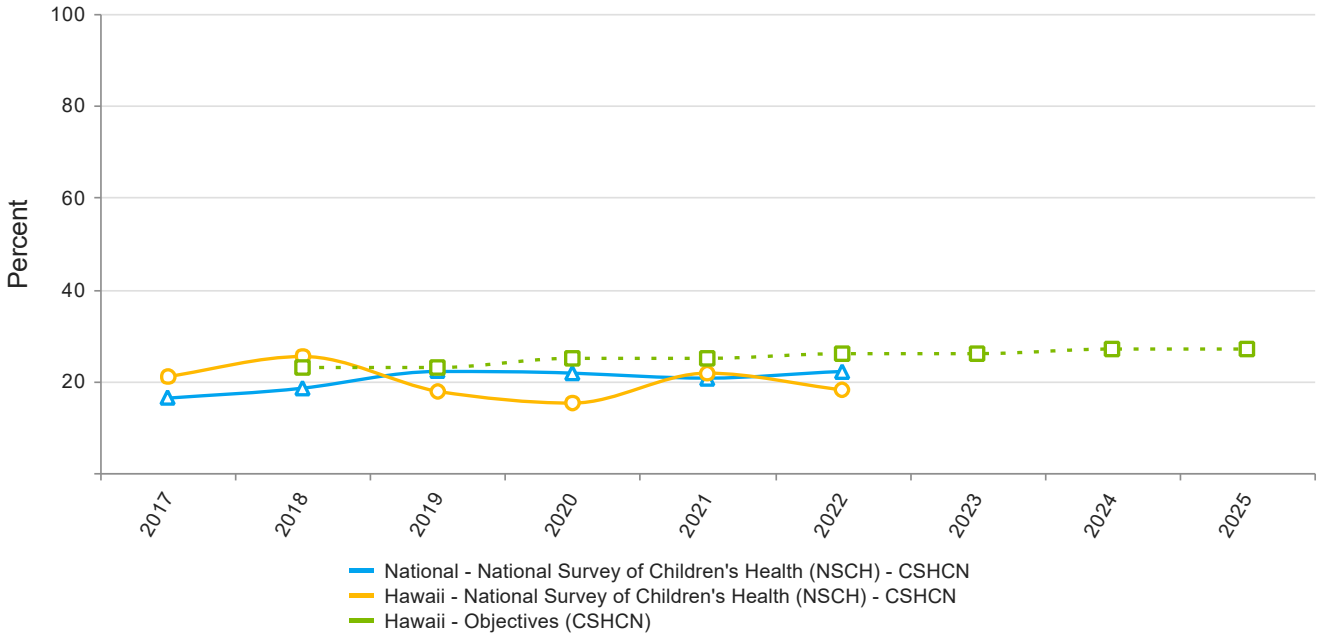
Pediatric Mental Health Access Grant: The PHMCA grant was awarded in 2021 to establish a state system of behavioral health teleconsultation and care coordination for pediatric primary care providers, especially those in underserved areas and rural communities. Overall, the goal is to promote integration of primary care and behavioral health to better service children, youth, and their families in their communities.

Reproductive Health Care & Support Services: Reduces risk factors contributing to infant mortality and provides various services to address risk factors that lead to poor birth outcomes. This is achieved through contractual services for uninsured and underinsured pregnant women through pregnancy and six months postpartum. Services include assistance in enrolling for public/private health insurance (Medicaid).

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR Indicators and Annual Objectives



NPM TR - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	23	25	25	26	26
Annual Indicator	24.7	17.1	15.9	21.9	18.1
Numerator	5,037	3,214	3,171	4,086	3,025
Denominator	20,412	18,758	19,924	18,629	16,749
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	27.0	27.0

Evidence-Based or –Informed Strategy Measures

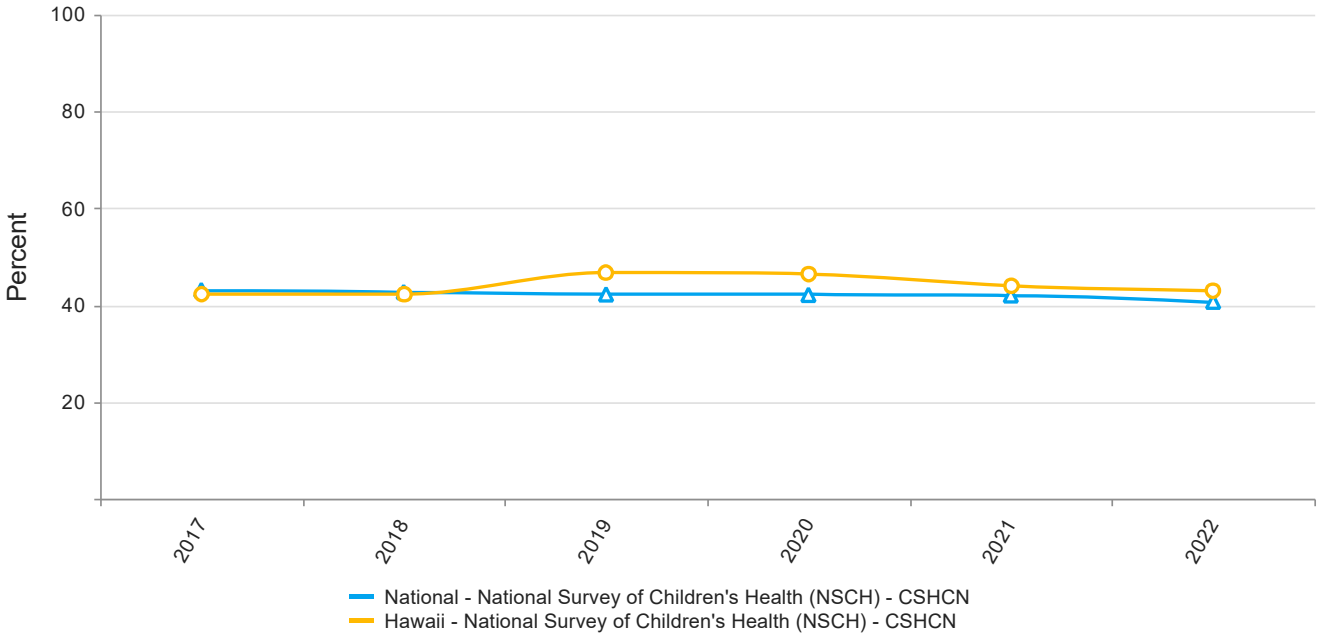
ESM TR.1 - Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	21	24	26	28	30
Annual Indicator					
Numerator	22	25	26	31	32
Denominator	33	33	33	33	33
Data Source	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	33.0	33.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2023
Annual Objective	
Annual Indicator	43.1
Numerator	17,813
Denominator	41,372
Data Source	NSCH-CSHCN
Data Source Year	2021_2022

Evidence-Based or –Informed Strategy Measures

None

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 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	
Five-Year 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 and care coordination into the Children and Youth with Special Health Needs Section to serve enrolled youth and their families..	
Provide education and public awareness on transition to adult health care for children/youth with and without special health care needs, and promote the incorporation of transition into planning and practices, in collaboration with state and community partners.	
Develop and expand efforts to address health disparities in transition services for youth	
ESMs	Status
ESM TR.1 - Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.	Active
NOMs	
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC	

State Action Plan Table (Hawaii) - Children with Special Health Care Needs - Entry 2

Priority Need

Improving access to medical homes for all children including children with special health care needs.

NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Five-Year Objectives

By July 2025, increase the percent of children with special health needs, ages 0-17, who have a medical home to 43.1%.

Strategies

Define the issues around the pediatric medical home for CSHN by implementing a mixed method review of all available data on this population, with a focus on disparities including race/ethnicity.

Review existing evidence-based literature, emerging best practices, and expert opinion resources to identify CSHN strategies to improve medical home establishment and related care.

ESMs | Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

NPM TR – 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) MCH population domain, Hawaii selected NPM TR, *Transition to Adult Health Care*, based on the five-year Department of Health (DOH) needs assessment results. By July 2025, Hawaii seeks to increase the percentage of youth, with and without special health care needs, who receive transition services from 18% to 27%.

Data: Although the NPM TR measure for this indicator reports on transition services received by youth with and without special needs, the federally available data is reported separately for each sub-group of adolescents. Data specific for youth with special health care needs was used for this measure to represent targets for the CSHCN population domain.

The aggregated 2021-2022 data indicates that the estimate for Hawaii (18.1%) did not meet the 2023 state objective (26.0%) but was not significantly different from the national estimate of 22.1% or youth with special health care needs. The decrease from 2020-2021 (21.9%) was not significant. The related national Healthy People 2030 objective for this measure is under development. The sample size was, unfortunately, too small for subgroup analysis.

For youth without special health care needs, aggregated 2021-2022 data indicates that the estimate for Hawaii (19.5%) was statistically similar to the nation (17.8%). There were no significant differences in reported subgroups.

Objectives: Hawaii's objectives were set to reflect an incremental improvement of 27% in 2025.

Title V lead/funding: The Children and Youth with Special Health Needs Section (CYSHNS) in the Children with Special Health Needs Branch (CSHNB) is the lead program for this priority measure. The CYSHNS Section Supervisor provides the leadership for NPM TR activities. To ensure that transition planning benefits all youth, CYSHNS partners with the Maternal and Child Health Branch's (MCHB) Adolescent Health Program to integrate transition planning into MCHB's Title V activities that promote adolescent wellness visits. The statewide CYSHNS Transition team meets monthly via Zoom.

Title V does not directly fund transition activities but funds key CYSHNS staff positions, including the CYSHNS Section Supervisor and Nutritionist. It also funds the CSHNB Chief, Research Statistician, and administrative staff, who provide support to the NPM TR team.

Key Partners: Professional, state, and community partners in Hawaii who actively support and promote youth transition to adult life include:

- Title V Adolescent Health Program
- American Academy of Pediatrics-Hawaii Chapter
- Hilopa'a Family to Family Health Information Center (Hilopa'a F2FHIC)
- Hawaii State Council on Developmental Disabilities (HSCDD)
- Hawaii State Special Parent Information Network (SPIN)
- Hawaii State Disability and Communication Access Board (DCAB)
- Hawaii State Department of Education (DOE)
- TeenLink Hawaii
- University of Hawaii at Manoa Center on Disability Studies (CDS)
- Kaiser Permanente Hawaii
- Special Olympics Hawaii
- MedQUEST (Medicaid), Department of Human Services (DHS)
- EPSDT Coordinators (DHS)
- Maternal and Child Health Leadership Education in Neurodevelopmental and Related Disabilities Program (MCH-LEND)
- Community Children's Councils, Department of Education (DOE)
- Leadership in Disabilities and Achievements of Hawaii (LDAH)
- No Wrong Door, Hawaii Executive Office on Aging

Strategies: Hawaii's three strategies for health care transition are:

- Incorporate transition planning in care coordination activities for youth enrolled in CYSHNS and their families.
- In collaboration with state and community partners, provide education and public awareness on transition to adult health care and promote the incorporation of transition services into organizational practices.

- Develop and expand efforts to address health disparities in transition services for youth.

Evidence: Strategies 1 and 2 are based on input collected from the 2020 Title V needs assessment; Association of Maternal and Child Health Programs (AMCHP) NPM TR Toolkit; the MCH Evidence Center; MCH Workforce Development Center technical assistance; *Got Transition* website; and the 2020 Federal Youth Transition Plan and national best practice recommendations from Centers for Medicare and Medicaid Services (CMS) 2014 report titled, *Paving the Road to Good Health*. Strategy 3, focused on health equity, was added in 2021. Progress on the strategy measures is described below. The MCH Evidence Center identifies this ESM as an 'innovative tool' to track transition activities and "is a strong measure of an evidence-based strategy."

Strategy 1: Incorporate transition planning in care coordination activities for youth enrolled in CYSHNS and their families

Strategy 1, which serves as the NPM TR strategy measure (ESM TR 1), is assessed using a scale that monitors progress on integrating transition planning into CYSHNS practices and protocol, based on *Got Transition's Six Core Elements of Health Care Transition™ 3.0*.

Core Elements: CYSHNS transition to adult health care efforts are guided by *Got Transition's Six Core Elements of Health Care Transition™ 3.0*. The Core Elements are integrated into CYSHNS policy and procedure for all youth receiving CYSHNS care coordination services and their parents/caregivers.

Core Element 1: Transition and Care Policy/Guide and Tracking and Monitoring

Elements 1 and 2 focused on developing a transition policy and a database to track transition activity and progress. Both elements were completed in 2019. All CYSHNS staff were educated on transition approach, policy, the Six Core Elements, Title V, and the roles of CYSHNS, youth/family, and pediatric/adult health care teams in the transition process.

Core Elements 3 and 4: Transition Readiness and Transition Planning

CYSHNS staff meet with youth and parents/caregivers at least annually to assess transition readiness and to develop a transition plan, starting at ages 12-16. This activity was completed in 2022.

CYSHNS continued to utilize and update transition tools to guide youth and parents/caregivers through the transition process with practitioner, youth, and family input. CYSHNS assisted youth in downloading *Got Transition's* Medical ID phone application onto their mobile phones to store important health-related information that is easily accessible to the user.

Core Elements 5 and 6: Transition Transfer of Care and Transition Completion

Elements 1 through 4 culminate in the youth and their parents/caregivers successfully transitioning to adult health care providers. CYSHNS provides guidance, resources, and training to help youth apply for health insurance coverage as an adult, select adult health care providers, and learn to manage their adult health care. This activity will be completed in 2025.

CYSHNS staff assist with referrals to adult service agencies through the state's *No Wrong Door* program. This integrated online person-centered system supports individuals of all ages, disabilities, and payers. The *No Wrong Door* referral system provides a universal intake and referral point to facilitate better access to care.

ESM TR 1 Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to *Got Transition's Six Core Elements of Health Care Transition™ 3.0*.

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective		10	17	21	25	27	29	30	33	33
Annual Indicator	12	13	18	22	24.5	26	31	32		

Strategy Measure Progress: ESM TR 1 measures the progress of CYSHNS' work for Strategy 1. The rating scale has 11 strategies adapted from *Got Transition's Six Core Elements of Health Care Transition™ 3.0*. CYSHNS scores each item from 0-3 for a maximum total score of 33. For FFY 2023, the ESM TR 1 score was 32, meeting the annual target (30).

Data Collection Form – FFY 2019

ESM TR 1: Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to *Got Transition's Six Core Elements of Health Care Transition™ 3.0*. The scores below indicate the historical progress since 2016.

	0 Not Met	1 Partially met	2 Mostly met	3 Completely met
Transition and care policy/guide (core element #1)				
1. Develop a CYSHNS transition policy/statement, with input from youth, families, and providers, that describes the approach to transition, including consent/assent information.	0 2016			3 2017
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, considering cultural preferences.	0 2016	1 2017	2 2018	3 2019
Transition tracking and monitoring (core element #2)				
3. Establish criteria and process for identifying and tracking transitioning youth in the CYSHNS database.	0 2016	1 2017-18		3 2019
4. Utilize individual flow sheet or database to track youth's transition progress.		1 2016-18	2 2019/20	3 2022
Transition readiness (core element #3)				
5. At least annually, assess transition readiness with youth and parent/caregiver using the TRAC, beginning at age 12, to identify needs related to the youth managing their health care (self-care).	0 2016	1-1.5 2017-21		3 2022
6. Jointly develop goals & prioritized actions with youth & parent/caregiver, & document in a plan of care in the TRAC.		1-1.5 2016-19	2 2020-21	3 2022
Transition planning (core element #4)				
7. At least annually update TRAC goals, in partnership with youth and families, including readiness assessment findings, goals, and prioritized actions.	0 2016	1 2017-21		3 2022
8. Prepare youth and parent/caregiver for adult approach to care before age 18, including legal changes in decision-making, privacy, and consent; self-advocacy; access to information; and insurance continuity.		1-1.5 2016-19	2 2020-22	3 2023
9. Develop and implement referral procedures to adult service agencies.		1 2017	2 2018-19	3 2020
Transition transfer of care (core element #5)				
10. Prepare youth and parent/caregiver for transferring to an adult health care provider and planning for health insurance coverage as an adult.		1-1.5 2017-19	2 2020-23	
Transition completion (core element #6)				
11. Contact youth and parent/caregiver when CYSHNS services end to confirm having an adult health care provider and health insurance coverage or provide further transition guidance.		1 2017	2 2018-21	3 2022
	2023 TOTAL = 32/33 (96.9% completion)			

Activities for the Six Core Elements are anticipated to be completed by 2025. The focus will be on ensuring that all

children aged 12-21 enrolled in CYSHNS successfully transition to adult health care. Currently, CDS is conducting a needs assessment of youth with special health needs and their families to identify areas of need, which will be used to develop new measures for transition to adult health care by 2025.

Strategy 2: Provide education and public awareness on transition to adult health care for children/youth with and without special health care needs and promote the incorporation of transition into planning and practices, in collaboration with state and community partners

This strategy focuses on partnership activities to promote transition awareness among youth and their families and workforce training on transition planning practices for youth-serving organizations and health care providers. The partnership strategy reflected local input from stakeholders and community/agency partners.

Educational/Awareness Events: In FY 2023, most events and outreach activities returned to in-person while incorporating safety precautions since COVID remained a concern. Remote options or hybrid events were also offered as a proven method to increase access for youth and families.

The most significant event for youth with special health needs and their families is the annual Special Parent Information Network (SPIN) statewide conference. This event was held virtually on October 22, 2022, and again on April 22, 2023. SPIN is a statewide parent-to-parent organization established to enhance parents' participation for children with disabilities and provides information, support, and referral services. It is funded through a unique partnership between DOE and DOH DCAB. The conference is an important means to share key transition information with an estimated 500 family members and service providers who typically attend. CYSHNS staff presented on health care transition at each of the SPIN conferences.

The Footsteps to Transition Fair, held virtually on February 4, 2023, is a partnership with DOE and other state agencies. This yearly event is for youth with special needs and their families. It offers support and resources on health, education, employment, recreation, and social opportunities and is open to all families and professionals across Hawaii.

Partnerships & Networking: CYSHNS continued collaboration with a broad network of government and community groups that assist with systems coordination and advocacy for health care transition. Key planning partners included: MCHB Adolescent Health Program (responsible for the Title V NPM AWV), DOE, SPIN, DCAB, DOH Developmental Disabilities Division, NWD, Hawaii State Council on Developmental Disabilities, Hilopa‘a F2FHIC, MCH-LEND, Community Children's Council Office, Division of Vocational Rehabilitation, TeenLink Hawaii, and other community organizations.

Partnerships with the Kauai, West Hawaii, and Hilo Legislative Disability Forums, sponsored and conducted by the HSCDD, provided an opportunity to share transition messages with district state legislators.

TeenLink Hawaii: *TeenLink Hawaii* is an organization for and by youth that provides information and referral services for youth and young adults. *TeenLink Hawaii's* young adult staff developed messaging for their website and Instagram site. Information on children with special health needs and transition to adult health care was added to the *TeenLink Hawaii* website (https://www.teenlinkhawaii.org/). A series of Instagram posts were developed on topics such as how to find an adult health care provider, make a medical appointment, fill out a medical history form, and types of medical specialists. In 2023, TeenLink Hawaii partnered with the Serteens Club of Hawaii to develop and produce health care messaging and videos on hearing health for youth.

Kaiser Permanente: Through a partnership with the pediatric providers at Kaiser Permanente Hawaii (KPH), youth transition to adult health care was incorporated into the Kaiser Hawaii HMO system of care. With technical assistance from *Got Transition* and CYSHNS, KPH adopted the *Six Core Elements of Health Care Transition*^{TM} into their pediatric department services, incorporating the Hilopa‘a Transition Workbook and CYSHNS transition planning tools into the KPH health care system. In 2023, KPM and CYSHNS staff partnered to develop flyers on health care transition, confidentiality, and minor consent, which will be available to practitioners and youth. This partnership has expanded transition planning to a more significant number of youth and young adults. KPH is Hawaii's second-largest health insurer, caring for more than 250,000 members of all ages.

Title V Programs: Transition planning was incorporated into other CSHNB programs, including neighbor island cardiac and nutrition clinics, and within MCHB-contracted adolescent programs.

Family Voices & AMCHP Transition Presentations: At the national October 2022 Family Voices conference, CYSHNS, Hilopa‘a, and the DOE presented on Hawaii’s unique agency partnership experience. Driven by traditional

Hawaiian values, these dynamic partnerships support and engage youth and families statewide. CYSHNS and MCHB Adolescent Health staff presented at the 2023 AMCHP conference, highlighting their partnership on health care transition and adolescent health.

Educational Materials: The CYSHNS Transition workgroup meets monthly to work on transition activities and outreach materials designed for populations with limited English proficiency and/or educational level limitations.

Strategy 3: Develop and expand efforts to address health disparities in transition services for youth

CDS Needs Assessment. The University of Hawaii Center for Disabilities Studies (UH-CDS) was contracted to conduct a needs assessment on youth with special health needs and their families. The 2018-2019 CSHCN data from the National Survey on Children's Health (NSCH) was analyzed to identify key health issues.

Since the NSCH does not provide county-level data or detailed Hawaii-based race/ethnicity data, CDS designed a survey for youth with special health needs, including key underserved populations, to gain more data on these youth. The survey was translated into Tagalog, Ilocano, and Hawaiian to gather more data from Filipino and Native Hawaiian youth.

The findings will inform future Title V priorities and strategies. Based on the findings, transition services, messaging, and outreach may be revised.

CYSHNS will continue to seek and establish new partnerships to address health disparities, including Medicaid recipients and clients of Native Hawaiian/Pacific Islander youth-related organizations. CYSHNS plans to provide further training to its staff on diversity, equity, and inclusion strategies.

Current Year Highlights for FY 2024 (10/1/2023 – 6/30/2024)

Medicaid/EPSDT meeting: CYSHNS staff attend bi-monthly Medicaid meetings with Medicaid health insurance plan EPSDT coordinators and state community partners. An overview of FHSD programs and Title V priorities was presented at the first meeting. In subsequent meetings, CSHNB staff have presented on transition to adult health care, lead poisoning prevention, and developmental screening. Discussions have also focused on areas to improve services to CSHN by Medicaid, such as access to care and transportation.

Outreach Events: The annual SPIN statewide conference was held at the University of Hawaii at Manoa campus on April 6, 2024, utilizing both an in-person and virtual format. CYSHNS was a member of the SPIN advisory board and helped plan this conference. CYSHNS staff participated as speakers and exhibitors to provide information on health care transition, developmental screening, and lead poisoning prevention. Over 600 registered attendees and 60 resource tables were present. SPIN provided travel scholarships for neighbor island families to attend the conference.

The Footsteps to Transition Fair, held in partnership with the Department of Education and other state and community agencies, is expanding statewide. It was held at Ewa Makai Middle School on the island of Oahu on February 3, 2024, and on Maui on April 11, 2024. CYSHNS staff participated on the planning committee and presented a session on youth transition to adult health care. CYSHNS staff on Kauai and Hawaii Island are planning their Footsteps to Transition fairs, to be held in late 2024.

TeenLink Hawaii continues to work on outreach on transition to adult health care. They will continue to work with CYSHNS messaging on health equity. On April 13, 2024, TeenLink Hawaii and Serteens Club of Hawaii presented on youth engagement at the 2024 AMCHP Conference.

Serteens Club of Hawaii: In 2024, CYSHNS partnered with TeenLink Hawaii and the Serteens Club of Hawaii on a project related to health care transition and adolescent health. Serteens is a youth group with members statewide focusing on leadership and community service.

UH CDS is finalizing its report on YSHN in Hawaii. Follow-up focus groups and individual meetings were conducted to gather more detailed information.

Review of Action Plan for 10/1/2022 - 9/30/2023

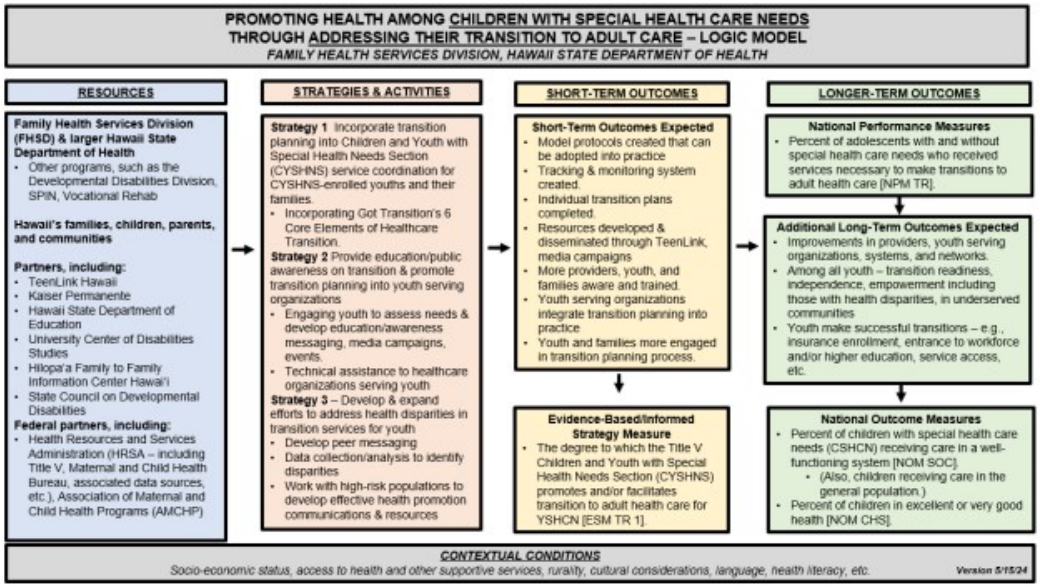
A logic model was developed and updated for NPM TR to ensure alignment among the strategies, activities, measures, and desired outcomes. By working on the three strategy areas, Hawaii focused on increasing the percentage of adolescents receiving transition services.

Strategy 1 focuses on integrating the *Got Transition's* Six *Core Elements of Health Care Transition™ 3.0* into CYSHNS care coordination protocols to ensure CSHCN and their parents/caregivers prepare for the transition to adult health care.

Strategy 2 focuses on increasing public health education and awareness by encouraging other youth services organizations to adopt adult transition planning as part of their service model.

Strategy 3 focuses on health equity. Investments in data collection and analysis will help target resources toward under-resourced populations and communities with health and social disparities.

Together, the strategies are designed to improve transition services, with greater adult transition readiness among youth, and increase the number of successful transitions to adult care.



Challenges Encountered FY 2023

Maui wildfires: Maui CYSHNS staff continue to assist families affected by the wildfires by ensuring seamless continuation of medical care and specialty clinics. CYSHNS staff work with state and Maui County agencies and community organizations to provide program services and resources and participate in community events to support new and ongoing community needs.

When the COVID Public Health Emergency (PHE) expired in May 2023, CYSHNS staff were trained to assist families in completing the redetermination process for Medicaid and CYSHNP enrollment. CYSHNS staff also contacted primary care providers, providing them with current program information and resources. Information from other FHSD programs, including home visiting, newborn hearing screening, Hawaii lead poisoning prevention program, and early intervention, was also shared.

Data Limitations: The National Survey of Children's Health (NSCH) data and the small sample size for Hawaii

continue to be challenging. The variability in the NPM TR shows ostensibly substantive changes, but none are statistically significant; thus, it's difficult to determine whether the data reflects real change and may not reflect the large amount of work and effort that CYSHNS staff devote to NPM TR work. During the COVID pandemic, when child wellness visits decreased, transition planning data showed an increase. As noted in other narratives, the funding, administrative, and epidemiologist staffing limitations prohibit Hawaii from pursuing an NSCH oversample that could generate more stable estimates for NPM TR and data on important ethnic disparities. Concerns were raised with the MCH Bureau about greater investments in the NSCH. Hawaii has since pursued other primary methods of data collection that seek to address this data limitation.

The partnership with UH CDS will provide more state-specific data to more accurately represent the CSHCN population in Hawaii and to better understand disparities that impact the YSHCN population in the state. There is also a need to research the long-term consequences of COVID. CDS data will help support the development of strategies/partnerships that more effectively target groups and communities of greatest need.

Reaching All Youth. Highlighting the importance of transition planning for all youth, with and without special health care needs, also remains challenging. Increasing partnerships with the Title V Adolescent Health Program, DOE, and community youth groups have helped expand our programmatic reach.

Overall Impact FY 2023

Transition System. CYSHNS has successfully completed 5 out of 6 Core Elements of their system to help youth transition to adulthood. CYSHNS fully integrated transition planning into its standard program care coordination services. Assessment tools and outreach materials were developed by CYSHNS, with continuous feedback from youth, families, staff, and partners. Along with the Hilopa'a Transition Workbook, these tools have been valuable statewide in educating, developing, and tracking life goals, such as youth transition to adulthood. They are also widely utilized by system partners, including DOE, pediatricians, and health centers, as an element of their adolescent transition planning services. Collaboration with Kaiser Permanente Hawaii pediatric services to integrate transition planning into their system practices demonstrates the utility and ability to replicate CYSHNS protocols and practices. Partnership with the Adolescent Health Program and TeenLink Hawaii is helping to further strengthen family and youth engagement.

Partnerships. Another major success was the development of strong partnerships among service providers and agencies to help Hawaii youth transition to adulthood, as evidenced by the number of youth/family community events promoting transition, including the annual SPIN conference and the *Footsteps to Transition* fairs. Events are held annually across all counties and have expanded to include a comprehensive array of services and educational providers. In partnership with DOE, the Transition Fairs have created other outreach and educational events for public and adult health care providers and workforce training events for service providers. The success of many of these events and trainings involves a high level of family and youth engagement.

NPM TR – 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 TR Transition to Adult Health Care as a continuing priority, based on the 2020 DOH 5-year needs assessment results. By July 2025, the state seeks to increase the percentage of youth with (and without) special health care needs who received transition services from 18% to 27%. Plans to address this objective and NPM are discussed below.

Strategy 1: Incorporate transition planning into CYSHNS care coordination for CYSHNS-enrolled youths and their families

ESM TR 1 focuses on ensuring that youth enrolled in CYSHNS programs receive transition evaluation and planning. This strategy is nearly complete and may be discontinued in 2025. A review of activities and target goals is being conducted to develop future planning for expanding on the Six Core Elements.

Strategy 2: Provide education and public awareness on the transition to adult health care for children/youth with and without special health care needs and promote the incorporation of transition into planning and practices in collaboration with state and community partners

CYSHNS will continue to work with agency and community partners to develop and modify outreach materials and events that effectively engage youth and their families and deliver transition information and needed services.

CYSHNS will meet with Medicaid EPSDT coordinators bi-monthly to improve health and related services, including transition planning and completion for all Medicaid-eligible children.

CYSHNS will continue to identify new and emerging community partners, including community-based nonprofit organizations, state programs, and adult health care providers, capable of supporting and implementing transition planning.

CYSHNS will continue to engage youth in assessing, developing, evaluating, and sharing appropriate transition messaging through ongoing partnerships with the Title V Adolescent Health Program and other community-based youth organizations.

CYSHNS will continue to partner with organizations interested in integrating transition planning into their services, including health care provider systems, such as community-based youth organizations, Kaiser Permanente Hawaii, and private-sector pediatricians.

Strategy 3: Develop and expand efforts to address health disparities in transition services for youth

Needs assessment collaboration with the University of Hawaii Center for Disabilities Studies is documenting the impact of COVID-19 on CSHCN and their families, focusing on populations at increased risk for poor health outcomes (Native Hawaiians, Pacific Islanders, and Filipinos). Data from the NSCH, the UH CDS survey, and focus group data will yield important insights on emerging access issues and key disparities. These findings will help develop and define future Title V priorities and strategies. Transition services, messaging, and outreach are specifically anticipated to be revised based on the findings of the UH CDS survey.

NPM Medical Home (MH): Percent of children with special health care needs, ages 0-17, who have a medical home

For the CSHN Health domain, the new Title V grant guidance added a new universal performance measure that all states are now required to address: children who have a medical home for CSHN and all children. Objectives for this measure were set through FY 2025:

- By July 2025, increase the percent of children with special health needs, ages 0-17, who have a medical home to 43.1%.

Data: The data for this measure is from the National Survey on Children's Health (NSCH). Aggregated data from 2021-2022 show that the estimate for Hawaii (43.1%) was similar to the national estimate of 40.7% for those with special health care needs. Note that there was a minor change in question from "how much of problem was it to get referrals?" in 2016 and 2017 to "how difficult was it to get referrals" in 2018. The related HP 2030 Objective for the proportion of children and adolescents who receive care in a medical home (53.6%) has not been met. No differences were found in subgroup analysis based on aggregated 2021-2022 data. This does not mean no disparities exist but is a limitation of the sample size.

Objectives: The state objectives through 2025 remain the same as the baseline data over the next 2 years since programmatic initiatives have yet to be implemented.

Strategies: The strategies for this priority are:

- Define the issues around the pediatric medical home for CSHN by implementing a mixed method review of all available data on this population, with a focus on disparities including race/ethnicity.
- Review the evidence based literature, emerging best practices, and expert opinion on to identify CSHN strategies to improve medical home establishment and related care

Plans to address this objective and NPM are summarized below.

Strategy 1: Define the maternal care health public health problem by completing a mixed method review of data with a focus on disparities

This strategy recognizes that both quantitative and qualitative data for this measure should be reviewed, collected and analyzed. The work on the Title V needs assessment will be used to develop a better understanding of access to a medical home for CSHN particularly since this measure is a composite of 5 separate questions regarding:

- care coordination
- family centered-care
- having a personal doctor or nurse practioner
- accessing referrals as needed
- having a usual source of care.

Strategy 2: Review the evidence based literature, emerging best practices, and expert opinion on the pediatric medical home for CSHN to identify strategies to improve medical home establishment and related care.

Strategies and activities to address increasing the percentage of pediatric medical homes for CSHN will be developed, based on the 2024-25 needs assessment findings and recommendations, a review of the evidence based research, as well as recommendations and input from medical home care providers, as well as CSHN families, and programs.

Title V CSHCN Programs

Children with Special Health Needs Branch (CSHNB) is working to ensure that all CSHCN will reach optimal health,

growth, and development. Programs include:

Birth Defects: Provides population-based surveillance and education for birth defects in Hawaii and monitors major structural and genetic birth defects that adversely affect health and development.

Childhood Lead Poisoning Prevention: This program reduces exposure to lead by strengthening blood lead testing and surveillance, identifying and linking lead-exposed children to services, and improving population-based interventions to mitigate further exposures. The Centers for Disease Control and Prevention (CDC) funds the program.

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

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

Early Intervention Section: Provides early intervention services for eligible children, ages 0-3 years, with developmental delay or at biological risk as mandated by Part C of the Individuals with Disabilities Education Act. Some 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 with a teaming approach to help families navigate the various services.

Hi'ilei Developmental Screening: A free resource for parents of children from birth to 5 years old that provides developmental screening via a paper or online screening tool; activities to help a child develop; referrals for developmental concerns; and information about state/community resources to support child development.

Newborn Hearing Screening: Provides newborn hearing screening for babies as required by Hawaii state law and to identify hearing loss early so that children can receive timely early intervention services.

Newborn Metabolic Screening: Provides newborn blood spot testing for babies as required by Hawaii state law. The tests help detect rare disorders that can cause serious health, developmental problems, and even death if not treated early.

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide.

Measure Status:	Active

State Provided Data				
	2020	2021	2022	2023
Annual Objective			20	40
Annual Indicator	0	0	98	108
Numerator				
Denominator				
Data Source	Hawaii Pediatric Mental Health Care Access grant	Hawaii Pediatric Mental Health Care Access grant	Hawaii Pediatric Mental Health Care Access grant	Hawaii Pediatric Mental Health Care Access grant
Data Source Year	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	60.0	80.0

SPM 4 - Number of new telehealth access points established with health and digital navigators in public libraries located in underserved communities statewide

Measure Status:	Inactive - The Title V telehealth infrastructure project is continuing with a significantly longer completion timeline & is no longer an urgent COVID priority.			
State Provided Data				
	2020	**2021**	**2022**	**2023**
Annual Objective			9	15
Annual Indicator	0	0	0	0
Numerator				
Denominator				
Data Source	Hawaii Title V Genetics Program	Hawaii Title V Genetics Program	Hawaii Title V Genetics Program	Hawaii Title V Genetics Program
Data Source Year	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final

State Action Plan Table

State Action Plan Table (Hawaii) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Address health equity and disparities by expanding pediatric mental health access in rural and under-served communities
SPM
SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide.
Five-Year Objectives
By July 2025, provide training and support services on pediatric mental health care to 80 pediatric and/or mental health care providers in underserved communities statewide.
Strategies
Refine, develop and implement pediatric mental health care access model
Promote workforce development and training on pediatric mental health care
Support services and linkages in communities

SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide.

Introduction: Children's Mental Health Access

For the Cross-Cutting domain, Hawaii added this state priority in 2021 to expand children's mental health services in response to emerging concerns during the COVID pandemic. Hawaii received the federal Pediatric Mental Health Care Access (PMHCA) grant in September 2021, focusing on developing a pediatric warmline to address mental health concerns of children and youth up to age 21. Community partners also identified mental health as a concern, and government and non-governmental entities are collaborating to address rising mental health needs in the community.

Data: The state measure for this project-focused priority is a process indicator that reports the number of providers receiving training in behavioral health care topics and, eventually, data on the teleconsultation model (once established). Training was provided to 98 pediatric or behavioral healthcare providers through the Project ECHO series of webinars, exceeding the year's objective. There were 191 attendees participating in the ECHO training series; however, 93 were not specifically healthcare providers.

Evidence: HRSA promotes the Pediatric Mental Health Care Access Program as a strategy to address the shortage of behavioral health providers by providing pediatric primary care providers with behavioral health training and a telephonic/telehealth consultative warmline. The warmline, staffed by a psychiatrist, psychologist, care coordinator, and social worker, provides teleconsultation, training, technical assistance, and care coordination so that pediatric primary care providers can more effectively diagnose, treat, and/or promptly refer children and youth with behavioral health conditions. The program's overarching goal is to use telehealth modalities to provide timely detection, assessment, treatment, and referral of children and adolescents with behavioral health conditions, using evidence-based practices, such as web-based education and training sessions. The MCH Evidence Center provided ample evidence indicating that telehealth services improve access to healthcare for underserved MCH populations.

Title V lead/funding: The PMHCA grant is administered by FHSD and funds two staff positions to manage and build the program. Although no Title V funds are used to support the program directly, Title V-funded staff assist with data, contractual, and media support. In kind contributions from two FHSD staff and contracts supporting Health Equity initiatives and data training was utilized for the state match. FHSD will support and coordinate community mental health needs for children and youth.

Key Partners: This project is a unique collaboration between the Department of Health, John A. Burns School of Medicine (JABSOM), DHS Med-QUEST Division, Project ECHO Hawaii, Hawaii Primary Care Association, American Academy of Pediatrics-Hawaii Chapter, and University of Hawaii Pacific Basin Telehealth Resource Center. This multi-agency collaboration will strengthen pediatric providers' access to needed mental health consultation services in underserved communities statewide.

Objective: By July 2025, provide training and support services on pediatric mental health care to 80 pediatric and/or mental health care providers in underserved communities statewide.

Strategies: The strategies to implement the project focus on three key areas:

- Refine, develop, and implement a pediatric mental health care access model.
- Promote workforce development and training on pediatric mental health care.
- Support services and linkages in underserved communities.

Updates for FY 2023 on the three strategies follow.

Strategy 1: Refine, develop, and implement pediatric mental health care access model

The first strategy focuses on the system infrastructure to support the PMHCA grant. The PMHCA grant deliverable is developing a pediatric mental health care access model that pediatric providers will access to work with behavioral health providers. Activities are highlighted.

Staffing. The PMHCA Coordinator and Specialist were hired in the Fall of 2022, continued hosting Advisory Committee meetings, and met with stakeholders to promote and develop the model. The grant Coordinator left the grant for another FHSD position; however, the Specialist easily transitioned into the lead and continued the grant work.

Model Development for Hawaii. Staff worked with the HRSA Project Officer who provided technical assistance (TA) to connect Hawaii to national consultants who lent their expertise to help develop the Hawaii warmline model.

Logo Development. The logo for the Pediatric Mental Health Care Access model was approved by the Advisory Council. Developing a logo was considered effective by other states to help promote the training and warmline efforts. The logo is based on the traditional weaving arts, symbolizing the many cultures of Hawaii working together. It represents unity and community within the Pediatric Mental Health Care Access network and the support this network brings to both pediatric providers and their patients. The logo is shaped into a heart to show PMH's support for pediatric providers while highlighting how professionals from differing practices come together to care for patients.

Partnering with Pacific Jurisdictions. The Hawaii project merged with efforts in the Pacific jurisdictions. The HRSA Project Officer convened the Pacific Jurisdictions - Palau, Federated States of Micronesia (FSM), - Commonwealth of the Northern Mariana Islands (CNMI) and Guam- and encouraged Hawaii to develop a warmline that could be used throughout the Pacific given the severe shortage of behavioral health providers in this region. HRSA hosts monthly calls among the Pacific Jurisdictions to support this critical partnership.

Strategy 2: Promote Workforce development and training on pediatric mental health care

Like most of the nation, Hawaii has a workforce shortage of behavioral health and primary care providers. There are 230.2 FTE pediatricians and 351.4 FTE family medicine and general practice providers statewide (as of November 2020), with an estimated workforce shortage of 567.4 FTEs across all islands (AHEC).
This strategy focused on identifying providers and providing training on pediatric mental health care to address shortages of both pediatric and behavioral health providers and enhance knowledge and skills of existing providers.

Because of the workforce shortages and increases in youth mental health needs, FHSD focused on offering providers access to timely mental health training. This strategy focuses on workforce training efforts.

Project ECHO. FHSD continued working with Hawaii's Project ECHO to conduct training for healthcare providers. In FY 2023 a series of nine pediatric behavioral health sessions were offered. A second round of mental health topics was developed and presented to providers starting in the summer of 2023.

REACH Institute. The PMHCA Staff met with The REACH Institute (Resource for Advancing Children's Mental Health) to provide training on evidence-based therapies to better diagnose, treat, and manage child and adults with mental health issues. A contract is under development to pilot this training in Hawaii.

AAP-Hawaii Chapter. The AAP-Hawaii Chapter selected a Pediatric Mental Health Champion to assess provider needs around mental health and promote the PMHCA model. With the PMHCA coordinator, focus groups were conducted with pediatricians across the counties. This work is supported through the PMHCA Program Utilization

Chapter Funding Opportunity grant submitted collaboratively by HRSA.

Workforce Summit. The PMHCA staff sponsored a behavioral health track at the annual Hawaii Health Workforce Summit in September 2023 for approximately 900 participants, including physicians, physician assistants, ARNs, Community Health Workers, Medical Directors, Office Managers, Allied health Professionals, and more.

Strategy 3: Support services and linkages in the community

FHSD identified service capacity issues and linkages needed to support children's mental health. Hawaii continues to look at a coordinated intake and referral system to help promote the coordination of services to ensure no gaps between intakes and referrals and services. There is the recognition, however, that not all communities have mental health services and treatment options available. This strategy focused on assuring mental health service availability and access for families throughout the state.

Needs Assessment. The PMHCA Coordinator is partnering with the DOH Child and Adolescent Mental Health Division (CAMHD) and Suicide Prevention Coalition to conduct an environmental scan of existing mental health services statewide, including behavioral health services, inpatient treatment programs, treatment programs, inpatient hospitalization or emergency departments, clinical providers, nonprofits addressing mental health and practicing mental health clinician as part of the CAMHD Needs Assessment.

Promising Minds. PMHCA partnered with Hawaii Community Foundation's *Promising Minds* initiative to improve early childhood behavioral health in Hawaii. *Promising Minds* will be funding the Maui Warmline Pilot and collaborating with the PMHCA team on a series of Early Childhood training for pediatric providers.

Current Year Highlights for FY 2024 (10/1/2023 – 6/30/2024)

This section highlights the Year 3 work for the PMHCA grant. Significant progress has been achieved in the grant over the past year, thus, current year activities are outlined by strategy.

Strategy 1: Refine, develop, and implement pediatric mental health care access model

Staffing. The vacancy for the PMHCA Specialist position was filled in Fall of 2023. The PMHCA team continued hosting Advisory Committee meetings and met with stakeholders to promote and develop the model. The PMHCA team alongside partners from JABSOM, AAP and Hawaii Community Foundation (HCF)

Maui Fire Updates/pilot. With the recent devastating impacts of the Maui wildfires, FHSD recognizes the immediate need of resources and services needed for disaster aftermath recovery for community members directly and indirectly impacted. The focus is to pilot the consultation access line in Maui. The Maui Pilot is in collaboration with Hawaii Community Foundation's Promising Minds Initiatives and Queens Medical Center.

Sustainability. The PMHCA team is exploring long-term sustainability for PMHCA beyond the completion of grant funding. This includes engaging in discussions with Medicaid, health plans, and state legislators. In January, the PMHCA Coordinator spoke to the Health and Homeless Committee about the PMHCA grant and the importance of addressing children's mental health needs in Hawaii.

Strategy 2: Promote Workforce development and training on pediatric mental health care

This strategy focuses on workforce training efforts. Highlights of activities include:

- Worked with Hawaii's Project ECHO and completed a third round of mental health topics and to provide training to providers starting in the Fall of 2023.
- The PMHCA Staff continues to attempt to contract REACH Institute (Resource for Advancing Children's

Mental Health) to provide training on evidence-based therapies to better diagnose, treat, and manage child and adults with mental health issues. However, REACH has not been able to meet the compliance status preventing Hawaii PMHCA from contracting with them.

- During the focus group meetings held last fiscal year with the AAP, pediatricians expressed interest in learning about mental health resources in Hawaii, including CAMHD services, DOE Behavioral Health Services and School-Based Health Care. In response, the AAP-Hawaii Chapter and PMHCA team organized a series of meetings featuring speakers from these organizations to inform and educate providers about their services.
- PMHCA is sponsoring the second year of the pediatric mental health track at the annual Hawaii Health Workforce Summit in September 2024.
- PMHCA team in collaboration with the Promising Minds and Association for Infant Mental Health Hawaii (AIMHI) Initiative will be hosting trainings for providers and allied professionals in diagnosing and treating mental health needs for ages 0 to 5.
- PMHCA team and Hawaii's Project ECHO partnered to develop another round of mental health topics for the pediatric ECHO for sessions from November 2023 to February 2024. A total of six sessions were offered to continue providing pediatric mental health topics. Topics included introductions of the PMHCA models and CPAP interventions, trauma-informed care for caregivers, suicide prevention/resiliency, infant mental health, and ADHD medication management.

Strategy 3: Support services and linkages in the community

The PMHCA Coordinator continues to connect with community providers, help learn and support community-based efforts, and identify partnership areas.

- The PMHCA Coordinator is partnering with the DOH Child and Adolescent Mental Health Division (CAMHD) and Suicide Prevention Coalition to conduct an environmental scan of existing mental health services statewide, including behavioral health services, inpatient treatment programs, treatment programs, inpatient hospitalization or emergency departments, clinical providers, nonprofits addressing mental health and practicing mental health clinician as part of the CAMHD Needs Assessment
- The PMHCA Coordinator with CSHNB conducted the Mental Health Snapshots event, bringing together mental health partners to share information about their respective programs. This event aimed to enhance understanding of statewide services and promote collaboration across sectors and the community. Based on the post evaluation comments another event is being held to support for system coordination/collaboration.
- PMHCA Coordinator and Specialist collaborate with community partners such as Hilopaa Family to Family Information Center and Family Hui Hawaii with family and youth engagement meetings to discuss perspectives on mental health and experiences in accessing care.

Challenges Encountered

Some of the major challenges for this priority measure include:

- Although HRSA provided extra funds to support PMHCA efforts in Hawaii, systemic procurement challenges and contracting delays make it difficult to encumber and expend funds promptly.
- Like many other states, Hawaii saw an increase in children and youth mental health needs exacerbated by COVID, which continues to be a problem. Mental health issues existed prior to COVID; however, there is an increase in mental health needs for children and youth due to anxiety and depression caused by social distancing and lack of socialization of youth; increased social media and cyberbullying; and family stress due to economic concerns.
- Limited mental health services and treatment options are currently available, which often means that children and youth in rural communities and neighbor islands must fly in or drive to Honolulu for services. This is true for

both intensive treatment options and preventive services.

- Mental Health services along the continuum of care are being worked in different sectors and silos creating a fragmented mental health system. This creates a challenge for the PMHCA team to ensure there is no overlap of services that could further complicate access to necessary mental health services in the community.
- There is a lack of comprehensive/directory of system services. New federal and state funding for mental health services resulted in new service options; however there is little awareness of many of the new and existing available services.
- Based on the experience of other states, even those with a larger population size than Hawaii, building a well-staffed/costly warmline service for a relatively low call volume is challenging.
- Cultural understanding and responses to mental health need more research and evidence for best practices as an effective option to traditional Western therapy and mental health treatment.
- Staffing/ Workforce Capacity Projects and initiatives are delayed due to our partners not having sufficient staffing or capacity to take on new projects.

Overall Impact

The PMHCA grant allows FHSD to implement primary prevention efforts addressing the mental health needs of children in Hawaii, primarily by supporting pediatric providers to increase children's access to mental health services. The PMHCA team has shifted its focus to a systems-building approach, aiming to break down silos and enhance collaboration across sectors, thereby extending the reach of mental health services at all levels.

In addition, the PMHCA team is incorporating a health equity perspective into their initiatives, ensuring that cultural components and the geographical barriers faced by residents of neighboring islands are considered. Despite the onboarding of PMHCA staff, challenges remain in establishing the warmline and encouraging pediatric providers to participate in trainings and utilizing the consult model.

Cross-Cutting/Systems Building - Application Year

SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide

For the Cross-Cutting domain, Hawaii selected this new state priority and performance measure, which emerged from Title V assessment efforts in 2020. By September 2025, FHSD's Pediatric Mental Health Care Access grant will establish and provide training to at least 80 pediatric and behavioral health providers in underserved communities statewide. Specific plans to address this objective and SPM are aligned with the work of the Title V Pediatric Mental Health Care Access (PMHCA) grant. Plans for the three strategies and activities are presented below.

Strategy 1: Refine, develop, and implement pediatric mental health care access model

This strategy focuses on the infrastructure to support the PMHCA grant, which will lead to developing the mental health care warmline and systems model.

- The PMHCA Coordinator and Specialist will continue to meet with other state PMHCA grantees, and partners to work towards improving the warmline model
- The PMHCA team will be undergoing the Request for Proposals (RFP) process to accept proposal ands bids to contract out the statewide consultation line
- Hawaii will continue working with the federal project officer and the Pacific Jurisdictions to build a model that will work for the Pacific Island communities.

Strategy 2: Promote Workforce development and training on pediatric mental health care

This strategy focuses on workforce training efforts, and Hawaii will continue to build capacity through training efforts.

- Evaluation of the first training series has led to additional Project ECHO topics to provide workforce training,
- The PMHCA Coordinator and the AAP-Hawaii Chapter Pediatric Champion will continue to conduct meetings and outreach events among AAP chapter across all islands and will work to expand these outreach meetings and events to Family Practitioners and APRNs
- The PMHCA Coordinator looks for other venues to support training through the REACH Institute pilot, the Hawaii Healthcare Workforce Summit, and other opportunities.
- The PMHCA team is exploring various methods to incentivize providers to participate in training. Longer-format training, such as the REACH training, requires providers to leave work or close their practices, creating a barrier to participation. Hawaii PMHCA is seeking guidance from other states on how they incentivize their training, such as offering stipends or recognition of trainings from health plans leading to providers getting compensated more after getting training.
- CSHNB received the Substance Abuse and Mental Health Services Administration's Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant, and one of the strategies is promoting training on behavioral health topics and the use of the PMHCA warmline (once developed) as part of supporting wellness of young children. CSHNB will partner with the PMHCA Coordinator to support consistent training and information about the warmline.

Strategy 3: Support services and linkages in the community

FHSD recognizes the need to support and develop linkages around children's mental health. Mental health services are needed across healthcare, schools, and community settings. To better service children and youth, linkages in the community are important to diagnose, treat, and connect children and families.

- FHSD is collaborating with Hawaii Primary Care Association (HPCA) to convene with mental health providers and stakeholders at the Federally Qualified Health Centers and School-Based Health Centers to identify

resources that address the needs of rural communities. Additionally, the PMHCA team is exploring ways to integrate PMHCA support into these health centers to increase capacity for mental health services.

- To ensure availability of mental health surveillance data, the Mental Health Data Dashboard will be able to provide updated data to be used in program planning and community surveillance. The Dashboard may be expanded to include new Title V mental health measures in the proposed 2024 grant guidance.
- PMHCA team received additional funding from HRSA to strengthen collaboration with school health systems– Hawaii PMHCA team will utilize these funds to further collaborate with the DOE on youth and family engagement along with hosting a youth mental health summit to promote mental health wellness among youth.
- The PMHCA and CSHNB will continue with hosting the Mental Health Snapshots event. The goal is to gain a comprehensive understanding of the current mental health resources and to establish a foundation for mapping the mental health landscape for children in Hawaii.

III.F. Public Input

The Family Health Services Division (FHSD) involves communities, stakeholders, and program participants, including families, in policy and program decision-making at many levels. Integrating public input into the Title V MCH Block Grant is critical to assure alignment with partners to strengthen our collective impact. Consumer input also ensures Title V efforts are effective with the populations we serve. Input on Title V performance and strategy measures is collected continuously throughout the year. Since much of the Title V work is done in partnership, community partners help select strategies and assist with implementation and evaluation.

Communications. Because FHSD does not use Title V to fund local health departments or community-based providers, no stakeholders are vested in Title V as a funding source. Thus, general input for the Title V grant is difficult to garner. The extensive scope of the Title V report, compounded by FHSD's numerous and diverse programs, is a challenging informational topic to share publicly.

Most FHSD agency/program partners are vaguely aware of the Title V grant. Since the funds are used primarily for staffing, it is difficult to demonstrate the grant's direct benefits for the MCH population. Moreover, partners that receive HRSA/MCH Bureau funding also tend to be knowledgeable about the Title V grant.

In FY 2020, FHSD was fortunate to hire an Information Specialist a few months before the COVID outbreak. The position is Title V funded. As engaging families became challenging during the COVID shutdowns, FHSD was able to divert funding toward television/radio media campaigns coupled with digital media promotion to support health messaging, online resources, and service programs to engage the public.

Media outreach has continued as the state moves out of the public health emergency to meet the changing service needs of families along with remote communications. The exponential growth in telehealth visits, virtual webinars, conferences, health fairs, and meetings continues with many events/services now using hybrid approaches.

Strong Agency/Program Partners. Hawaii's strength continues to be its work conducted in partnership with agencies, community providers, and families. Being a small island state, Hawaii's local values are strongly influenced by indigenous and introduced immigrant cultures that uphold the importance of community and family. These values are reflected in the many partnerships ingrained in Title V efforts (and those of public health). Public input is largely provided throughout the year through these collaborations.

See the Family Partnership narrative for efforts to solicit and work with parents to improve FHSD programs and services.

Community Input for Title V Strategies and Measures

FHSD program continue to expand partnerships with community programs and agencies. Examples of community input/coordination that shaped/changed elements of the Title V five-year plan strategies are shared.

NPM 1 Women's Wellness Visits. The work for this priority is conducted in partnership with the Hawaii Maternal and Infant Health Collaborative (HMIHC), comprised of over 120 participants, including physicians, clinicians, public health professionals, community service providers, insurance representatives, and healthcare administrators. The Pre/Inter-Conception Workgroup, co-chaired by the state Medicaid agency, continued remote meetings to address access to contraception and reproductive life planning, which continue as the primary focus for Title V. The Healthcare Association of Hawaii who is administering the HRSA Maternal Health Innovation (MHI) grant is partnering with the HMIHC to develop a maternal health strategic plan. Title V is coordinating with the MHI grant on

needs assessment.

NPM 5 Safe Sleep. The work for this priority is conducted in partnership with Safe Sleep Hawaii (SSH), the statewide coalition that promotes safe sleep efforts. SSH has a diverse membership, representing government, nonprofits, for-profits, grassroots organizations, individuals, and family champions committed to preventing infant mortality through safe sleep practices. SSH just completed a needs assessment with recommendation that will inform Title V strategies/activities.

NPM 6 Developmental Screening. The Developmental Screening program organized a diverse statewide network of partners to gather ongoing feedback on the state developmental screening guidelines. These were reviewed to ensure the practices remained appropriate with the change to virtual/telephonic provider visits. Title V programs supported purchase and utilization of remote/online developmental screening tools for service providers since in-person visits remained challenging through the COVID shutdowns. Title V increased parent input/partnerships to improve outreach efforts for developmental screening. The *Learn the Signs Act Early* project used parent social influencers to develop and promote messaging on the importance of developmental screening using their social media platforms on Facebook, Instagram, and Facebook Live.

NPM 10 Adolescent Health. The Adolescent Health Unit (AHU) continued to collect input from youth, working with TeenLink Hawaii, a youth empowerment, outreach, and education program that provides information and referral services for youth and young adults. Survey findings indicated more resources and support were needed for mental health issues like depression, managing stress, and the importance of sleep. Social media was reported as the best way to meet the need for easier access to health information. Anonymous online access with ease of use was cited as highly desired, including a secure website where questions can be asked and answered anonymously. Teens also cited other useful information modes, from classes to resources through school, email, and special events. Youth also appear to use multiple sources for information/learning; thus, a multipronged approach may be needed. The survey data is used to update the TeenLink Hawaii resources and a future TeenLink media campaign.

NPM 12 Transition to Adult Care. The CSHN Branch continued to collect input from youth and families on transition information and planning tools. CSHNB and the Title V Adolescent Health program worked with TeenLink Hawaii to conduct a second youth survey to:

- Assess knowledge of their own health and ability to access health care.
- Assess the continuing effects of COVID-19 on their lives.
- Assess their preferred sources for healthcare information and planning tools.

The young adult staff at TeenLink Hawaii used the assessment findings to develop transition messaging posted on Instagram and TikTok. Also, based on the survey results, CSHNB will revise the transition planning printed materials and PDFs to interactive digital apps and formats. CSHNB will also be working with families to the effectiveness of it's transition planning services and materials.

SPM 1 Child Abuse and Neglect CAN prevention has two primary mechanisms for community input including: 1) The Hawaii Children's Trust Fund (HCTF) Advisory Committee (11 private and public members) and 2) The HCTF Coalition (30 active members representing key community partners working to prevent child maltreatment across the islands). These groups serve a range of consumers and provide an important voice for their communities. Based on input, the Title V CAN Prevention programs diverted funding toward a network of community-based programs and services to address/support the immediate needs of the most vulnerable, under-resourced populations and areas in the state.

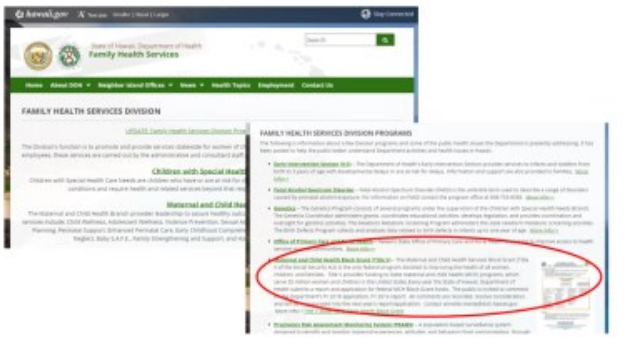
SPM 2 Food Insecurity & WIC. To improve WIC services, a community advisory workgroup was formed in 2022 and met regularly for a year to identify barriers and recommendations to improve utilization and enrollment to WIC services. Members include WIC staff from the state WIC office, WIC community clinics (including those in Federally Qualified Health Centers), university researchers, the Native Hawaiian healthcare system, family advocates, and current WIC recipient mothers.

The participation of WIC clients in the working group provided an invaluable perspective, helping members understand how WIC works – and does not work – for its clients. For example, WIC clients shared the pervasive misinformation that employed families could not qualify for WIC benefits. It was suggested that outreach via workplaces could be especially effective. Other client input shared the difficulty tracking the expiration of WIC benefits (that need to be continuously renewed). She suggested regular reminders via text, or a smartphone app would help clients better utilize their benefits. This input is being incorporated into service recommendations/plans. More qualitative research with WIC clients will be used to address under-utilization and attrition in WIC enrollment as children age.

SPM 3: Child Mental Health Access. The major aim of this project funding was to develop a real-time consulting service staffed by mental health professionals, to support pediatric primary care providers in addressing the behavioral needs of their clients. Over the past year, PMHA staff have developed critical relationships with pediatric providers, including a new AAP PMHA Champion to conduct informal meeting discussions with pediatricians statewide around mental health concerns. Meetings were held on each of the counties with particular attention provided to rural neighbor islands including Maui pediatricians. When the Maui wildfires occurred in August 2023, the pediatricians were ready and open to consider piloting the warm-line as Maui's burgeoning mental health crisis started to worsen, fueled by COVID and now the Lahaina fires. As part of the statewide Maui response efforts, PHMA is now partnering with the Queen's Healthcare System, one of the state's largest integrated health systems, and the Hawaii Community Foundation to establish the Maui pilot warmline.

Public Access to the Title V Report/Application

The FHSD Title V reports are posted on the Hawaii website (https://health.hawaii.gov/fhsd/home/title-v-maternal-child-health-block-grant/) once the report has been submitted. The Hawaii Title V website also archives the PPT presentations and videos used during past years' block grant reviews.



Comments can be submitted throughout the year via a return email function on the website. No comments were received on the report submitted in FY 2023, with the exception of a research inquiry and several solicitations from national companies interested in marketing their services. The information was shared with appropriate agencies.

III.G. Technical Assistance

Hawaii contracts for national and local technical assistance (TA) for ongoing, long-term support for completion of the Title V annual report and needs assessment. Staff TA is also contracted to assist with evaluation, review of data, and evidence-based planning.

Hawaii has no short-term TA request at this time.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title_V-Medicaid_IAA_MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Maps and Policies.pdf

Supporting Document #02 - PM OM Summary References.pdf

Supporting Document #03 - FHSD Program Descriptions (July 2023).pdf

Supporting Document #04 - Logic Models.pdf

Supporting Document #05 - Glossary of Terms.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - VI.Organizational Chart.pdf

VII. Appendix

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