



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

In reply, please refer to:

December 22, 2020

The Honorable Ronald D. Kouchi,  
President and Members of the Senate  
Thirtieth State Legislature  
State Capitol, Room 409  
Honolulu, Hawaii 96813

The Honorable Scott K. Saiki, Speaker  
and Members of the House of  
Representatives  
Thirtieth State Legislature  
State Capitol, Room 431  
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the

Annual Report on Child Death Review and Maternal Mortality Review Activities pursuant to Act 203, S.B. 2317, Session Laws Hawaii 2016 § 621-622. In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:

<https://health.hawaii.gov/opppd/departments-of-health-reports-to-2021-legislature/>

Sincerely,

A handwritten signature in black ink, appearing to read "Elizabeth A. Char", is written over a horizontal line.

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

Enclosures

c: Legislative Reference Bureau  
Hawaii State Library (7)  
Hamilton Library

**REPORT TO THE THIRTY- FIRST LEGISLATURE**

**STATE OF HAWAI'I**

**2021**

**PURSUANT TO ACT 203, S.B. 2317, (SLH 2016 § AT 621-622)**

**REQUIRING THE DEPARTMENT OF HEALTH TO PROVIDE AN ANNUAL REPORT  
ON CHILD DEATH REVIEW AND MATERNAL MORTALITY REVIEW ACTIVITIES**



**PREPARED BY:**

**STATE OF HAWAI'I  
DEPARTMENT OF HEALTH  
HEALTH RESOURCES ADMINISTRATION  
FAMILY HEALTH SERVICES DIVISION  
MATERNAL AND CHILD HEALTH BRANCH**

**December 2020**

## **2021 REPORT TO THE HAWAII STATE LEGISLATURE**

Requiring the Department of Health (DOH) to provide an annual report on child death review and maternal mortality review activities.

### **CHILD DEATH REVIEW**

#### **A. Family Health Services Division, Maternal and Child Health Branch**

The Mission of the DOH Family Health Services Division (FHSD) is to assure the availability of and access to preventive and protective health services for individuals and families by providing leadership in collaboration with communities and public-private partners. These services are carried out by the administrative staff of the Division office and through three branches: Children with Special Health Needs (CSHN); Women, Infants, and Children (WIC), and Maternal and Child Health Branch (MCHB).

A core aspect of MCHB is the administration of services to reduce health disparities for women, children, and families of Hawai'i. One key element of administering preventative public health services directed by MCHB is through three fatality reviews: child death, maternal mortality, and domestic violence. The Division's three branches work in collaboration, sharing information to assist in identifying critical facts to prevent and reduce future similar deaths.

#### **B. Child Death Review Summary**

The COVID-19 pandemic greatly altered statewide, in-person fatality reviews and training and informational opportunities for staff and families. From March through May 2020, there was a period of transition as MCHB redesigned the regular in-person Child Death Review team meetings to videoconferencing via Zoom.

National and local conferences with sessions supporting child death prevention strategies and partnership opportunities were postponed or canceled during the start of the pandemic. Due to the dedication and commitment of members statewide, the Hawai'i Child Death Review teams in all counties (Hawai'i, Kaua'i, Maui, and O'ahu) were able to continue with child fatality reviews and the implementation of recommendations.

Fatality reviews are theories and methods grounded in public health and designed to identify and understand risk factors for death. It is an examination of relevant records relating to the decedent by a multidisciplinary and multiagency team of professionals. The goal is to understand the causes, circumstances, and incidences of these deaths in Hawai'i and identify objectives, recommendations, and outcomes to reduce the number of preventable child deaths. Information is then shared with the general public.

Child death reviews provide essential information needed to identify strategies to improve child health and safety. Through this review process:

- 1) Child deaths in Hawai'i are reviewed one year after the death occurs.
- 2) Public-private members of the community examine the circumstances surrounding a child's death.
- 3) Data is analyzed and recommendations are made in order to assess which deaths may be preventable.
- 4) Interagency collaboration assists team members in understanding why children die and promotes the development of interventions to protect other children and prevent future deaths.

### **C. Legislation for the Child Death Review**

In Hawai'i, the Child Death Review System was legislatively established in 1997 by HRS §321-341. MCHB was designated as the responsible state agency to implement these multidisciplinary and multiagency reviews of child deaths.

In 2016, the Legislature passed Act 203, S.B. 2317 authorizing comprehensive multidisciplinary reviews of child deaths and adding the review of maternal deaths with the submission of an annual report to the Legislature. The stated purpose of these reviews is to understand risk factors and prevent future child and maternal deaths in Hawai'i.

HRS §321-343 also provides access to information from all providers of healthcare, social services, and state and county agencies for the use of child death reviews upon written request from the Director of Health. HRS §321-346 immunity from liability states that all agencies and individuals participating in the review of child deaths shall not be held civilly or criminally liable for providing the information required under this part.

Funds for a registered nurse position was also approved through the 2016 Legislation Session and established in 2018. Recruitment was curtailed in March 2020 and is now currently in process. During the interim period, DOH contracted with a registered nurse and collaborated with the DOH Public Health Nursing Branch that worked with MCHB, screening data received from the DOH Office of Health Status Monitoring to identify deaths for review.

These child death categories selected for review have been defined by the National Center for Fatality Review and Prevention and supported by the U.S. Department of Health and Human Services, Health Resources and Administration, and Maternal and Child Health Bureau to include: child abuse and neglect, homicide, suicide, undetermined, natural, and unintentional injury.

#### **D. Other Child Death Review Support**

- 1) The Hawai'i Maternal & Infant Health Collaborative, a public-private agency, is an influential group that assists in improving maternal and infant health outcomes and enhancing systems and supports for families and communities in Hawai'i. Specific workgroups with community members place emphasis on preventative activities to reduce and limit child deaths.
- 2) There are two sections within MCHB: (1) Women and Reproductive Health and (2) Family Support and Violence Prevention. These sections promote healthy lifestyles for children, using federal and state funds, including:
  - a) Community-Based Child Abuse Prevention (federal grant) – focuses on prevention programs and activities designed to strengthen and support families to prevent child abuse.
  - b) MCHB Domestic Violence Sexual Assault Special Fund – uses a public health approach to incorporate the special funds, implementing strategies and activities to prevent, reduce, and eliminate sexual violence and domestic-intimate partner violence.
- 3) Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) (federal grant) – voluntary, evidence-based home visiting service for at-risk pregnant women and families with children through kindergarten entry. MIECHV provides:
  - a) Home visiting professionals that are paired with families who have limited supports and resources.
  - b) Promotion of positive birth outcomes for pregnant women with referrals for other needed services.
  - c) Parenting education on child development, maternal and child health, and preparing children for school readiness.
  - d) Services that are also available for homeless/houseless families.
- 4) Personal Responsibility Education Program (federal grant) – supports organizations and communities to reduce the risk of youth homelessness, adolescent pregnancy, and domestic violence.
- 5) Rape Prevention and Education Program (federal grant) – guides the implementation of sexual violence prevention efforts, which includes stopping sexual violence before it begins; reducing risk factors; and using the best available evidence when planning, implementing, and evaluating prevention programs.
- 6) MCHB also utilizes funds through FHSD's Title V Maternal and Child Health (MCH) Block Grant authorized in 1935 as part of the Social Security Act. Title V's mission is to improve the health and well-being of the nation's mothers, infants, children, and youth, including children and youth with special healthcare needs and their families. The program is funded through the Health Resources and

Services Administration's Maternal and Child Health Bureau and administered by FHSD.

Title V – The priority needs for children identified in the Title V Hawai'i State Action Plan 2021 and 2019 Annual Report are:

- a) Perinatal/Infant Health – increase the rate of infants sleeping in safe conditions;
- b) Child Health – improve the percentage of children screened early and continuously for ages 0-5 years for developmental delay and reduce the rate of confirmed child abuse and neglect cases per 1,000 with special attention to children ages 0-5 years;
- c) Adolescent Health – improve the healthy development, health, safety, and well-being of adolescents; and
- d) Children with special healthcare needs – improve the percentage of youth with special healthcare needs ages 12-21 years who receive services necessary to make transitions to adult healthcare.

## **E. Pertinent Data**

Statewide Child Death Review teams examine cases one year after the death occurs.

- 1) **Total number of child deaths** for 2019 was 141. There were 42 non-natural deaths and 99 natural deaths.
  - a) Cause of death for non-natural deaths: accidents; suicide; homicide; undetermined cases that are difficult to establish with reasonable medical certainty; drowning; falls; unintentional asphyxia; assault with a weapon; poisoning; overdose; and acute intoxication.
  - b) Natural deaths are those attributed to disease process related causes, such as congenital anomalies, genetic disorders, cancers, serious infections, Sudden Infant Death Syndrome, Sudden Unexpected Infant Death, pneumonia, and respiratory failure.
- 2) **Number of children deaths in state custody (Department of Human Services, Social Services Division, Child Welfare Services)** for 2019
  - a) There were no deaths for children in state custody.
- 3) **Trends – Data gathered through DOH Vital Records**
  - a) More than half of the non-natural child death cases were in Honolulu – 24
    - i. Hawai'i County – nine
    - ii. Kaua'i County – three
    - iii. Maui County – six
  - b) Most of the non-natural causes of death for children in Honolulu were accidents and suicide.
  - c) The age group of suicide ranged from 9-17 years and were all males.
  - d) Most of the non-natural infant deaths were sleep-related and undetermined.

- e) Overall, further assessments will be needed to review the 2020 trends and determine whether the coronavirus pandemic influenced the number of preventable deaths.
- f) There were increased adverse socio-economic conditions beginning in March 2020 for children due to the state lockdown in an effort to slow the spread of the coronavirus, including school closures; changes from in-person instruction to online instruction; lack of internet capability and electronic devices for some families; and a decrease of in-person interaction with peers and teachers. Outdoor activities and exercise for children were also limited.
- g) Future assessments and activities on the impact to the well-being of children and families during the pandemic are in process.

#### **4) Recommendations for System Changes**

- a) Increase the percent of adolescents ages 12-17 with preventive medical visits.
- b) Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits.
- c) Increase prevention strategies for promoting child and adolescent wellness, including developing social media and other online content that is mobile-responsive for both parents and adolescents.
- d) Provide opportunities for youth to be a part of decision-making for suicide and motor vehicle preventative strategies.

#### **5) Proposed Legislative Recommendations**

- a) Submit a plan in 2022 identifying specific actions required to create a Fetal and Infant Mortality Review for Hawai'i.
- b) Require homes (residences and vacation rentals) to install childproof fencing and self-latching gates for swimming pools.

### **F. Preventative Program Activities**

- 1) **O'ahu** – There were nine Child Death Review team meetings completed in 2020 for a total review of 20 cases.
  - a) Due to the coronavirus pandemic, in-person meetings needed to be temporarily arranged via videoconferencing. The Child Death Review team members were able to obtain the proper equipment and consents from their agencies to participate in videoconferencing, maintaining case confidentiality and security of documents shared.
  - b) Contracted with Hilopa'a to assist in implementing Child Death Review recommendations, while partnering with multiple community organizations on O'ahu and in Hawai'i County.
    - i. Education and Information – provided to families to increase knowledge of resources and an understanding of systems to improve family strengthening and child health.
    - ii. Developed information for families on the importance of integrating cultural values and traditions into parenting and caregiving practices.

- iii. Worked with partners in Hawai'i County and on the O'ahu Leeward Coast to determine prevention priorities for children.
    - iv. Created written information for private businesses and schools on child prevention priorities for adolescent wellness to prevent teen suicides and developed planned advertisements for venues generally attended by adolescents (e.g. movie theaters, malls, beaches, etc.) .However, due to the state lockdown in March 2020 caused by the pandemic, efforts for implementation were placed on a temporary hold.
  - c) Transition of the Child Death Review Council Committee to the Collaborative Fatality Review to include statewide fatality review members from multiple State of Hawai'i departments and other DOH divisions.
    - i. Focused areas and planning discussed: developing opportunities for interaction with local hospitals and statewide fatality reviews; addressing child death trends occurring in specific geographic areas; partnering with community agencies with similar prevention goals for children; developing specific apps for teens and caregivers/families; increasing media presence; developing a guide for fatality teams, providing information to legislators for system changes; and developing evaluation methods of effectiveness.
    - ii. The MCHB website is currently in the process of being updated to include more resource information for families, caregivers, and the general public.
- 2) **Hawai'i County** – There were six Child Death Review cases completed and prevention efforts were on linking families to mental health supports due to an increase of undue stress caused by the pandemic. Public awareness messaging (paid through community partner donors) via radio ads were focused on the prevention of domestic violence and identified where families could seek help.
  - a) Initially, there were limited opportunities to conduct business in person due to the state lockdown and other competing work priorities of community partners caused by the pandemic. Community partners worked in collaboration with DOH and were able to reconnect and resume services and supports to community members by using videoconferencing for planning meetings. Hawai'i County continues to address interventions needed in limiting and reducing preventative child deaths, while working towards restructuring local system changes.
  - b) A training curriculum on drowning awareness and prevention was created by a Hilo agency, PATCH (People Attentive to Children), in response to drowning accidents of children in Hilo catchment tanks.
- 3) **Maui County** – Worked on implementing Child Death Review recommendations from previous reviews.
  - a) Safe Sleep Prevention – meet with the Hawai'i Safe Sleep Coalition and distributed safe sleep promotional materials.
    - i. Partnered with Maui Family Support Services, Ka Hale A Ke Ola Homeless Resource Center, Maui Children with Special Health Needs

- Program, and WIC to distribute play yards to pregnant women and women with infants to promote safe sleep practices.
- ii. Distributed additional safe sleep materials to community partners: Ho‘oikaika Partnership, IMUA Family Services, Mālama Family Recovery Center, Ka Hale A Ke Ola Homeless Resource Center, and PATCH Maui.
- b) Motor Vehicle Accident Prevention – The causes of motor fatalities were often due to youth driving under the influence of alcohol or drugs. Met with the Youth Services Program leaders at the Maui Economic Opportunity agency to discuss prevention strategies to deter youth from drinking alcohol and driving under the influence.
- i. Partnered with Maui Vision Zero, which aims to prevent traffic fatalities and discussed crash prevention interventions.
  - ii. Distributed information on child car seat safety and booster seat brochures to Ho‘oikaika Partnership and DOH contracted Home Visiting agencies.
- c) Youth Suicide Prevention – distributed preventative information and provided trainings on mental health and suicide prevention to the Maui community. Trainings were conducted by Maui partner organizations.
- i. Partnered with the Prevent Suicide Maui County Task Force and Mental Health America to provide the Maui Chapter on Suicide Prevention 101 training to the Maui Police Department, Maui Department of Education, and Youth Servicing Agencies. Also addressed was the socio-economic and mental health stressors families and youth were experiencing during coronavirus-related responses and shutdowns.
  - ii. Community partners participated in the Mental Health America Virtual Conference sponsored by the Prevent Suicide Maui County Task Force.
  - iii. In collaboration with Maui partners, supported the Suicide Prevention Awareness video PSA that aired on Akakū Maui Community Media, radio, and Facebook.
- d) Child Abuse and Neglect Prevention – conducted monthly Ho‘oikaika Partnership Zoom meetings on Community Based Child Abuse Prevention.
- i. Virtual conference trainings were provided with funds through the DOH Community Based Child Abuse Program (federal grant), VOCA, and the Casey Family on the implication and applications of protective factors to promote social justice during the pandemic and digital world addressing the health stressors.
  - ii. Participated in the April 2020 Virtual Child Abuse and Neglect Prevention Awareness Campaign. Partners for this event included organizations and individuals: Islands of Hope Maui, Ho‘oikaika Partnership, John Cruz, Maui Family Support Services, and ECCS-County of Maui Multiagency Interdisciplinary Team. There was also a proclamation signing by the County of Maui Mayor’s Office in support of Child Abuse and Prevention Awareness.
- 4) **Kaua‘i County** – There were three Child Death Review cases completed and the emphasis for 2020 was to continue implementing preventative activities identified from previous child death review recommendations.

- a) Safe Sleep Prevention – The Kauaʻi Child Death Review team members met with the Hawaiʻi Safe Sleep Coalition and distributed safe sleep promotional materials.
  - i. The Kauaʻi Child Death Review team also partnered with Kauaʻi Public Health Nursing, Kauaʻi Children with Special Health Needs program, and Kauaʻi WIC to distribute play yards to pregnant women and post-pregnant women to promote safe sleep practices for their infants. Distributed Safe Sleep promotional materials to community partners.
- b) Child Drowning Prevention – formed a drowning prevention working group in 2019. In 2019 and 2020, the group did presentations to pediatricians and other physicians at Wilcox Hospital, Kauaʻi Veterans Memorial Hospital, and Kauaʻi Business Association on child drowning prevention.
  - i. Water Watcher lanyards with messaging were also purchased to remind parents and guardians to watch children closely when in the water.
- c) Motor Vehicle Accident Prevention – Motor vehicle fatalities on Kauaʻi were often due to driving under the influence of alcohol or drugs. Meetings were held with the Kauaʻi Youth Alcohol Coalition to discuss prevention strategies for youth drinking alcohol and driving under the influence of alcohol.
  - i. Other prevention motor vehicle meetings were held with Kauaʻi Vision Zero, an agency with the aim of preventing highway systems fatalities or serious injuries involving road traffic.
  - ii. Distributed information on child car safety checks created by Wilcox Hospital.
- d) Youth Suicide Prevention – in collaboration with community partner organizations, distributed information and provided trainings on mental health and suicide prevention to the Kauaʻi community.
  - i. Purchased family strengthening and positive messaging materials for children: “kindness matters” stickers and t-shirts.
  - ii. Organized peer-led parenting classes.
  - iii. Supported funding for meetings with the Kauaʻi Child Abuse Prevention Group and Family Strengthening Coalition to address socio-economic and mental health stressors families and youth were experiencing from the coronavirus lockdowns.
  - iv. Contributed to the development of a comprehensive Kauaʻi Community Resource flyer with resources for promoting family strengthening and healthy mental health.

## **G. Collaborative Efforts**

MCHB contracted with community agencies (public and private) to assist in providing preventative strategies to reduce child deaths.

- 1) Hilopaʻa – to assist in implementing Child Death Review prevention recommendations.
  - a) Increase training and information for families – arranged for attendance at a national conference, Association of Maternal & Child Health Programs, for

- two families from Moloka'i (Maui County) and one family advocate. Unfortunately, the in-person conference was canceled due to the pandemic and instead a virtual conference was convened several months later.
- b) Provided support, equipment, and supplies to families and children statewide in domestic violence shelters as requested by the Hawai'i State Coalition Against Domestic Violence, ensuring health and safety during the onset of the pandemic. The equipment also assisted families of the shelters to access healthcare providers via telehealth.
  - c) Arranged for informational sessions on O'ahu to incorporate cultural values and traditions into preventative interventions (i.e., safe sleep practices, adolescent wellness, and drowning prevention) for families and children.
  - d) Launched "Promoting Connectedness," an evidence-based strategy for suicide prevention (identified through the Centers for Disease Control and Prevention [CDC]), encouraging peer-to-peer programs to connect through social media amid the social isolation caused by the pandemic.
- 2) Child and Family Services – to develop and maintain a resource directory for families in Hawai'i, The Parent Line, a premier resource on child behavior, child development, parenting support, and community resources.
- 3) Advancement Services for Native Nonprofits – developed a Child Death Review recommendation implementation action plan for O'ahu and Hawai'i County, identifying priority strategies to assist in the coordination of clinician services during the interim period before the DOH Child Death Review/Maternal Mortality Review registered nurse is hired. Priority strategies also included assistance in the distribution of authorized and approved preventative informational materials via social media to private and public stakeholders as determined by DOH.
- 4) University of Hawai'i at Mānoa, Center on Disability Studies – to assist in updating the MCHB website where vital information for family resources will be available.
- 5) Spectrum, KITV, Hawaii News Now, & KHON – to assist in producing and airing PSAs available through broadcast and cable television, digital platforms, apps, web banners, and online searches.
- a) The "Family Strengthening Campaign" was developed by FHSD staff and included morning news interviews with MCHB staff and TV anchors from the broadcast stations: KITV, Hawaii News Now, and KHON. Topics discussed promoted positive emotional health for children during the onset of the pandemic and how families, caregivers, and children could participate in activities together at home.
  - b) All interviews and messaging directed people to The Parent Line.
- 6) Indices Consulting – to conduct a Hawai'i Fetal, Infant, and Child Mortality assessment by reviewing prevalence factors associated with fetal, infant, and child death and developing a baseline for ongoing surveillance, working in

collaboration with FHSD, Hawai'i Children's Action Network, and the DOH Office of Planning Policy and Program Development.

## **H. State Collaboration**

- 1) Hawai'i County partnered with the DOH Public Health Nursing agency to promote interventions for safe sleep among high-risk families. Play yards and other incentives were provided to Pacific Islander families where common practices included multi-families living in the same dwelling and bed sharing. Play yards purchased with federal and state funds provided a safe place for infants to sleep. The distribution of the play yards and other incentives for Pacific Islander families provided opportunities for the public health nurses to arrange for home visits sharing health and safety education.
- 2) The Child Death Review registered nurse coordinators from the Hawai'i, Maui, and Kaua'i counties work in collaboration with the District Public Health Offices to assist with related coronavirus activities for the community, including testing, counseling, and contact tracing.
- 3) MCHB's Home Visiting Unit had discussions with the Hawai'i State Department of Human Services to explore joint partnerships with Home Visiting Services for families and children.

## **I. National Collaboration**

- 1) MCHB is currently participating in the National Center for Fatality Review and Prevention combined project with the Injury Leaders Training Collaborative of the John Hopkins Center for Injury Research and Policy on preventing injury leading to child deaths. The Hawai'i team project is promoting adolescent wellness to reduce the prevalence rate of youth suicide.
- 2) Continued consultation with the CDC for maternal mortality guidance and its impact on the health of women, infants, and the entire family.
- 3) Continued consultation with the National Center for Fatality Review and Prevention for technical support and use of the Case Reporting System.

## **MATERNAL MORTALITY REVIEW**

### **A. Background and Purpose**

The Hawai'i Maternal Mortality Review was established in 2016 and held its first review of maternal deaths in 2017. The purpose of the Hawai'i Maternal Mortality Review 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.

A Hawai'i Maternal and Mortality Review policy and procedure manual was developed in 2016 and identifies that the Hawai'i Maternal Mortality Review Committee reviews all maternal deaths in Hawai'i.

- 1) An abstractor reviews the available medical and other specialty reports to create case summaries discussed during the committee reviews.
- 2) The multiagency and multidisciplinary team reviews the case summaries.
- 3) A determination is made as to whether the death is pregnancy-related or pregnancy associated.
- 4) Pregnancy-related deaths are those that result from complications of pregnancy, the chain of events initiated by the pregnancy, or aggravation of an unrelated condition by the pregnancy.
- 5) Pregnancy associated deaths of a woman are from any cause while she is pregnant or within one year of termination of pregnancy.
- 6) Following the review of each maternal death, recommendations are made by the Hawai'i Maternal Mortality Review Committee to create plans of action that address preventative strategies for pregnant women to limit and reduce future deaths.

According to the CDC, "a maternal death is defined as the death of a woman while pregnant or within 1 year of the end of a pregnancy—regardless of the outcome, duration or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."

The CDC collected data to support that over 700 women die from pregnancy related complications each year in the United States, and in Hawai'i, 80% of pregnancy-related deaths were found to be preventable.

Amid the current coronavirus pandemic, the CDC advises that pregnant people are at an increased risk for severe illness from COVID-19 as compared to non-pregnant people. The World Health Organization recommends strong surveillance and testing of pregnant women to ensure well-being and that pregnant women should take the same

precautions to avoid COVID-19 infection as others: frequent hand washing, avoid crowded places, maintain distance from others, and wear a mask.

The increased focus on maternal mortality during the pandemic has exacerbated the need for continuous collaboration between Hawai'i public health agencies and medical healthcare organizations.

## **B. Program Activities**

The activities below were completed in 2020:

- 1) There were two Hawai'i Maternal Mortality Review Committee review meetings in June and December to review 2018 and 2019 maternal deaths. Also discussed were prevention strategies based on the findings. In-person fatality review meetings were also transitioned to videoconferencing meetings due to the pandemic.
- 2) MCHB Family Planning and Perinatal Support Services Programs continued to administer contracts with providers to offer an array of clinical and reproductive health services for adolescents, women, and men before, during, and after pregnancy, promoting healthy lifestyles and reproductive health planning.
- 3) During the interim period while MCHB continues to recruit for a child and maternal death review registered nurse, Healthy Mothers, Healthy Babies was awarded a contract from MCHB to assist with the activities listed below:
  - a) Medical abstraction services required for the Hawai'i Maternal Mortality Review case summaries.
  - b) Transcription of medical notes during the Hawai'i Maternal Mortality Review team meetings.
  - c) Data inputting of the medical notes and team decisions into the CDC Maternal Mortality Review Information Applications (MMRIA) database.
  - d) Healthy Mothers, Healthy Babies also arranged for Hawai'i advocates and several Federally Qualified Health Center administrators to attend the Association of Maternal & Child Health Programs Conference in Washington, D.C. The conference goals were to provide support, best practices, and information to participants on improving the health of women, children, youth, and families, including those with special healthcare needs. The in-person conference was canceled in March 2020 due to the pandemic and participants were able to participate in a virtual conference from August 4-6, 2020.
- 4) MCHB is a recipient of federal funds from the Maternal Infant Early Childhood Early Home Visiting Program (MIECHV) made available through the U.S. Department of Health and Human Services. FHSD Office of Primary Care and Rural Health provided supports for pregnant and postpartum Native Hawaiian and Pacific Islander women.

MIECHV funds via the HlePRO state procurement process were awarded to the agencies listed below. All agencies provided information and referrals to the MCHB Home Visiting Program.

- a) Hawai'i County – Advancement Services for Native Nonprofits partnered with a pediatric and new baby care coordinator and secured relationships with healthcare providers within the County of Hawai'i, including the Native Hawaiian Health Center's Papa Lawe Hānai Kaiāulu, to create software systems allowing for the identification of Native Hawaiian and Pacific Islander pregnant women including other pregnant and postpartum women.
  - i. Established alternative options to in-person visits via technology by purchasing tablets, laptops, printers, linkages to text messaging, connectivity, and licensing to offer telehealth options.
  - ii. Created health and safety kits for pregnant and postpartum women with infants.
  - iii. Developed tracking, communications systems, and access to virtual platforms.
  - iv. Connected families with DOH Early Intervention and Public Health Nursing, Hawai'i State Department of Human Services, and other essential providers when concerns were identified.
  - v. Provided access to healthcare specialists to assist in determining a child's eligibility where there may be a disability. Established alternative options to in-person visits via technology by purchasing tablets, laptops, printers, linkages to text messaging, connectivity, and licensing to offer telehealth options.
- b) Kaua'i County – Mālama Pono Health Services supported an engagement opportunities coordinator that facilitated essential care supports and referrals to postpartum mothers with limited access to resources.
  - i. Developed telehealth stations to provide postpartum women access to information by purchasing laptops, tablets, and internet connectivity.
  - ii. Created virtual websites on multiple topics, reducing in-person exposure to COVID-19.
  - iii. Provided "dignity kits" to postpartum mothers with limited resources that included diapers, cribs, hygiene items for mothers and infants, car seats, and strollers.
- c) Maui County – Partners in Development Foundation worked with a mental health access support coordinator and provided remote telehealth equipment stations for conducting depression screenings with increased access to behavioral health and other medical services.
  - i. Purchased engagement supplies: breast pads, infant car seats, diapers, etc. to help build a support system for Pacific Islander and Native Hawaiian pregnant women and postpartum women.
  - ii. Social media and videoconferencing were used to engage postpartum women by offering classes online incorporating cultural values for childrearing.

- iii. Supports were also offered to address postpartum depression and the referral of resources for financial supports amid the pandemic.
- d) Maui County, Moloka'i & Lana'i – Advancement Services for Native Nonprofits collaborated with a pre and post pregnancy resource coordinator to work with community healthcare specialists in providing virtual support via videoconferencing and text messaging for participants. Virtual topics included nutrition, exercise, reducing stress, infant care, breastfeeding, and the importance of cultural traditions and values related to childbirth and childrearing.
  - i. Families were connected to telehealth resources and the agency created an informational hub to provide remote support to perinatal women.
  - ii. Created prenatal and post-pregnancy support packages, including maternal and infant essentials promoting safe-sleep practices in rural communities with limited resources.
  - iii. Established new partnerships, provided options for additional resources, and provided internet connectivity allowing for telehealth access, on-going training, and videoconferencing sessions.
  - iv. Continued distribution of resources to be coordinated through the Native Hawaiian Healthcare System – Nā Pu'uwai, INPEACE Hi'ilei (Moloka'i), Moloka'i Family Support Services, Lana'i Health Center, Lana'i Keiki Network, and Family Hui Hawai'i on Lana'i.
- e) O'ahu – Kōkua Kalihi Valley Comprehensive Family Services established a resource and technical support coordinator position and engaged pregnant women and their families in Native Hawaiian cultural birthing curriculums and connected the women with other support services.
  - i. Provided couples with sessions on ho'oponopono (preparing the pathway for relationships); 'ai pono (healthy eating using traditional foods); la'au lapa'au (plant medicine); lomilomi (Hawaiian massage); and other traditional knowledge-based practices for healthy pregnancies and births.
  - ii. Cultural practices assisted the women and their families in gaining knowledge and skills for long-term health and well-being.
  - iii. Cultural practitioner classes supported Hawaiian families in pregnancy and birth practices, and old editions of newspapers written in Hawaiian were read and translated for families to learn more about cultural ancestral practices.
  - iv. Developed informational resources via videos portraying Native Hawaiian mothers in various stages of labor and birth. Interviewed women to discuss breastfeeding practices and made the information available online.

### **C. State Collaborative Efforts**

- 1) The University of Hawai'i, John A. Burns School of Medicine, Department of Obstetrics, Gynecology, and Women's Health, Division of Maternal-Fetal Medicine completed maternal postpartum depression group supports. MCHB contributed towards some initial start-up funds for the Rose Study. Currently, Kapiolani Medical Center for Women and Children and Healthy Mothers, Healthy Babies are two of 70 organizations that are participating in the ROSE Study.
  - a) ROSE (Reach Out, Stay Strong, Essentials for mothers of newborns) Study
    - i. Essential for mothers of newborns with classes provided in prenatal clinics.
    - ii. Provides pregnant women with the skills and information they need to lower their risk of postpartum depression.
    - iii. Teaches women to recognize the signs of depression.
- 2) The Hawai'i Maternal & Infant Health Collaborative places emphasis on improving maternal and infant health outcomes for families and children of Hawai'i. The group consists of public-private partners including representatives from MCHB and DOH Office of Planning Policy and Program Development. The group provides announcements, recommendations, and supports to the partners of the Collaborative.
  - a) Perinatal Quality Collaborative – meetings are hosted to improve the quality of care for mothers and babies by sharing information with each other and understanding best practices.
  - b) Coordinated discussions between healthcare providers and state agencies to discuss how the coronavirus pandemic has impacted hospitals.
  - c) Discussions on maternal telehealth access for families.
  - d) Reported to the group on the Hawai'i State Commission on the Status of Women and Healthy Mothers, Healthy Babies (private partner of the Hawai'i Maternal & Infant Health Collaborative) recent completion of a survey of pregnant mothers during the COVID-19 pandemic in Hawai'i.
  - e) Discussions on improvements of system care for high-risk pregnant women.
  - f) The Child Death Review and Maternal Mortality Review Recommendation Implementation is one of the workgroups formed by the Collaborative.
    - i. Merged two workgroups together to improve coordination and impact a broader focus for multiple initiatives aimed at preventing preterm birth and maternal infant mortality.
    - ii. Challenges – continuing efforts during the COVID-19 pandemic by meeting remotely through videoconferencing with limited opportunities for networking and small in-person group discussions.

### **D. National Collaborative Efforts 2019-2020**

- 1) The State DOH and Hawai'i Maternal Mortality Review team continue to receive consultation and technical assistance from the CDC Maternal Mortality Review Program. This assists the Hawai'i Maternal Mortality Review Committee in using

best practices and ensuring that quality data and recommendations are in place to prevent and reduce maternal deaths.

- a) DOH was appreciative of the opportunity to send a Hawai'i Maternal Mortality Review registered nurse team member to participate in the CDC Maternal Mortality Prevention Team, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion "Maternal Mortality Review Information Application (MMRIA) User Meeting."
  - i. MMRIA is a public software tool created by the CDC to collect, store, analyze, and summarize information related to maternal deaths.
- b) MCHB – created a poster describing the Hawai'i Maternal Mortality Review process to participate in the CDC Maternal Mortality Poster Walk in Atlanta, GA.

## **E. Hawai'i Maternal Mortality Review Data**

During 2020, the committee reviewed maternal deaths occurring in the calendar year 2018 and started the 2019 review. Information on the deaths were obtained from the DOH Office of Health Status Monitoring (Vital Records).

- 1) 2018 – There were 10 maternal deaths and 10 case reviews completed.
- 2) 2019 – There were 11 maternal deaths. The number of cases to be reviewed at the December 2020 meeting is in process.
- 3) 2020 – As of October 2020, there were 9 maternal deaths reported.

## **F. Recommendations and Action**

- 1) Hospitals and health systems to work together on reporting maternal and morbidity data.
- 2) Participate in discussions with interested community partners on AIM (Alliance for Innovation on Maternal Health), a national data-driven, maternal safety and quality improvement initiative.
- 3) MCHB plans to work in collaboration with healthcare providers to coordinate training and informational sessions to physicians by physicians on the importance of accurately completing Hawai'i birth and death certificates.
  - a) Death certificates provide important information about the decedent—circumstances and the causes of death. The importance of knowing if the decedent was pregnant assists physicians in determining if the death was a maternal death. This information assists Maternal Mortality Fatality Reviews, epidemiologists, and others in accurately reporting the number of maternal deaths and determining interventions for improvement in maternal care to prevent future maternal deaths.

- b) Obstetrician-gynecologists play an essential role in ensuring accurate representation of pregnancy-related and pregnancy-associated deaths.
- c) The American College of Obstetricians and Gynecologists, Committee Opinion, "The Importance of Vital Records and Statistics" #748, August 2018, recommends that obstetricians-gynecologists:
  - i. Become well-informed of state and local regulations regarding medical certifications for deaths and registration of births;
  - ii. Ensure prompt documentation of vital events (i.e. births, maternal, and fetal deaths) in the medical record by appropriate personnel;
  - iii. Advocate for sufficient funding to modernize and standardize the vital statistics system in the United States;
  - iv. Support training for everyone involved in vital records collection (e.g. birth attendants, birth clerks, and hospital administrators); and
  - v. Advocate for widespread adoption of the 2013 revised U.S. Standard Certificate of Death; U.S. Standard Report of Fetal Death; and National Center for Health Statistics standardized reporting guidelines, definitions, and worksheets.
- 4) DOH to continue as a committee member on the Hawai'i Maternal & Infant Health Collaborative and Recommendation Implementation Workgroup Preterm, Child Death Review, and Maternal Mortality Review.
- 5) Engage in Perinatal Quality Collaborative discussions with interested community partners to continue working towards improving accessibility and the quality of health services for mothers and babies. DOH is currently working with the Healthcare Association of Hawai'i on a perinatal collaborative.
- 6) In recognition of the importance of healthy pregnancies, MCHB will continue to lead the effort to encourage improved coordination of implementing the "One Key Question®" (the power to decide if, when, and under what circumstances to get pregnant and have a child) in hospitals, health centers, and private physician offices.
- 7) Continued meetings with interested private and public stakeholders to discuss plans of action for the implementation of Hawai'i Maternal Mortality Review recommendations from a public health and medical perspective.