



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

In reply, please refer to:

Jan 3, 2022

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

The Honorable Scott K. Saiki, Speaker  
and Members of the House of  
Representatives  
Thirty-first 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 combined report:

- Act 203, SB 2317, Session Laws Hawaii 2016, 621-622
- §321-346 Child Death Hawaii Review System, Hawaii Revised Statutes (HRS)

In accordance with Section 93-16, HRS, I am also informing you that the report may be viewed electronically at:

<https://health.hawaii.gov/opppd/departments-of-health-reports-to-2022-legislature/>

Sincerely,

A handwritten signature in black ink, appearing to read "Elizabeth A. Char", followed by a small flourish.

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

Enclosures

c: Legislative Reference Bureau  
Hawaii State Library System (2)  
Hamilton Library

**REPORT TO THE THIRTY- FIRST LEGISLATURE**

**STATE OF HAWAI‘I**

**2022**

**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 2021**

## **2022 REPORT TO THE HAWAII STATE LEGISLATURE**

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

The information within this report emphasizes the importance of continued Hawai'i Child Death Reviews identifying strategies and recommendations to greatly reduce and limit preventable child deaths and improve child health and safety.

Life events play an important role in ensuring healthy environments for children and families. The Centers for Disease Control and Prevention (CDC) puts out guidance for parents raising their children; disease and conditions; staying safe at home and out of the home; raising healthy children; milestones and schedules; engaging parents in school health; and back to school resources amid the COVID-19 pandemic for parents.

The CDC has also confirmed through research that during the developmental period, children develop habits and behavior that can affect their lifelong health. Addressing and working with these childhood experiences is a preventive measure to reduce adult disparities. It is instrumental to be able to provide parents and families with the "appropriate resources" to keep their children safe at home and in the community.

### **CHILD DEATH REVIEW**

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

The worldwide COVID-19 pandemic of 2020-2021 has greatly changed the lifestyles of many children, parents, and families, resulting in extraordinary modifications and adjustments to everyday living. Public and private agencies have redesigned the wide array of services and resources in order to continue providing needed public health supports to children and families in Hawai'i.

The DOH Family Health Services Division (FHSD) is committed to continuously working towards improving 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 preventive 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**

Child death reviews provide essential information needed to identify strategies to improve child health and safety. These child 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 deceased 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.

- 1) Child death reviews in Hawai'i are reviewed one year after the death occurs and public and private members of the community examine the circumstances surrounding a child's death.
- 2) Interagency collaboration assists team members in understanding why children die and promotes the development of interventions to protect other children and prevent future deaths.
- 3) Data is then analyzed and recommendations are made in order to assess which deaths may be preventable.
- 4) Public and private agencies collaborate to ensure prevention strategies and recommendations are available for families, parents, and the entire community.
- 5) The National Center for Fatality Review and Prevention funded in part by Cooperative Agreement from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau and provides support to Hawai'i in the following areas:
  - a) Ensures consistent reporting of the cause and manner of death within the National Fatality Review Case Reporting System that is available to the Hawai'i Child Death Review team
  - b) Encourages the improvement of communication and linkages among local and state agencies enhancing the coordination of efforts
  - c) Provides webinars, training, data support, and resource development to Hawai'i

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

The Child Death Hawai'i 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 due to the COVID-19 pandemic and resumed in 2021. A Registered Nurse was recently hired through the DOH FHSD/MCHB to support the Child Death Review and Maternal Mortality Review administration practices.

The child death categories selected for review in Hawai'i 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, Maternal and Child Health Bureau to include: child abuse and neglect, homicide, suicide, undetermined, natural, and unintentional injury.

### **D. Federal Funds for Child Death Review Support through the DOH FHSD/ MCHB**

- 1) Within MCHB, there are program areas that develop strategies with public and private partners to assist in limiting and reducing preventive child deaths. These program areas 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 and neglect
  - 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

- c) 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:
    - i. Home visiting professionals that are paired with families who have limited supports and resources
    - ii. Promotion of positive birth outcomes for pregnant women with referrals for other needed services
    - iii. Parenting education on child development, maternal and child health, and preparing children for school readiness
    - iv. Services that are also available for homeless/houseless families
- 2) Personal Responsibility Education Program (federal grant) – supports organizations and communities to reduce the risk of youth homelessness, adolescent pregnancy, and domestic violence.
- 3) 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.
- 4) 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.
  - a) Title V Priorities & Measures for Children FY 2022.
    - i. Women's & Maternal Health – Promote reproductive life planning
      - Promote women's wellness through systems building efforts
      - Promote pre/inter conception health care visits
      - Promote reproductive life planning
    - ii. Perinatal & Infant Health
      - Increase the rate of infants sleeping in safe conditions
      - Increase the awareness of the importance of Safe Sleep and provide safe sleep education through public service announcements and digital media
      - Reduce food insecurity for pregnant women and infants through Women, Infants, and Children (WIC) program promotion and partnerships

- Expand outreach to non-English speaking families and caregivers through translation of educational materials and safe sleep messages.
- iii. Child Health
- Improve the percentage of children screened early and continuously from ages 0-5 years for developmental delay through family engagement and public awareness; systems development; data collection and social determinants of health with vulnerable populations; and policy and public health coordination
  - Reduce the rate of confirmed child abuse and neglect cases per 1,000 with special attention to children ages 0-5 years by promoting health equity addressing disparities in confirmed child abuse and neglect cases
  - Promote child wellness immunizations among young children ages 0-5 years by collaborating with pediatric providers and community advocates to promote messaging on the importance of well-child visits
- iv. Adolescent Health
- Improve the healthy development, safety, and well-being of adolescents through developing collaborative partnerships with community health and youth services providers promoting adolescent wellness visits
  - Work with adolescents and youth service providers to disseminate informational resources to promote access to preventive health services
  - Develop self-help resources, tools, and services for Pacific Islander teens and young adults experiencing health disparities (e.g., lack of access to care, mental health situations, disease, uninsured/underinsured, etc.)
- v. Children and Youth with Special Health Care Needs
- Improve the percentage of youth with special health care needs ages 12-21 years who receive services necessary to make transitions to adult healthcare
  - 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 planning and practices in collaboration with state and community partners
- vi. Cross-Cutting Systems Building
- Address health equity and disparities by expanding pediatric mental health care access in rural and underserved

communities thorough the refinement, development and implementation of pediatric mental health care access models

- Promote workforce development and training on pediatric mental health care
- Support services and linkage in communities
- Address health and digital equity by expanding access to telehealth information and services in state public libraries located in underserved communities

## **E. Pertinent Data**

- 1) Total number of child deaths for 2020 was 113. There were 39 non-natural deaths and 74 natural deaths.
  - a) Cause of death for non-natural deaths: accidents (15); suicide (4); homicide (2); undetermined cases (10) that are difficult to establish with reasonable medical certainty and included: drowning, unintentional asphyxia, assault with a weapon, poisoning, overdose, and acute intoxication; and (8) for which the manner of death is pending.
  - 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 2020 there was one death.
  - a) The cause of the death was injuries sustained before child welfare foster placement.
- 3) Trends – Data gathered through DOH Vital Records
  - a) During 2020, there were 113 child deaths and in 2019 there were 141 child deaths, a decline of child deaths noted during the worldwide COVID-19 pandemic of 2020.
  - b) More than half of the non-natural child death cases were in Honolulu – 31.
    - i. Hawai'i County – 1
    - ii. Kaua'i County – 1
    - iii. Maui County – 6
  - c) Most of the non-natural causes of death for children in Honolulu were accidents (12).
  - d) Of the (4) Honolulu and Maui County suicides, the age group ranged from 9-16 years and included both males and females.
  - e) Most of the non-natural infant deaths were sleep-related and undetermined.



#### 4) Recommendations for System Changes

- a) Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits of youth ages 12-17.
- b) 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.
- c) Provide opportunities for youth to be a part of decision-making for suicide and motor vehicle preventive strategies.

#### 5) Proposed Legislative Recommendations

- a) The Honolulu Child Death Review team will continue to work on submitting a plan in 2022, identifying specific actions required to create a Fetal and Infant Mortality Review for Hawai'i.
  - i. Differences in child death and fetal death reviews is that fetal reviews include family member interviews and abstraction of deaths by clinicians. There is also more of an emphasis on prematurity factors.
  - ii. In Hawai'i, child deaths and fetal deaths are also linked between Title V performance measures especially with sleep-related deaths and prevention.
- b) Maui County – Support and increased availability and access to mental health providers in rural areas, including through telehealth and insurance coverage support
- c) Kaua'i County – Efforts in process to submit a plan to Legislature for requiring private residences and vacation rentals to install childproof fencing and self-latching gates for swimming pools.
  - i. Kaua'i County advocates have started meeting with insurance companies to discuss incentives for pool owners and hotels who install safety features, such as child safety fencing.
  - ii. Provide pool safety education to residential pool owners and hotel personnel.

### **F. Preventive Program Activities**

- 1) O'ahu – A Child Death Review recommendation list was created for 2021 for year 2020 and efforts to start the implementation of the list is in process. Challenges include less face-to-face interactions with families and stakeholders due to the COVID-19 pandemic. However, as the State of Hawai'i COVID-19 restrictions are being lifted, more in person opportunities may soon be available. Virtual workshops and informational sessions will continue in 2021.
- 2) The Family Health Services Division (FHSD), Maternal and Child Health Branch contracted with Tufts Medical Center for virtual webinars, "Spreading Healthy Outcomes from Positive Experiences HOPE)."

- a) These webinars and training series talk about experiences that support children's growth and development to become healthy resilient adults even in the face of childhood traumatic adversity.
  - b) The webinars are offered to families, public and private agencies, and other interested stakeholders.
  - c) There is a basic 1-hour introductory webinar to HOPE, a more in-depth workshop (2 hours) on implementation for interested families and public and private agencies, and a final workshop offering a train the trainer session.
- 3) FHSD also offers community health services funded by the Community Health Center Special Fund for contractual services to improve access to health care for medically underserved populations through the Federally Qualified Health Centers, including clinical primary care, behavioral health, dental and pharmacy.
- 4) FHSD's Early Intervention Section, Early Childhood Comprehensive Systems program utilizes a collective impact model to improve children's developmental health with emphasis on the families' well-being for families with children from ages 0-5 with focus on the county of Maui.
- 5) FHSD's Children with Special Needs Branch works to assure that all children and youth with special health care needs will reach optimal health, growth, and development.
  - a) Birth defects – provides population-based surveillance and education for birth defects in Hawai'i and monitors structural and genetic birth defects that adversely affect health and development
  - b) Childhood Lead Poisoning Prevention – reduces children's exposure to lead by strengthening blood lead testing and surveillance as well as identifying and linking lead-exposed children to services. (funded by the CDC)
  - c) Genetic services – provides information and education about topics in genetics statewide and services to neighbor island families
  - d) Children and Youth with Special Health Needs – provides assistance with service coordination, social work, nutrition, and other services for children with special health care needs ages 0-21 years with chronic medical conditions
  - e) Early Intervention Section – provides services for eligible children ages 0-3 years with developmental delays, including: care coordination, family training, counseling, home visiting, occupational therapy, physical therapy, psychology, social work, special instruction, and speech therapy

- 6) FHSD's Women, Infants, and Children (WIC) Services Branch, a federally funded program, provides Hawai'i residents with supplemental foods, nutrition education, breastfeeding promotion, and health and social services referrals. The participants of WIC are women who are pregnant, breastfeeding, or postpartum or infants and children under age 5 who meet income guidelines and have a medical or nutritional risk.
- 7) DOH launched a media campaign in October 2021 on Safe Sleep and Sudden Infant Death Syndrome (SIDS) to educate parents and caregivers on how to keep infants safe while sleeping. The hope is to increase awareness of safe sleep practices with clear and practical steps for parents, families, and caregivers.
- 8) DOH initiated a forum for members of public and private fatality reviews. Collaborative Fatality Review team members have agreed with community recommendations to conduct a death and birth certificate training by physicians for physicians. Support will also include experts from the DOH Vital Records office. DOH is currently in the process of scheduling a training. Data utilized from birth and death certificates are critical pieces of information reviewed to be able to reduce and limit preventive child and maternal deaths.
- 9) Contracted with local television and radio stations to utilize media for public service announcements on education and prevention for family strengthening activities (spending quality family time together cooking, fishing, etc.), youth resiliency (TeenLink Hawaii) with youth and adolescent supports sponsored by the Coalition for a Drug-Free Hawai'i, and safe sleep best practices.
- 10) Contract with the Child & Family Service for the administration of the "Parent Line," a DOH/MCHB funded program that is a resource on child behavior, child development, parenting, caregiver support, and community resources.

### **Maui County – Child Death Review Implementation Activities (January 2020 – December 2021)**

- 1) Youth Suicide Prevention & Mental Health
  - a) The Maui County DOH coordinator actively participates in the Prevent Suicide Maui County Coalition with two virtual conferences held in 2020 and 2021.
  - b) Mental Health America of Hawai'i, in partnership with the "E Ola Hou Prevent Suicide Maui County Task Force" hosted the Maui Suicide Prevention Awareness Virtual Mini Conference, "Building Connection and Honoring Culture to Save Lives." This conference, sponsored by Johnson & Johnson and Sutter Health Kāhi Mōhala is designed to provide attendees with information relating to suicide prevention awareness and

its impact on the diverse cultures in Hawai'i. This free conference provided the general public and professionals with enhanced knowledge of suicide prevention basics with an emphasis on cultural aspects, race/ethnicity, spirituality, lesbian, gay, bisexual, transgender, (or questioning), intersex, and asexual (or allies) LGBTQ+, and others.

- c) In September 2021 was the 2nd annual Maui Suicide Prevention Mini Conference, "Embracing Cultural and Social Protective Factors in Suicide Prevention." This conference was sponsored by Kamehameha Schools and Papa Ola Lokahi. Mayor's Proclamation naming September Suicide Prevention Month in Maui County was held in August 2020 and 2021.
  - d) Sign-waving in communities was held in 2020 and 2021 to raise awareness about suicide risk, protective factors, and community resources with Task Force Members and included youth and children. Youth Mental Health First Aid Training was held in September 2021. Maui Suicide Prevention Public Service Announcements were created and produced by "AKAKU Public Television" in June 2020 and speakers were members of the Prevent Suicide Maui County Task Force, Maui County Mayor, Maui County Council, providers, and survivors. The public service announcement is on YouTube and to date has generated 584 views.
  - e) Supported increased availability and access to mental health providers in rural areas of Maui County through telehealth and insurance coverage support.
- 2) Ho'oikaika Partnership Coalition to Prevent Child Abuse and Neglect
- a) The goal of the 2020 Conference was to highlight awareness, increase collaboration, and build on connections within the community to prevent child abuse and neglect. Over 300 service providers attended the virtual two-day conference.
  - b) The 2021 conference reinforced the ongoing commitment of service providers during these challenging times. Direct service staff, leadership, and agencies further developed and refined the tools needed to adapt to a new normal that includes not only safety for all children, but to also enhance agency and self-resilience so that agencies are able to thrive more efficiently. There were over 400 service providers that attended the partnership's second three-day virtual conference.
  - c) Family Engagement and Strengthening Families – The Ho'oikaika Partnership received a grant to hire a Ho'oikaika Navigator to assist families in their questions about supports in the community and how to access them.
  - d) An independent contractor was hired to support the Ho'oikaika Partnership Core Partners, coordinate the partnership, and facilitate implementation of the Ho'oikaika Partnership 2021-2024 Strategic Plan.
  - e) Family strengthening activities; e.g. spending quality family time together, cooking, fishing, talking, etc. Resources were also provided to families during the "Stand Up for Children Month" and included 300 care packages delivered to families.

- f) Food Distribution – from May to December 2020 to families with lost wages from the pandemic and the community at large. This was in partnership with the Maui Food Bank, Binhi at Ani Filipino Community Center, County of Maui, Hawai'i National Guard, Maui DOH, and other community organizations.
- 3) Early Childhood System of Care Activities Strengthening and Supporting Families
- a) A coordinator was hired to facilitate the County of Maui Multi-Agency Impact Team (CoMMIT). Over 500 3-year-old children were screened (approx. 834 screens) during the five-year Early Childhood Comprehensive System Grant (ECCS) grant period.
  - b) Certified Trainers conducted trainings on the Ages and Stages Questionnaire (ASQ) Developmental Screening Tool to their respective staff and other community interested programs.
  - c) There were fifteen ASQ Trainings conducted in Maui County over the five-year grant period. Two hundred twenty-four direct service staff became certified to conduct ASQ screens with their families.
  - d) There are eight Maui County Early Childhood Education (ECE) programs where ASQ Screens are now being conducted at least one time a year. Early childhood healthy development and caregiver support promotion will continue with at least nine annual community events.
  - e) The Facebook platform has reached 8,568 people to support all facets of early childhood healthy development (212 Followers and 175 Likes) with expansion to Instagram that started in October 2021.
  - f) There were over 10 Mental Health trainings offered in Maui County and statewide with a more prioritized focus on resources and referral process for all levels of emotional need.
  - g) Over 10 Trauma-Informed Care and Resiliency Trainings were conducted. Fifteen Maui County providers participated in Promising Minds Trauma Informed Care program implementation support.
  - h) Funding through the Family Health Services Division created a position to carry out efforts for one year beyond the grant period.
- 4) Maui County COVID-19 Pandemic Response and Mitigation
- a) Involved in the pandemic response as Case Investigator, Contact Tracer, Vaccinator, and other positions in the Vaccination PODS and at the Maui District Health Office
  - b) Community Resources Access and Availability – Distributed resources directory at the In Person/Tele-Cardiology Clinics, E-WIC, Drive-Thru/Walk-Up Vaccination PODS
  - c) Strengthening Male Involvement in the Care of Children – Drive-Thru Celebration of Fathers Annual Event held in June 2021 in collaboration

with many community partners to recognize fathers and their critical role in the care of children

- 5) Initiatives to Increase Social-Emotional Learning (SEL) in Schools: SEL is the process of developing the self-awareness, self-control, and interpersonal skills that are vital for school, work, and life.
  - a) Increase funding and support for In-Home Based Services programs for high-risk families and youths
  - b) Initiatives to increase Trauma-Informed Care approaches to adolescent behavioral issues in schools. Trauma-Informed Care involves understanding, recognizing, and responding to the effects of trauma in the lives of individuals and promoting resiliency to address trauma.
  - c) Develop and enforce policies that address underage alcohol use and social norms, such as banning alcohol use at parks and beaches
  - d) Support programs that provide on-site classes and childcare for teen mothers at local high schools, including online distance learning classes, thus allowing them to complete their education and build parenting skills
  - e) Advocate for Local County Council to enact countywide civil Social Host Ordinance that will hold accountable those who host a gathering where individuals under age of 21 consume alcohol to reduce underage consumption of alcohol and related consequences occurring at home gatherings; improve the quality of youth, parents, and the community; and potentially reduce intentional or unintentional injury or death from alcohol consumption
  - f) Expand Home Visitation Programs to at-risk families with children and youth ages 3-2
  - g) Adopt a Universal Consent Policy that can be used to consent for services from multiple agencies
  - h) Adopt a Data Sharing Policy that would allow client data to be accessed and shared by agencies serving a family/mutual client, reducing the need for clients to provide the same information to multiple agencies
  - i) Policy to strengthen a trauma-informed coordinated system of care and collaborative partnership between Department of Human Services, Department of Education, Department of Health, and the Judiciary to strengthen and support at-risk families
- 6) Future Goals
  - a) Create a Community Navigator Position in every social services agency to assist families in what, when, and how to access community resources
  - b) Support and create a funding stream for a paid position to coordinate and organize respective community coalitions
  - c) Create more opportunities for male involvement in community events and activities that support and strengthen families

## **Hawai'i County – Child Death Review Activities 2020-2021**

- 1) Participated in crib distribution for families to discourage bed-sharing for infants
- 2) The Domestic Violence Fatality Review for Hawai'i County meets several times a year facilitated by the O'ahu Domestic Violence coordinator and reviews child and adult deaths and near deaths as related to domestic violence occurrences.
- 3) The Hawai'i County Child Death Review team spent 2020 and 2021 working towards the implementation of child death review recommendations. Sadly, the registered nurse coordinator, who was an integral part of the Hawai'i County Child Death Review and child prevention efforts for many years, was ill during the latter part of 2020 and passed away in mid-2021. Efforts for recruitment of a new nurse coordinator for Hawai'i County is in process.

## **Kaua'i County – Child Death Review Implementation Activities 2021**

- 1) Distributing Child Safety Information to the Public
  - a) Started a Kaua'i 'Ohana Resource Kiosk at the main Kukui Grove Shopping Mall in Līhu'e in July 2021 for access to multiple brochures and videos on health resources, including information on safe sleep practices for infants, water safety, drowning prevention, suicide prevention, car seat safety, and prevention of driving under the influence
  - b) Future plans are in process to create animated videos on safety items with distribution to other Kaua'i locations
  - c) Purchased and distributed child safety coloring books.
- 2) Safe Sleep Prevention
  - a) Kaua'i Houseless Outreach event in Nov 2020 – distributed five play yards to houseless families with infants living in the tent camps
  - b) Partnered with Kaua'i Children with Special Health Needs Program and WIC to distribute play yards to infants in Kaua'i to promote safe sleep.
- 3) Started a Kaua'i Child Abuse Prevention & Family Strengthening Coalition. The coalition addresses socioeconomic and mental health stressors that may be at the root causes of child fatality cases involving driving under the influence, drug use, mental health, and child abuse and neglect.
- 4) Kaua'i County also contributed to the development of a comprehensive Kaua'i Community Resource six-page flyer with family strengthening strategies and activities, socioeconomic, and mental health resources.

- 5) Child Abuse and Neglect Prevention – During April 2021, promoted child abuse and neglect prevention via newspaper articles; large public banner in main town square; blue pinwheel events (national symbol for child abuse and prevention, reflecting the bright future for all children); and held the Kaua'i Mayor's proclamation. Involved Department of Education (DOE) participation for blue pinwheel events in several DOE schools on Kaua'i.
- 6) Participated in Multiple COVID Response Activities for Kaua'i County
  - a) Kaua'i County Public Health Office – conducted COVID nasal testing on several hundred people
  - b) Administered COVID vaccines to hundreds of clients
  - c) Served as the registered nurse vaccine team lead for some of the Kaua'i mass vaccination clinics
  - d) Conducted COVID contact tracing phone calls to multiple residents and other contacts
  - e) Distributed information to clients on COVID symptoms and prevention strategies, such as wearing masks, washing hands frequently, and practicing social distancing
- 7) Youth Suicide Prevention & Mental Health
  - a) Purchased and distributed family strengthening and positive messaging materials for children, such as 'kindness matters' and '33 ways to praise a kid' stickers and passed out t-shirts and bags
  - b) Created five Protective Factors fliers and distributed
  - c) Developed and distributed "Smart Parenting booklets"

## **G. Collaborative Efforts**

MCHB works in collaboration with community agencies (public and private) to assist in providing preventive strategies to reduce child deaths.

- 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 preventive activities to reduce and limit preterm babies' deaths. The World Health Organization (WHO) defines preterm birth as babies born alive before 37 weeks of pregnancy is completed.
- 2) Some of the partners include: Kapiolani Medical Center for Women and Children; Child and Adolescent Mental Health Division; Hawai'i Youth Correction Facility; Hawai'i Youth Services Network; Hawai'i Judiciary; Honolulu Police Department; Hawai'i Fire Department; Honolulu Medical Examiner Office; Department of Human Services (Child Welfare Services); Emergency Medical Services; medical physicians; military family advocates; Department of Education; Child and Family



Service; mental health representatives from Queen's Medical Center; and many other consultants and public-private agencies.

## **H. State Collaboration**

- 1) The Child Death Review registered nurse coordinators from Hawai'i, Maui, and Kaua'i counties during 2020 and 2021 continue to work in collaboration with the District Public Health Offices to assist with coronavirus related activities for the community, including testing, providing vaccines, counseling, and contact tracing.
- 2) MCHB's Home Visiting Services Unit continues discussions with the Hawai'i State Department of Human Services to explore joint partnerships with Home Visiting Services for families and children.
  - a) July 23 & 24 – The MCHB Home Visiting Services Unit participated in a joint project with community agencies to host a Trauma-Informed Care presentation with over 300 participants.
- 3) MCHB has combined project efforts with the DOH Emergency Medical Services Injury and Prevention and Control Section to further combine resources for suicide prevention, safe sleep practices, mental health, and water safety initiatives in Hawai'i.

## **I. National Collaboration**

- 1) MCHB, along with the "Safe Kids Hawai'i" representative led by the Kapiolani Medical Center for Women and Children, participated in a seven-month "Injury Prevention Leaders Training Collaborative" with several other states developed by the National Center for Fatality Review and Prevention in collaboration with the Injury Leaders Training Collaborative of the John Hopkins Center for Injury Research and Policy. The Hawai'i team project was encouraging 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**

Requiring the Department of Health (DOH) to provide an annual report on the review of maternal deaths conducted by the department.

As experts in providing maternal guidance to all 50 states, the Centers for Disease Control and Prevention (CDC) describes positive pregnancy outcomes as healthy pregnancies that begin before conception and continue with regular prenatal care.

In Hawai'i, healthcare providers are instrumental in helping women prepare for pregnancy and for any potential problems that may arise during pregnancy. Early initiation of prenatal care by pregnant women and continuous monitoring of pregnancy by health providers are important in helping to prevent and treat severe pregnancy-related complications.

### **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 revised in 2021. The manual identifies that the Hawai'i Maternal Mortality Review Committee reviews all maternal deaths in Hawai'i. The process for a maternal mortality review in Hawai'i is as follows:

- 1) A DOH Maternal and Child Health Branch (MCHB) research statistician works in collaboration with the DOH Vital Records Office to gather information on maternal deaths.
- 2) An abstractor then reviews the available medical and other specialty reports to create case summaries discussed during the committee reviews
- 3) The multiagency and multidisciplinary team reviews the case summaries.
- 4) A determination is made as to whether the death is pregnancy related or pregnancy associated.
  - a) 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.
  - b) Pregnancy-associated deaths of a woman are from any cause while she is pregnant or within one year of termination of pregnancy.

- 5) 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 preventive 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 CDC recommends the COVID-19 vaccination for everyone 12 years of age and older, including people who are trying to get pregnant now or might become pregnant in the future, as well as their partners.

Professional medical organizations serving people of reproductive age, including adolescents, emphasize that there is no evidence that the COVID-19 vaccination causes a loss of fertility. These organizations also recommend COVID-19 vaccination for people who may consider getting pregnant in the future.

The World Health Organization also 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 2021:

- 1) Continued to follow the national and local recommendations from the Centers for Disease Control and Prevention and the Hawai'i State Department of Health (DOH) on the guidelines for COVID-19 prevention and other related health information amid the pandemic.

- 2) There were two Hawai'i Maternal Mortality Review (HMMR) Committee review meetings in June and December to review 2019 and 2020 maternal deaths. Also discussed were prevention strategies based on the findings. Fatality review meetings were held via videoconferencing utilizing a secure virtual platform due to the ongoing pandemic.
- 3) Created the HMMR public health and clinical recommendations list by category: system, provider, medical, community based, cultural, social support and care, drug, alcohol, substance abuse, and mental health recommendations. Efforts in 2022 will be made to create a written plan and process to identify priorities; select who will facilitate and lead; determine timelines, social media involvement, funding amounts, public/private agency and community supports; determine if further legislative support is needed; and track/monitor success and challenges.
- 4) The Family Health Services Division (FHSD) continues to administer the Pregnancy Risk Assessment Monitoring System (PRAMS) funded by the CDC, which is a population-based surveillance system that identifies and monitors maternal experiences, attitudes, and behaviors from preconception through pregnancy and into the interconception period. Data reviewed from the Hawai'i PRAMS is utilized by professionals and public/private agencies to plan for future interventions promoting healthy outcomes for the women and children of Hawai'i.
- 5) Contracted with a public health community organization, "Hawai'i Children's Action Network" to coordinate trainings and build workforce capacity for individuals/agencies that provide services to expectant and new moms. Primary stakeholders include physicians, healthcare providers, and other non-clinical staff. Planned training topics include Implicit Bias and Death Certificate training.
- 6) MCHB signed a Data Sharing agreement with the CDC to allow for sharing of HMMR Committee data collected in the CDC's Maternal Mortality Review Information Application (MMRIA). The CDC utilizes this data to improve data quality, identify technical assistance needs, and perform detailed analyses across MMRIA users regarding maternal deaths.
- 7) FHSD/MCHB continue to co-lead the Pre/Inter-Conception Workgroup of the Hawai'i Maternal and Infant Health Collaborative (HMIHC). The Pre/Inter-Conception Workgroup is one of several workgroups of the HMIHC's Early Childhood Action Strategy Team One "Healthy & Welcomed Births." The goal of HMIHC is to improve maternal and infant health outcomes while advancing health equity and reproductive justice by enhancing systems and support for Hawai'i families and communities.

- 8) FHSD/MCHB provided support and resources for three major projects of the HMIHC Pre/Inter-Conception Workgroup: Statewide One Key Question Certification, Access to Birth Control Methods, and the Pregnancy and Sexually Transmitted Disease Prevention Incentive Project for Adolescents and Young Adults. These projects were implemented in collaboration with a health or community-based organization. All three projects focus on increasing access to birth control methods, family planning, and preventing the spread of STDs and Sexually Transmitted Infections.
- 9) October 2021 – MCHB provided an informational “talk story” session for the “Hawai’i Young Healthcare Professionals” on tips for successful team building and working in collaboration with other professionals in both public and private organizations.
- 10) FHSD/MCHB contracted with a community-based organization, “TeenLink Hawai’i” under the Coalition for a Drug-Free Hawai’i. TeenLink Hawaii is a web-based support for teens that provides youth empowerment, outreach, education, and training on many topics (e.g., relations building, cooking, mental health supports, etc.), including referral services for teens, parents, caregivers, educators, and the general public.
  - a) Contracted for a 12-week resiliency campaign utilizing television spots, public services announcements, and digital media to promote TeenLink Hawaii.
  - b) Some topics on TeenLink Hawaii include: mental health, physical wellness, safe place, accessing healthcare, COVID-19, substance use, and birth control methods.
- 11) MCHB Family Planning and Perinatal Support Services Programs combined contracts for the underinsured and uninsured 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.
- 12) MCHB contracted with a public health community organization “Healthy Mothers, Healthy Babies” 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

### **C. Collaborative Efforts – Hawai‘i**

- 1) Trauma-Informed Care approaches are vital to address the impact of trauma that affects every aspect of health. The CDC has reported that there is no single technique to address trauma-informed approaches that benefits staff and clients. However, key elements include safety; trustworthiness/transparency; peer support; collaboration; empowerment; voice and choice; and considering cultural, historical, and gender issues.

In 2021, FHSD/MCHB engaged in activities to review and approach the impact of trauma from a public health perspective.

- a) Early Identification and Home Visiting contracts contain language requiring providers to “build their capacity” to implement a trauma-informed approach to care.
  - b) Forums were created to convene partners engaged in trauma-informed care and related initiatives to share existing work to review what is currently occurring across the state.
  - c) The MCHB-administered Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) grant implements a model “Healthy Families America” and provided opportunities for virtual attendance at a national conference to support professional development and to obtain information on integrating trauma-informed approaches into parent surveys.
- 2) FHSD has arranged for meetings with local experts on trauma-informed care to arrange for future activities including training for staff and community stakeholders on how to incorporate best practice trauma-informed care approaches, improving client and staff well-being.
- 3) Collaborative Fatality Review meetings are facilitated by FHSD/MCHB with public and private agencies to discuss system supports for fatality reviews and strategies to reduce and limit preventable deaths in Hawai‘i. Some topic areas discussed are:
  - a) Recommendations from the team have included possible legislative requests to improve state fatality systems
  - b) Strategies to reduce and limit preventable deaths for the residents and visitors of Hawai‘i
  - c) Identification of training/educational needs for fatality review stakeholders and the general public
  - d) Supporting existing relationships with agencies that provide information to fatality reviews (e.g., medical examiners, vital records, medical, and other specialty reports)
  - e) Establishing new relationships within the community to support preventive recommendation implementation for the general public

- 4) The Hawaii 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.

#### **D. National Collaborative Efforts 2021**

- 1) The State DOH and HMMR team will continue to consult with and attend pertinent trainings from the CDC, Partnerships & Resources Maternal Mortality Prevention Team. This practice will assist and support the HMMR in utilizing best practices, ensuring that quality data and recommendations are in place to prevent and reduce maternal deaths.
  - a) Technical assistance is available to the DOH FHSD/MCHB HMMR Committee from the CDC on items related to maternal mortality and morbidity.
  - b) Virtual resources and workshops are also offered throughout the year.
  - c) The CDC recently issued a factsheet based on data from states in the "Rapid Maternal Overdose Review Initiative 2015-2019" and reported that 89% of 104 overdose deaths during or within one year of pregnancy were potentially preventable.
    - i. Most (73%) pregnancy associated overdose deaths occurred in the late postpartum period; 19% were pregnant at the time of death; 8% were pregnant within 42 days of death; and 73% were pregnant within 43-365 days of death.
    - ii. Substance use disorder contributed to nearly all (94%) pregnancy-associated overdose deaths.
    - iii. Mental health conditions other than substance use disorder contributed to nearly three-fourths (72%) of pregnancy-associated overdose deaths.
    - iv. Most (86%) of pregnancy associated overdose deaths had an opioid present in autopsy toxicology.
    - v. Hawai'i has yet to analyze their data (2016-2021) on maternal deaths from overdose. However, FHSD/MCHB have started the process in 2021 of creating factsheets identifying the causes of death and preventive strategies.
- 2) FHSD/MCHB provided opportunities and paid registration fees allowing for virtual attendance at a national conference for families, community stakeholders, and FHSD/MCHB staff at the 2021 "Association of Maternal and Child Health Programs" (AMCHP), "Global Meet Local: A Global Approach for Local Outcomes" to gather information, resources, and guidance during the COVID-19 pandemic on maternal and child health.

- a) The Hawai'i based "Na Leo Kane" (collaboration of ALOHA minded individuals an organization that engages men and boys to prevent violence and promote healthy relationships) provided a presentation at the 2021 AMCMP conference on the value of relationships for stronger partnerships and the importance of men's health and wellness for positive maternal and child health outcomes.
- 3) FHSD/MCHB administered Community Based Child Abuse Prevention Grant (CBCAP) program that provided supports to assist with ensuring health, safety, and educational resources amid the ongoing pandemic to Pacific Islander and Micronesian families and their children.
  - a) Laptops, hot spots, and related technology were purchased to assist the children with distance learning and to enable families the opportunities to engage in virtual medical appointments with physicians and other healthcare providers.
  - b) Essential packages containing personal health products; dental items; diapers; bathing items; and personal protective equipment (i.e., masks, gloves, sanitizers, etc.) were also distributed to assist families in maintaining optimal health, safety, and hygiene. These packages were also made available and distributed to houseless/homeless families.
- 4) Domestic Violence & Sexual Assault supports continued in 2021 with the FHSD/MCHB "Domestic Violence Fatality Reviews" enabling public and private agencies to conduct virtual statewide near death and death reviews as related to domestic violence for men, women, and children.
- 5) FHSD/MCHB administered Maternal, Infant, Early Childhood, Home Visiting Program grant completed the following activities contributing to preventive measures for women, families, and children:
  - a) Technology was used to support contracted providers in submitting referrals and other required documents in an electronic system, allowing for more staff hours working with families
  - b) Home visiting providers were supported in conducting virtual visits to families, women, and children.
  - c) Continued voluntary, evidence-based services and supports empowering families with tools to thrive. Some of these services include providing family strengthening strategies, connections to clinical providers, and referrals to other needed community services.
  - d) The MIECHV Program supports home visiting for pregnant women and families with children up to kindergarten entry living in communities at risk for poor maternal and child health outcomes.
  - e) Home Visits are conducted by nurses, social workers, early childhood educators, or other trained professionals during pregnancy and early



childhood to support in improving the lives of women, children, and families.

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

During 2021, the committee reviewed maternal deaths occurring in the calendar year 2019 and started the 2020 review in December 2021. Information on the deaths were obtained from the DOH Office of Health Status Monitoring (Vital Records).

- 1) 2019 – There were 11 maternal deaths reported and the final number of cases will be reviewed during the December 2021 meeting.
  - a) Of the 11 maternal deaths, the categories of the cause of death include: bleeding (2), cardiorespiratory arrest (3), injuries (2), hanging (1), others (3).
  - b) The age range of the maternal deaths; 21-34 years
  - c) Ethnic background of the maternal deaths;
    - i. Part Hawaiian and other race (5)
    - ii. Filipino and other race (2)
    - iii. Filipino (2)
    - iv. Chinese and other race (1)
    - v. Other (1)
- 2) 2020 – There were 12 maternal deaths reported. During the December 2021 meeting, the 2020 case list will be started. Information below was abstracted from DOH Vital Records prior to the case reviews by the Hawai'i Maternal Mortality Review Committee.
  - a) Of the 12 maternal deaths, the categories of the cause of death include: accident (4), homicide (1), suicide (1), natural (6)
  - b) Trends – Four deaths were accidents.
  - c) The age range of the maternal deaths: 23-43 years.
  - d) Residence County of maternal deaths;
    - i. Accident – Honolulu (2), Hawai'i County (2)
    - ii. Homicide – Honolulu (1)
    - iii. Suicide – Honolulu (1)
    - iv. Natural – Honolulu (3), Mainland (1), Hawai'i Island (1), Maui (1)

## **F. Recommendations and Action**

- 1) Provide blood pressure equipment resources (e.g., some equipment not covered by insurance) for postpartum women with hypertension.
- 2) Discussion and decision in adding another Hawai'i Maternal Mortality Review meeting per year, increasing Hawai'i Maternal Mortality Review committee meetings from 2 to 3 per year.

- 3) DOH FHSD/MCHB to participate in discussions and possible decision-making to support recommending implementation from a public health perspective with interested community partners on Hawai'i-based AIM (Alliance for Innovation on Maternal Health), a national data-driven, maternal safety, and quality improvement initiative.
- 4) DOH FHSD/MCHB to continue as a committee member on the Hawai'i Maternal & Infant Health Collaborative and Recommendation Implementation Workgroups; Preterm/Maternal Mortality Review & Pre/Inter-Conception.
- 5) 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.
- 6) DOH FHSD/MCHB will continue to facilitate 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.