hmsa's

community grant:

Stringing Together Health and Community

Final Report | 2020

Aloha,

As a health organization, HMSA is committed to improving the lives of our members and the health of Hawai'i. With more than 80 years of experience in serving Hawai'i's communities, we've learned some valuable lessons. And one of the most important lessons is that we can't do this alone.

Community health centers (CHCs) play a key role in advancing the health and well-being of the communities they serve. CHCs provide comprehensive and holistic health care, understand the unique needs of their residents, and tailor programs and services to meet those needs.

In 2017, HMSA awarded grants to each of Hawai'i's 14 CHCs. Our goal was to learn more from these CHCs about how they address the social determinants of health for their patients and communities. We wanted to build better relationships and support their efforts to break down the barriers of cost and access. And we hoped to better collaborate to provide services to those who need it the most but can't afford to pay.

As we worked together to address the global pandemic that continues to affect our state, it's become even more obvious that CHCs are not only a medical safety net for communities, they continue to provide the support services that are critical in addressing health-related needs and social determinants of health.

We look forward to continued collaboration with CHCs to improve the health and well-being of our families, our friends, and our communities.

Mahalo,

Mark M. Mugiishi, M.D., F.A.C.S.
President and Chief Executive Officer
HMSA

Russell Park

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CHC 101

Introduction

A community health center (CHC), also known as a Federally Qualified Health Center, is a community-based health organization that provides comprehensive primary and preventive care in a medically underserved area.

CHCs were established in 1965 by the Office of Economic Opportunity as part of the President Lyndon B. Johnson administration's War on Poverty initiative. Initially called "neighborhood health centers," CHCs aimed to provide access to health and social services to medically underserved and disenfranchised populations, including the uninsured, underinsured, and impoverished, and to promote community empowerment.[1]

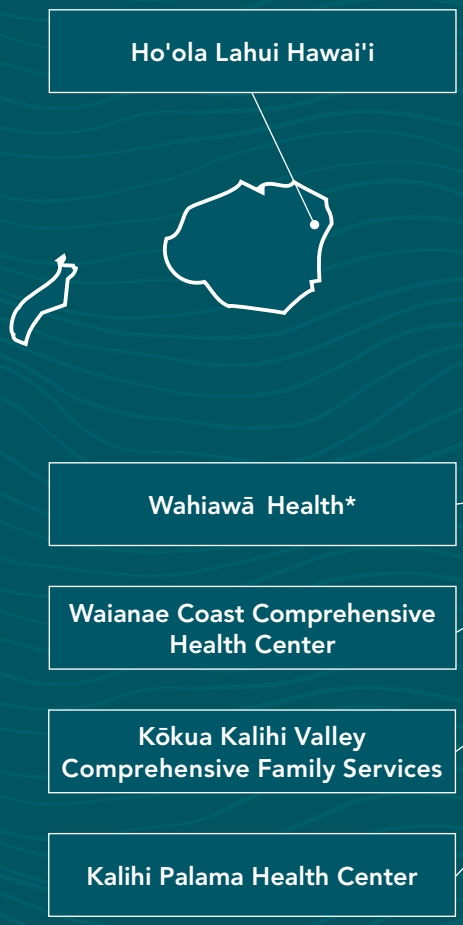
Earl Yoshii

CHCs have grown to more than 1,300 organizations serving over 27 million people nationwide.[2] Many CHCs target special populations such as veterans, homeless individuals, residents of public housing, and migrant/seasonal farmworkers. While no two health centers are the same, all share the goal of providing primary and preventive health care services that are coordinated, culturally and linguistically competent, and community-directed.[2]

About CHCs

CHCs are nonprofit organizations that qualify for funding under Section 330 of the Public Health Service Act and for enhanced reimbursement from Medicare and Medicaid.[3,4] CHCs operate under a board of directors that's comprised of at least 51% of current health center patients to ensure they're responsive to community needs.[5]

Services vary at each CHC, but at the core of all CHCs are comprehensive primary care services and robust enabling services, including case management, translation, transportation, eligibility assistance, and outreach. Many CHCs also offer dental and pharmacy services, behavioral health care, and substance abuse treatment. These services are provided to individuals regardless of their insurance status or ability to pay.



*Wahiawā Health was not yet designated as a CHC in 2017 when this grant program started.


Ko'olauloa Health Center
Waimānalo Health Center
Waikiki Health
Mālama I Ke Ola Health Center
Hāna Health
Molokai Community Health Center
Hāmākua-Kohala Health Center
Lāna'i Community Health Center
West Hawaii Community Health Center
Bay Clinic

Hawai'i CHCs at a glance

In Hawai'i, CHCs have a unique approach that allows them to reach people of all ages, incomes, and cultures. Their services can vary to help them focus on the specific needs of the diverse communities they serve. Some CHCs offer dental care, nutritional counseling, mental health care, pharmacy services, and more. Some even offer medical practices that are traditional to specific cultures.

Currently, there are 15 CHCs throughout Hawai'i with at least one CHC in each county.

Since 2010, the National Association of Community Health Centers reported that Hawai'i CHCs saw a 21% growth in patients.[6] In 2018, the 14 CHCs in the Community Grant Program leveraged about $30 million in federal investments and served 157,097 patients.[6,8] According to the Hawai'i Primary Care Association, over 75% of Hawai'i CHCs have been recognized by the National Committee for Quality Assurance as patient-centered medical homes.[7]

CHCs in Hawai'i are also economic drivers. For every $1 in federal investments, they generate $6.42 in economic activity across the state.[6]

Patient-centered Medical Home

A PCMH is a care delivery model that coordinates treatment through a patient's primary care provider to ensure that they receive the necessary care when and where they need it in a manner they can understand.

Demographic information 2018[8-9]

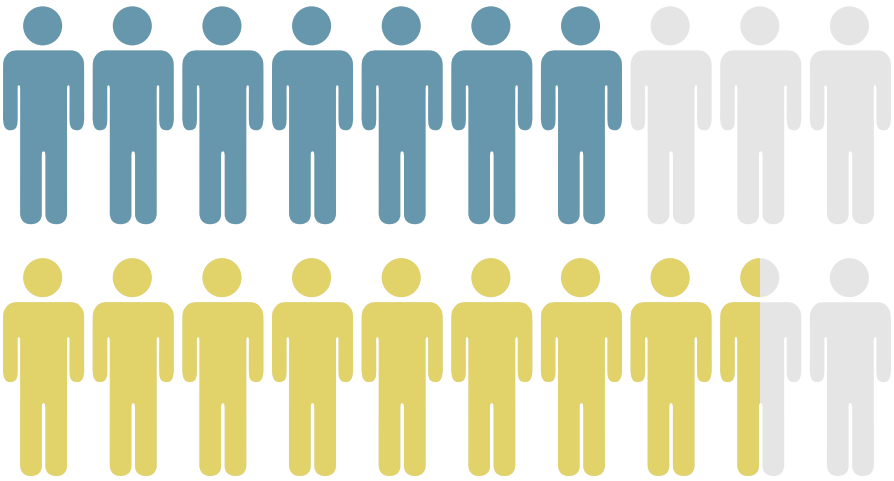
Total patients served:

157,097

Best served in another language:

9.7%

Poverty Level



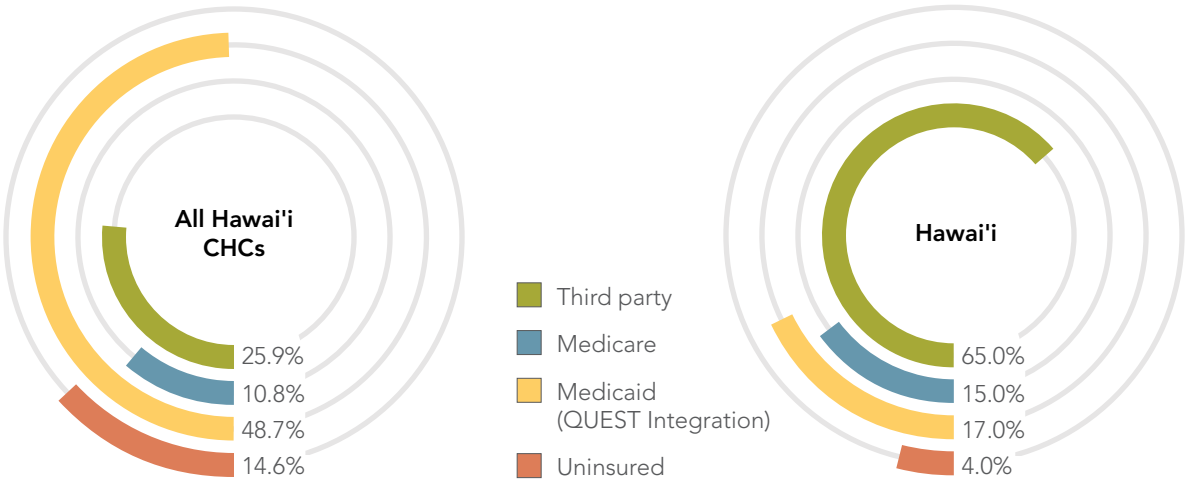
<100% federal poverty level

64.9%

<200% federal poverty level

86.7%

Insurance Type




Russell Park


Camille Rockett


Photo courtesy Kōkua Kalihi Valley

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Grant Overview

Traditionally, efforts to improve health have focused on the health system as a key driver of health and health outcomes. With the growing recognition of social determinants of health on health outcomes, the Hawai'i Medical Service Association (HMSA) looked to existing innovation in our communities to explore how we could collaborate to improve the health of Hawai'i more holistically.

In the summer of 2017, with savings realized in the prior year, HMSA reinvested the funds through a funding opportunity announcement (FOA) to all community health centers (CHCs) across the state. This was in recognition of the key role that CHCs play in advancing health and well-being through locally tailored programs that seamlessly provide whole-person care across medical and social needs.

The FOA introduced a two-year grant with funding that ranged from $400,000 to $900,000 for each health center to address a medical or nonmedical need in their community. The FOA required that grant funds must primarily benefit the QUEST Integration population, that evaluation plans define clear metrics demonstrating patient and community outcomes, and that CHCs would engage with HMSA throughout the grant period. Unlike a traditional grant, it was designed with co-learning and collaboration in mind. HMSA dedicated a team to work with the CHCs through the grant application and submission process, project implementation, and evaluation periods.

Starting in October 2017, HMSA awarded grants to all 14 CHCs in Hawai'i. This report highlights the achievements of each health center and HMSA's lessons learned.

Russell Park

Outcomes

Return on investment (ROI) is a metric used to evaluate the performance and value of an investment. Generally, ROI is measured by the amount of return on an investment compared with the cost of the investment, resulting in either a gain or loss of capital. Though most organizations measure their ROI based on financial or manufactured capital, ROI can also be exemplified in a variety of capital known as social return on investment (SROI). SROI factors the broader impacts that benefit society and the environment in recognition that value isn't created by or within an organization alone.[1] Instead, value is the result of influences from the external environment, relationships with stakeholders, and other dependencies.

For this report, the SROI framework was used to capture the impact holistically.[2] Below are the different domains of the SROI framework. Grants were measured in the domains that were applicable to their objectives.

Financial

The monetary gain or loss from an implemented program.

Example: Cost savings associated with reducing inappropriate emergency room use.

Manufactured

Products or services that were delivered. It can consist of human-created or production-oriented equipment and tools.

Examples: Jobs created to implement the program, individuals served in a program, and A1c level change.

Intellectual

Intangible impact to an organization. This could include brand recognition, reputation, and lessons learned that improve the organization's systems, procedures, and protocols.

Examples: Patents, copyrights, and intellectual property.

Human

Intangible impact to an employee of the organization or participant in the program.

Examples: Knowledge, skills, and experience gained from a participant in a program.

Social and relationship

Partnerships made and strengthened between health centers and stakeholders in the community.

Example: Cooperation within or among groups or organizations.

Although most organizations interact with all domains, not all capitals are equally relevant or applicable.

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Grant Summary

Earl Yoshii

Hawai'i Island

Bay Clinic

"The wife had called me for an appointment and, during the visit, she explained that she was pregnant and really wanted to quit vaping. She had smoked during her previous pregnancies and wanted to do better this time. She was also very concerned because she'd been hearing a lot of negative remarks about vaping that scared her. Once my assessment was complete, the patient expressed doubts about her strength to quit because her husband was a smoker. I suggested she bring him with her for a couple's session.

"It was very inspiring for me to watch them on this journey and to encourage them along the way."

"I was surprised to see her walk in with her husband at the first appointment. She was smiling. However, he didn't share her enthusiasm. I learned shortly after we began that it was important to him to do whatever was needed to help his wife succeed, but of course he wasn't thrilled about quitting. As each week passed, both of them did fantastic! When it came time to choose their quit date on week three,

Photo courtesy Bay Clinic

they both agreed on the day and ran with it. It was very inspiring for me to watch them on this journey and to encourage them along the way.

"By the end of the course, the couple had completely quit smoking and vaping. As a bonus, a nephew of theirs had been watching what they had been doing and gave up vaping, too. A good support system is a vital part of the tobacco cessation program."

- Bay Clinic tobacco cessation coordinator

Bay Clinic at a glance

Mission Bay Clinic, Inc. (BCI) is a community-directed health care organization that provides quality primary and preventive care services to the people of East Hawai'i Island. BCI ensures that patient-centered, culturally responsive, and affordable health care services are locally accessible.

History Founded in 1983, BCI started as a grassroots women's health clinic. Since then, it has grown into the second-largest federally qualified health center (FQHC) in the state and the largest nonprofit on Hawai'i Island with a network of eight health centers in East Hawai'i Island (North Hilo, South Hilo, Puna, and Ka'ū). BCI provides comprehensive primary medical, dental, and behavioral health care to 53% of Hawai'i Island residents.

Bay Clinic Community Program

BCI is a proud partner with Hope Services Hawai'i, the state's largest homeless services provider, and supplements their services with medical, behavioral, and pharmacy services for East Hawai'i Island's underserved and marginalized homeless community.

The most recent collaboration was with the island's first Ohana Zone, Keolahou. Located at the old Hilo Hospital, the site will provide homeless individuals and families with access to support services and emergent and permanent housing. These high-quality health care visits are meant to help reduce unnecessary urgent care and emergency room visits.

Demographic information 2018[1-2]

Total patients served:

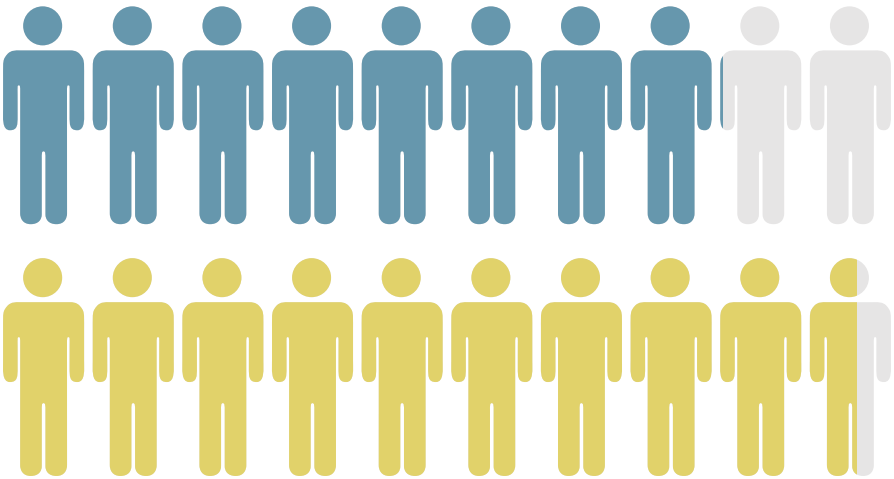
21,196

Best served in another language:

6.1%

Poverty Level

Bay Clinic



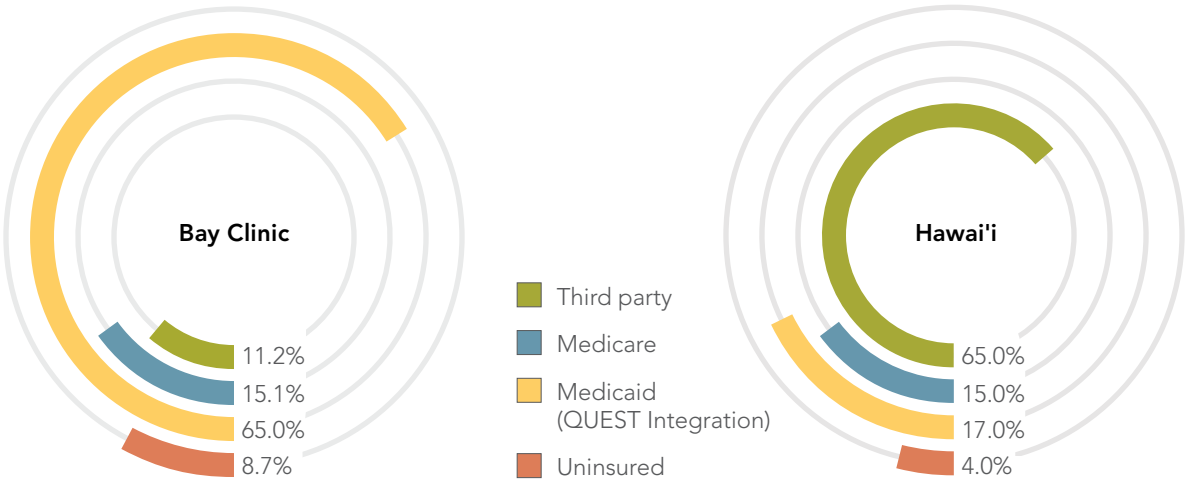
<100% federal poverty level

80.6%

<200% federal poverty level

96.1%

Insurance Type



HMSA Community Grant

Enhancing Access to Care for East Hawai'i Island Residents

Grant Overview

Executive Grant Summary

BCI's service area has the highest rate of diabetes in the county and has higher-than-average adult morbidity rates due to preventable conditions such as obesity, diabetes, high blood pressure, and tobacco use.[3] Combined with issues of remote geographies, designation as a health professional shortage area, disproportional rates of poverty, and a high-uninsured rate, a multi-pronged intervention was proposed.[3,4]

The goal was to expand access to preventive and chronic care management services to positively impact the social determinants of health needs of their community and address the health professional shortage in East Hawai'i Island. To achieve this goal, BCI deployed a mobile health unit (MHU) to remote schools and communities, expanded their smoking cessation and diabetes management classes, expanded residency rotations, and engaged with partners more effectively. Through these interventions, BCI improved access to care for vulnerable populations while applying lessons learned to address the unique disparities of their community.

Statement of Need

BCI's service area experiences some of the greatest health care disparities in the state. Four of the top five ZIP codes with the highest poverty rates in the Islands are in their service area. Collectively, the service area's adult morbidity rate due to obesity is 24%, tobacco use is 20%, diabetes is 11%, and high blood pressure is 32%. These rates, except for tobacco use, are higher than the state and county averages.

BCI's service area also includes the top three districts with the highest rates of people with diabetes in the county: Hilo at 12.6%, Puna at 10.5%, and Ka'ū at 9%. The youth in this service area also face disparities; 36% suffer from untreated tooth decay.

East Hawai'i Island residents also experience multiple barriers to health care access due to a high rate of those who are either uninsured or have a QUEST Integration plan, but lack access to a provider who accepts Medicaid. Furthermore, BCI's service area is federally designated as a Health Professional Shortage Area (HPSA) with scores of 17 for primary medical, 21 for dental, and 16 for mental health. HPSAs are scored on a scale of 0-25 for primary care and mental health and 0-26 for dental health, with higher scores indicating greater need.

In addition to these factors, the remote and expansive geography of the island add another layer of access issues.

Intervention

BCI proposed three interventions to address the issues identified in their community:

1. MHU and expanded chronic disease programs: To provide more residents with access to preventive and chronic care management services, BCI deployed their MHU equipped to provide medical and dental services. The MHU traveled to remote areas in Ka'ū and Puna (including Ocean View, Mountain View, Volcano Village, and lower Puna) and provided school-based services to the Hawai'i Department of Education's Kea'au, Ka'ū , and Pahoa (KKP) school complex, which serves over 5,500 students. In addition to the MHU, BCI increased outreach and participation in the tobacco cessation programs and their multidisciplinary Diabetes Self-Management Education class. This class includes support from BCI's pharmacist, psychologist, physician, registered nurse, and registered dietitian.
2. Expand residency programs: To address the health professional shortage, BCI expanded their partnerships with the University of Hawai'i at Mānoa John A. Burns School of Medicine (JABSOM) and the New York University (NYU) Lutheran Medical Center (dental) to expand residency rotations at BCI sites.
3. Expand accountable care initiatives: BCI established a performance-based dashboard to monitor accountable care and quality metrics; participated in quarterly consumer-based leadership workshops through AHARO Hawaii, a consortium of community-governed community health centers; engaged BCI's board of directors in goal setting and intervention strategies surrounding the impact on social determinants of health; and included patients in the evaluation process of the accountable care methodologies.

Photos courtesy Bay Clinic

HMSA Community Grant

Enhancing Access to Care for East Hawai'i Island Residents

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

The MHU was deployed at least once a month to locations ranging from Ocean View to the Hawai'i Department of Education's KKP school complex. The MHU achieved the following:

Mobile Health Unit (MHU)

Average Monthly Deployments	No.
To Pahoa (Dental only)	~3 per month
To Oceanview	~1 per month
To Volcano Village	~1 per month
To Mountain View	~1 per month
To KKP district schools	~2 per month

Achievements of the MHU	No.
New patients seen through the MHU	315
Medical (age 18+)	11
Medical (ages 3-18)	42
Dental (age 18+)	30
Dental (ages 3-18)	232
New patients enrolled in QUEST Integration	729
Patients who needed help renewing their QUEST Integration or marketplace insurance plan	384
Total encounters across locations	1,248
Medical	275
Dental	973

Photo courtesy Bay Clinic

BCI also expanded chronic disease management programs such as tobacco cessation and diabetes self-management classes. For the latter, workflow and referral issues prevented an optimal number of participants. However, the enrollment and completion rates are positive indicators of the program's success.

Tobacco Cessation

Counseling	No.
Patients enrolled in one-on-one counseling	700

Group Program	
Patients enrolled	110
Average class size	5
Completion rate	80%

Outreach	
Patients who received tobacco cessation outreach	3,000

Targeted Outreach	
Referrals received from the women's clinic	3,000
Women's clinic referrals who were pregnant	8
Percentage of referrals that enrolled in the program	75%

HMSA Community Grant

Enhancing Access to Care for East Hawai'i Island Residents

Photo courtesy Bay Clinic

Diabetes Self-Management Program

	No.
Patients screened and referred to the nutrition program	195
Patients enrolled	31
Classes offered	5
Percentage of patients that completed the program	90.3%
Percent of patients that reported meeting majority of their self-care goals	70%
Average reduction of HbA1c after completing the program	0.2 [7.9 to 7.7]

Intellectual Capital

The MHU outreach to the KKP school complex and remote communities enabled BCI to gain information that helped them to further impact their community.

- MHU outreach to the KKP school complex faced barriers to obtaining parental consent. Following several modifications such as editing the parental consent form to reduce barriers to authorization, using the schools' communication channels to increase awareness, and distributing forms before the last day of the instruction year to improve reach, BCI was able to increase the use of the MHU's services.

- BCI also learned that despite community input identifying the need for preventive dental services for adults, the community didn't take advantage of the services even when the MHU went to them.
- While the MHU is an ideal way to take preventive health care to remote communities, mechanical issues sometimes rendered it unreliable. This resulted in BCI evaluating ways to supplement the maintenance of their MHU through community partnerships and other solutions.

Similarly, for the chronic disease management program, there were many lessons learned that positively impacted how the organization will continue to provide the services. One of the major barriers to accessing programs was transportation. BCI explored solutions such as taxi vouchers and public bus tokens, but found that a limited number of vendors and geographic barriers continued to be a challenge. The health center is continuing to explore options to ensure that those who face transportation barriers can still access care.

However, BCI discovered a few ways to increase participation in their programs. For one, patients were more motivated to make a healthy change in their lives if they felt tired or didn't feel well. This prompted expanded outreach at the dental clinics. BCI also hired a new tobacco cessation coordinator who helped achieve the goal of reaching out to more than 2,000 residents.

Generally, BCI increased their presence in the community and reached over 10,500 residents with their services. BCI also received accreditation for the Diabetes Self-Management Education Program from the American Association for Diabetes Educators.

Human Capital

BCI hired a new tobacco cessation coordinator who completed smoking cessation and motivational interviewing training with the University of Colorado. BCI's registered dietitian also received a diabetes educator certificate.

The health center also partnered with NYU Lutheran Medical School to expand dental residency rotations at BCI sites. Over the two-year grant period, BCI has had eight dental residents. Also during the grant period, three ob-gyn residents and six JABSOM medical students provided services at BCI sites. The health center continues to partner with JABSOM, providing opportunities for residents and students while increasing the availability of health care professionals for patients.

HMSA Community Grant

Enhancing Access to Care for East Hawai'i Island Residents

Social Capital

BCI partnered with the KKP school complex through a memorandum of understanding and expanded access to preventive medical and dental services to communities. Schools in the complex include Kea'au High School, Na'alehu Elementary School, Mountain View Elementary School, and Kea'au Middle School. The health center staff attended events such as 'Ohana Nights to provide education about the MHU and other BCI services and increase the number of parental consents.

Over the grant period, the MHU team expanded their community partners and services to include Hope Services Hawai'i, Nanawale Community Association, and Ka 'Umeke Kā'eo Charter School. BCI plans to continue their partnership with these organizations beyond the end of the grant.

The tobacco cessation team collaborated internally and externally to exceed their outreach goals. Internally, this included nontraditional partners like their Hilo Women's Health Center while external partners included Kū Aloha Ola Mau, Hui Mālama Ola Nā 'Ōiwi, and the U.S. Department of Veterans Affairs.

Through collaboration with AHARO Hawaii, BCI accomplished many of their accountable care initiatives:

- Began steps for a telehealth mainframe.
- Increased Colorectal Cancer Screening by 7% as noted in BCI's 2019 Uniformed Data System clinical quality measures, which are required to receive federal funding.
- Started multiple approaches for risk stratification using social determinants of health data.
- Attempted improvement of other clinical quality measures outside of Colorectal Cancer Screening such as Cervical Cancer Screening (goal met for 2019), Controlling High Blood Pressure (remained consistent since 2018), Clinical Depression Screening (increased more than 50% over the past two to three years), and Weight Assessment/Counseling for Nutrition and Physical Activity for Children/Adolescents (exceeded their goal by over 25%).
- Shared modalities to improve clinical quality measures and improved utilization methods for patient portals.
- Developed and maintained data exchange through AZARA for improved patient management and Uniform Data System data gathering.

Conclusion

The success of partnering with organizations and agencies such as the Hawai'i Department of Education to take services via an MHU has proven successful in increasing access to much-needed health care in rural areas. This model of partnership has also been successful with the Diabetes Self-Management Education and tobacco cessation programs in nontraditional clinic locations such as dental offices and with external partners such as Kū Aloha Ola Mau and Hui Mālama Ola Nā 'Ōiwi. Looking forward, BCI will build on the success and lessons learned to continue to innovate to improve access to care for their community.

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Photo courtesy Bay Clinic

Hāmākua-Kohala Health

"Shannon has been a patient at our Hāmākua-Kohala Health Waimea location since it opened in early 2019. Before it opened, he would travel about 40 miles round trip to get to his primary care doctor. As a resident of Waimea, Shannon enjoys the convenience of having his primary care doctor close to home. He said, "Dr. Murray is great. He's thorough, really puts his time into my visit, doesn't rush me out the door, and he's a cool guy."

– Tobacco treatment specialist

"Shannon enjoys the convenience of having his primary care provider close to home."

Russell Park

Hāmākua-Kohala Health at a glance

Mission Provide quality health care that is responsive to our patients' and communities' needs.

History Previously, each plantation on the Hāmākua Coast had its own dispensary that would serve outpatients and inpatients for the workers and their families. In 1966, all the dispensaries were consolidated to form the Hāmākua Infirmary, which served families for 27 years. When the sugar plantation closed in 1993, Hāmākua Health Center was established.

In 2006, due to the reduction of health care service in North Kohala, Hāmākua Health Center acquired Kohala Family Health Center at the request of Kohala residents. Hāmākua Health Center was renamed Hāmākua-Kohala Health (HKH) in 2014. HKH's service area spans the Hāmākua and Kohala coastlines including Waimea.

HKH Community Program

The Amazing Tooth Bus is a mobile dental office that HKH owns and operates. Currently, services are provided only for children and include exams, digital X-rays, cleanings, fillings, extractions, root canals, crowns, and referrals to specialists.

Demographic information 2018[1-2]

Total patients served:

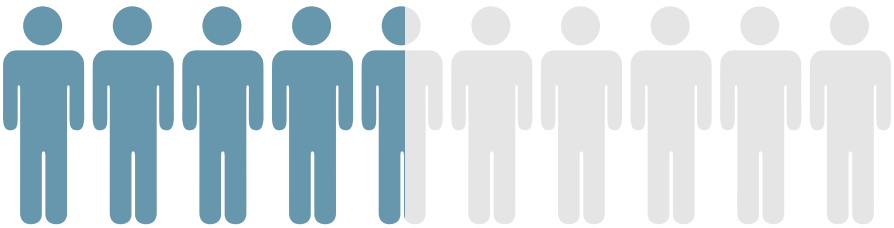
5,428

Best served in another language:

6.3%

Poverty Level

Hāmākua-Kohala Health



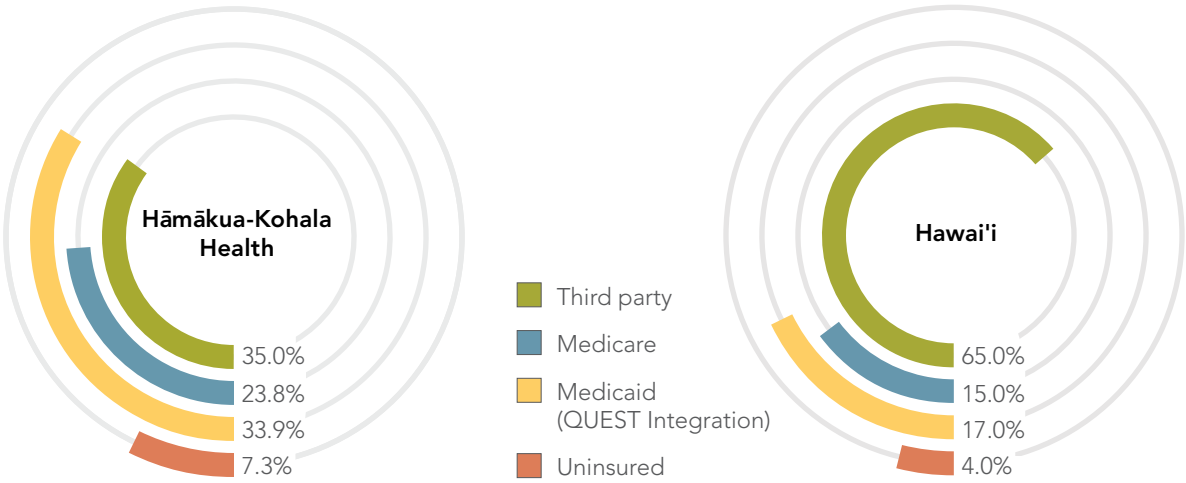
<100% federal poverty level

45.1%

<200% federal poverty level

76.3%

Insurance Type



HMSA Community Grant

Access to Health Care in North Hawai'i Island

Grant Overview

Executive Grant Summary

HKH serves all of North Hawai'i Island, which spans eight ZIP codes. Despite having multiple locations to cover their service area, many people still travel far to access care. Additionally, public transportation on Hawai'i Island is limited, further exacerbating the problem, especially for those in lower social-economic standings.

In early 2019, HKH opened a new clinic in Waimea to make health care more accessible to Waimea and Waikōloa residents. This clinic eased the commute for more than 700 patients. As of June 2020, the health center recorded over 3,200 visits to the new clinic for primary care, behavioral health care, and more.

Statement of Need

Hawai'i Island's vast geography makes the island unique, but also contributes to barriers in accessing health care. For many patients in Waimea and Waikōloa, the nearest health centers were HKH's Honoka'a and Kapa'au clinics, which were about 20 miles away. Limited public transportation added to the problem, making it difficult for patients to get the care they need.

According to Healthcare Association of Hawaii's 2018 Community Health Needs Assessment, "improving the transportation system" was noted as a high-priority need on Hawai'i Island.[3] For HKH specifically, a little over 25% of patients who took the health center's 2017 Community Needs Assessment survey also identified transportation as one of the greatest barriers to care. This need was greatest among behavioral health patients who indicated that this issue prevented them from making their appointments and for the elderly who were able to drive only a few miles from home.

Intervention

In January 2019, HKH opened their newest clinic in Waimea to make health care more accessible to the Waimea and Waikōloa communities. The clinic improved access for the health center's underserved patients in the area, serving as their patient-centered medical home. The clinic also gave patients the opportunity to seek a broader scope of services.

Overall, the clinic improved continuity of care closer to home by providing comprehensive services such as primary care, behavioral health services, and substance abuse counseling.

A portion of the grant was reallocated to provide aid during the COVID-19 pandemic.

Photos courtesy Hāmākua-Kohala Health

HMSA Community Grant

Access to Health Care in North Hawai'i Island

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

The Waimea clinic significantly increased access to health care for those who faced transportation barriers in Waimea and Waikōloa. As of June 30, 2020, about 18 months after it opened, the clinic achieved the following outcomes:

Waimea Clinic

	No.
Total clinic visits since opening	3,219
Office visits	2,595
Behavioral health visits	624

At the clinic, HKH implemented the following services to provide comprehensive care:

- Primary care.
- Behavioral health.
- Substance abuse courses and counseling.
- Prediabetic courses and groups.
- Tobacco cessation services and prevention.
- Women's health and prenatal services.
- A telehealth pain management program.

The clinic saw the greatest increase in the number of visits for primary care, behavioral health, and pediatric care. The clinic also saw increased participation in their tobacco cessation program as a result of their outreach initiatives and education.

Photo courtesy Hāmākua-Kohala Health

Intellectual Capital

The health center learned many things about their patient population. Since the clinic opened, the number of patients seeking primary care steadily increased, allowing the staff to engage with more patients and identify treatments for other needs. HKH learned that 94% of their patients come from populations with health disparities, of which 85% experience low socio-economic status and 34% are Native Hawaiian. They also learned that 39% of their patients who seek tobacco cessation also have a mental health condition. HKH is using this information to maintain or increase services to identified populations.

HKH also adapted and shifted resources due to the COVID-19 pandemic. The clinic has been dedicated to pediatric care only, while other services have converted to telehealth. The switch to telehealth decreased the no-show rate, particularly for behavioral health visits that are now below 5%.

HMSA Community Grant

Access to Health Care in North Hawai'i Island

Human Capital

To supplement primary care, HKH provided education and wellness services to address the top health disparities on Hawai'i Island. Preventive care and life coaches were available for patients to help prevent chronic diseases such as diabetes and hypertension. Most notably, the health center provided education and resources for their tobacco cessation program that continues to see success and growth in participation.

Social Capital

To provide a vast array of services, HKH partnered with other providers and organizations in the area. Using their tobacco cessation program, HKH combined efforts with the Hawai'i Community Foundation to help the Waimea community focus on vaping and smoking among children. The clinic also participated in the Baby & Me – Tobacco Free program, an evidence-based program to reduce the use of tobacco products among women during and after their pregnancy. HKH has also been developing a relationship with Waimea Women's Center and Hui Mālama, both of which now refer patients to HKH.

Most recently, HKH partnered with Waimea Medical Associates to grow their provider staff to focus on Waimea and the surrounding area, especially children in QUEST Integration plans.

Conclusion

HKH recognizes that to create change, you need to act. Instead of waiting for public transportation to improve, HKH brought a new clinic to the Waimea community. Instead of simply collecting patient data, HKH used it to make informed decisions and target health disparities in identified populations. HKH's dedication and strategic use of resources will continue to help them make great strides in improving the lives of those in the community they serve.

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West Hawaii Community Health Center

"A patient with diabetes came in with a wound that wouldn't heal. Testing showed that her glucose levels were dangerously high. Her provider asked the Care Coordination Program to help. While performing a routine social determinants of health screening, we found that she had been living in her car for several months. Our case manager helped her apply for low-income housing. In less than a month, she had an apartment in senior housing, her wound was healing appropriately, and her blood sugar was under control.

"Now, he looks forward to class, enjoys the weekly topics, and likes the social support from the rest of the class."

"Dan came in weighing 363 lbs. 14 weeks ago. His initial goal was to lose 5%. Today he weighs 325 lbs., a loss of 10.5%. Dan has not missed a Saturday class, keeps track of what he eats, and does chair yoga every day.

Photo courtesy West Hawaii Community Health Center

"In class, we noticed a change in his behavior. When class started, he was very upset that he didn't have the answers he was looking for. He blamed everyone for whatever was going on with him. Now, he looks forward to class, enjoys the weekly topics, and likes the social support from the rest of the class. His knee pain is lessened with the weight loss and he has enjoyed the relaxation techniques shared in class to reduce stress."

- Care Coordination Program staff member

West Hawaii Community Health Center at a glance

Mission To make quality, comprehensive, and integrated health services accessible to all who pass through our doors regardless of ability to pay. These services are culturally sensitive and promote community well-being through the practice of mālama pono.

History In 2002, the Salvation Army offered limited health care services in Kailua-Kona, but was eager to return to their social service foundation. They were concerned about the lack of medical and behavioral health services in the area and the growing population.

In 2003, a steering committee of community members was formed to garner interest in the development of a community health center and to take the necessary steps to make it a reality. In 2005, West Hawaii Community Health Center (WHCHC) entered into an agreement with the Salvation Army's Kona Community Clinic to assume the operation and opened its doors to the public. A year later, WHCHC received its Federally Qualified Health Center status, paving the way for a cost-effective health center that would deliver quality care to the underserved and uninsured community.

WHCHC Community Program

WHCHC's Street Medicine program reaches out to homeless individuals to provide medical, behavioral health (BH), addiction care, and social service interventions.

The Street Medicine team is an integrated treatment team that includes medical and BH providers, case managers, registered nurses, and enrollment specialists who frequently visit encampments across West Hawai'i.

Demographic information 2018[1-2]

Total patients served:

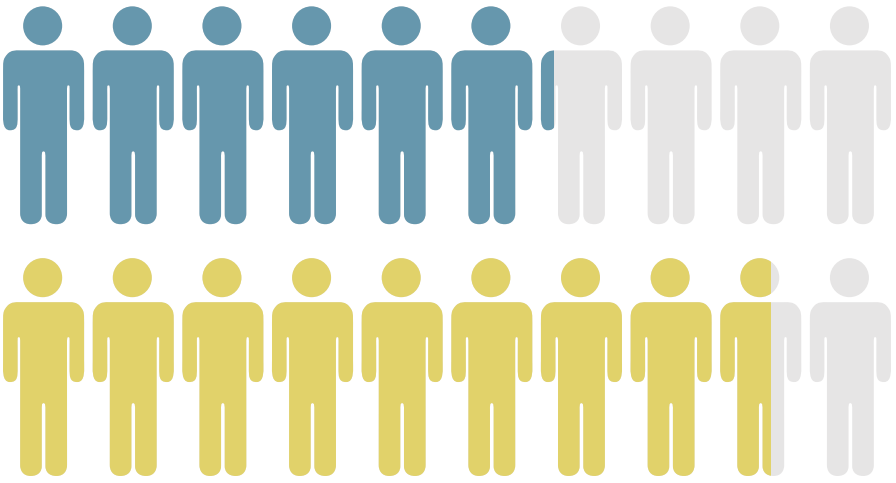
16,412

Best served in another language:

6.3%

Poverty Level

West Hawaii Community Health Center



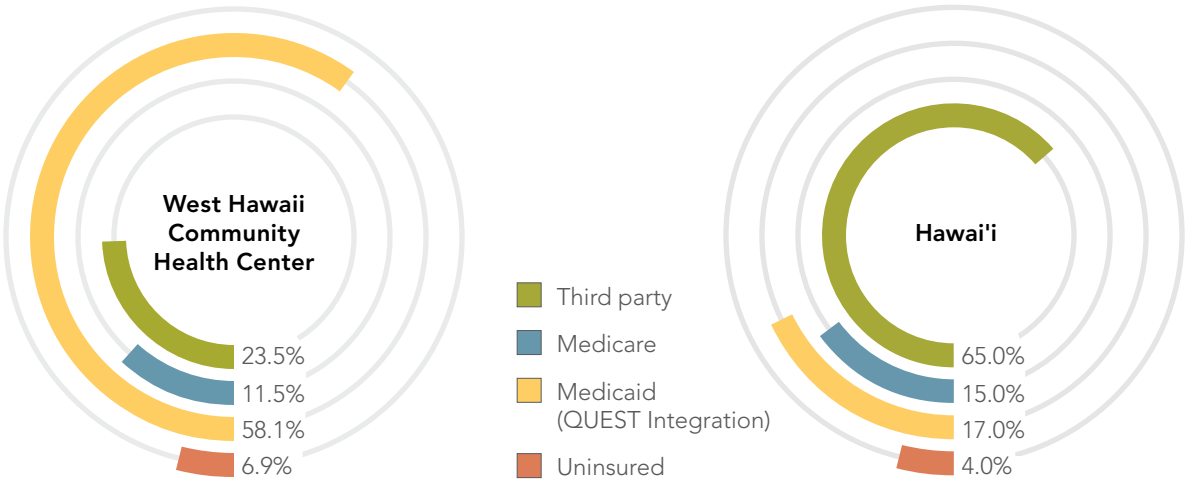
<100% federal poverty level

61.9%

<200% federal poverty level

86.3%

Insurance Type



HMSA Community Grant

Reducing BMI and Improving the Health of HMSA QUEST Integration Members

Grant Overview

Executive Grant Summary

Obesity and obesity-related diseases affect millions of individuals and families every year. Roughly 23% of adults in Hawai'i County are obese, the highest rate among the four counties in the state. Those who are obese are at risk for many serious diseases and health conditions. They often identify as Native Hawaiian or Pacific Islander and earn lower incomes.

WHCHC's interventions, the Diabetes Prevention Program (DPP) and Care Coordination Program (CCP), worked with patients who had greater health risks due to obesity. Patients worked with a team of providers including care coordinators, physicians, and community health workers. Through adaptive learning and community partnership, impressive progress was made in improving health outcomes of those enrolled in the intervention.

Statement of Need

According to the latest statistics from the Centers for Disease Control and Prevention (CDC), roughly a third of Americans are overweight or obese.[3-4] In 2008, the total cost associated with obesity-related diseases reached $147 billion in the United States.[5] Hawai'i County has the highest rate of obesity (23% of adults) in the state. HMSA QUEST Integration (QI) members were found to have a disproportionately high body mass index (BMI), putting them at greater risk of being or becoming obese.

Individuals who are at risk of obesity are also at increased risk for many serious diseases and health conditions, including:

- All causes of death.
- High blood pressure.
- High low-density lipoprotein cholesterol, low high-density lipoprotein cholesterol, or high levels of triglycerides.
- Type 2 diabetes.
- Coronary artery disease.
- Stroke.
- Gallbladder disease.
- Osteoarthritis.
- Sleep apnea and breathing problems.
- Some cancers such as endometrial, breast, colon, kidney, gallbladder, and liver.

- Low quality of life.
- Mental illnesses such as clinical depression, anxiety, and other mental disorders.
- Body pain and difficulty with physical functioning.[7]

Many studies, including the CDC's National Health Interview Survey, revealed that the highest obesity rates were associated with communities and individuals with the lowest income and educational levels. Additionally, obesity-related diseases contribute to a significant portion of health system costs in repeated emergency room visits, referrals to specialists, medications, imaging, hospitalizations, and medical procedures.[5]

Intervention

To target the growing need to manage obesity and related comorbidities, WHCHC launched a two-tiered program, the DPP and the CCP, to support the spectrum of patients and their needs.

Each month, the health center used reports from their electronic health records to identify HMSA QI members assigned to the health center. A community health worker assessed patients who had a BMI greater than 29, after which the CCP manager evaluated the patient's health risk factors and referred the patient to either the DPP or CCP.

The DPP followed the CDC's Prevent T2 curriculum that provided evidence-based, cost-effective interventions to prevent type 2 diabetes. The program consisted of 16 modules taught over six months followed by six months of maintenance support and reinforcement lessons in a group setting of up to 25 individuals.

The CCP was developed to assist high-risk patients and included an integrated team of a dietitian, psychologist, pharmacist, patient navigator, registered nurse, and the patient's primary care provider. This team modified and adapted the DPP curriculum for each patient and co-developed an individual care plan with the patient to focus on BMI reduction and healthy outcomes. The program focused on four areas: healthy food choices, stress and anxiety, movement, and a support team.

Both programs were supplemented with a wellness program that focused on fitness, fresh food, and cooking demonstrations. These programs were also available to individuals who weren't ready to enroll and to the general community.

HMSA Community Grant

Reducing BMI and Improving the Health of HMSA QUEST Integration Members

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

Collectively, the two-tier program reached 887 patients with a BMI greater than 29 with other comorbidities. About 398 patients or 45% were referred to and enrolled in the DPP and 489 patients or 55% were referred to and enrolled in the CCP.

During the grant period, the DPP held an average of two cohorts each month with an average of 17 participants. The DPP included a series of 16 modules supplemented with programs such as home blood pressure monitoring for patients with hypertension. The program achieved the following outcomes.

Diabetes Prevention Program

	Outcomes
Total participants	195
Average number of active cohorts per month	8
Patients who improved their A1c	33%
Patients who reduced their BMI	73%*
Patients who lowered their blood pressure	33%*

*HMSA QUEST Integration members only.

Russell Park

The CCP provided education, support, resource management, and follow-up to high-risk patients. This included home visits, coordination of specialty care, and collaboration with service coordinators. The value of this supportive care team was evident in a random chart review of 10 patients that found that after three or more months of no support from the CCP team, four regressed, three were lost to follow-up, and three were successful in self-managing their care.

Care Coordination Program

	Y1	Y2
Average monthly caseload	240	250
New patients enrolled	283	206
Patients who improved their A1c	50%	52%
Patients who reduced their BMI	49%*	49%
Patients who lowered their blood pressure	52%*	49%
Patients who improved their PHQ-9	31%	41%

*HMSA QUEST Integration members only.

HMSA Community Grant

Reducing BMI and Improving the Health of HMSA QUEST Integration Members

Photo courtesy West Hawaii Community Health Center

Participants in the DPP and CCP and other WHCHC patients who weren't ready to enroll in the programs were supported with wellness activities including fitness classes, fresh food programs, and cooking classes.

- **Fitness classes:** Over the course of the grant period, WHCHC introduced, tested, and developed classes that promoted physical activity in fun and engaging ways. The following table shows the classes offered and how the number of classes and participants increased.

	Number of Classes		Number of Participants	
Classes	Y1	Y2	Y1	Y2
Hula	58	32	507	261
Tai chi	27	50	425	796
Zumba/Pound	45	44	420	462
Zumba/Kahalu'u	7	4	62	38
Volleyball	2	3	75	24
Bike ride	1	9	11	88
Walking moai	21	12	202	66
Yoga	1	30	6	264
Genre dance	0	8	0	52
Total	162	192	1,708	2,021
Average participants per class			10	10

- **Fresh food program:** This program offered a variety of activities in partnership with many community sites to promote awareness, access, and knowledge about healthy eating. Activities included a "biggest loser" competition, Food Day KTA, Healthy 101 classes, and classes at schools for parents and keiki.

	Number of Activities		Number of Participants	
Classes	Y1	Y2	Y1	Y2
Total	54	27*	1,595	640*

*Based on six months of data.

- **Cooking classes:** WHCHC held a variety of cooking classes in the community at clinics and schools and in residential areas. Menus included healthy snacks, smoothies, vegan tacos, curry salad, and other healthy dishes. The following table shows the growth in cooking classes and reach of community members.

	Number of Classes		Number of Participants	
Classes	Y1	Y2	Y1	Y2
Total	11	105	25	274*

*Based on 10 months of data.

Intellectual Capital

During the grant period, WHCHC gained valuable insights that helped to refine and improve participation, retention, and outcomes overall.

The grant allowed the care coordination staff to proactively review patient charts to identify candidates for the DPP and CCP programs, which previously depended on provider referrals. The care coordination staff reviewed diagnoses and biomarkers such as A1c and PHQ-9 (patient health questionnaire for depression) and indicated a recommendation for enrollment in a highly visible section of the electronic health records for the provider to review and refer to. This contributed to the growth in enrollment and participation in the DPP, CCP, and wellness programs.

Despite the growth in participation, retention was another barrier identified.

HMSA Community Grant

Reducing BMI and Improving the Health of HMSA QUEST Integration Members

For DPP, feedback from those who opted not to participate or dropped out of the program reported challenges with juggling busy schedules, jobs, and children returning to school. Transportation was a common challenge, especially for those traveling from Ocean View into town and back. The average travel time is about 90 minutes one way with limited bus service. The program also received comments that the program was too long, resulting in loss of interest. To address some of this feedback, the DPP team augmented the content with guest speakers such as Marcus Cook, a healthy lifestyle motivational speaker, and connected with local community resources.

For both programs, WHCHC recognized that social determinants of health (SDOH) made it difficult for patients to focus on health-promoting behaviors. For example, as A1c increased, so did the rate of SDOH disparities. As a result, WHCHC expanded their team of community health workers and educators to focus on learning, partnering, and collaborating with communities that face obstacles. They focused on health education, access and navigation of the health care system, and other related services that promote health and well-being.

Additionally, CCP patients were screened for SDOH disparities using PRAPARE. Any positive screens were referred to a case manager for follow up. With the help of the case manager, WHCHC reduced positive screens by over 24% and over 56% of patients with poor glucose control were able to improve their A1c.

Human Capital

WHCHC hired and trained the following full-time employees: a health educator and a community health worker to support the DPP, a CCP manager, a care coordination registered nurse, and a patient navigator to support the CCP. Expanding their staff enabled WHCHC to increase the number of patients screened and referred to the DPP and CCP.

Social Capital

Community partnerships initiated through the community health workers and educators were key to the reach, participation rate, and outcomes reported for this grant. The following summarizes the partnership and programs established or enhanced during the grant period.

Education Systems

Hōnaunau Elementary School	• Monthly health services. • Presentations for parents every other week. • Healthy family cooking photo contest.
Kahakai Elementary School	• Tobacco cessation/vaping presentation.
Konawaena High School	• Tobacco cessation/vaping presentation.
Ke Kula 'O 'Ehunuikaimalino	• Seven weeks of nutritional eating classes and hula lessons for the Hawaiian Immersion elementary school in partnership with Lili'uokalani Trust. • Tobacco cessation/vaping presentation.

Health-related Organizations

Kona Paradise Club	• Monthly presentations for adults with severe mental health disorders.
Bikeshare Hawaii Island	• Supported monthly bike rides by providing safety training, bikes, and helmets.
People's Advocacy for Trails Hawaii (PATH)	• Supported monthly bike rides and partnered to hold a 5K Ohana Walk/Run.
One Island/Same Canoe	• Partnered to launch Veggie Rx Program. Eligible patients were given a prescription for Veggie Rx to exchange for fresh fruits and vegetables at participating stores.

Social Services Organizations

Kahalu'u Affordable Housing	• Monthly wellness programs - Cooking demonstration and dinner. - Volleyball tournament. - Other fun family activities. • Weekly youth group - Tobacco cessation youth empowerment leaders via Coalition for a Tobacco-Free Hawai'i (Hawai'i Public Health Institute). - Advocated for a playground in the housing unit. Identified the need as a result of a built environment survey. Besides one basketball court, kids played in the parking lot or walkways. - Address health concerns (physical, socioemotional — healthy self-esteem, bullying), aspire for college/higher education.
Na Kahua Hale O Ulu Wini (affordable rental and transitional housing complex)	• Monthly health presentations. • Monthly wellness programs: Pili Ohana weight loss challenges, cooking demos, and a volleyball tournament and other activities. • Weekly youth group: Advocated for a water fountain in the playground area.
Bridge House (transitional halfway housing)	• Smoking cessation.
Lions Club	• Health fair screening table for blood pressure, blood sugar, insurance, and hearing and dental screenings.
Parents and Children Together (PACT)	• Soup, salad, or sandwich contest. Judged on taste, nutrition, and presentation.

Photo courtesy West Hawaii Community Health Center

In addition to these partnerships and activities, WHCHC hosted a free community event in August 2018 and 2019 called Feel Good Fun Day. This event partnered with organizations to offer resources and activities to families such as games, dancing, bike rodeo, free screenings, and samples of healthy foods. In 2018, about 250 people attended the event. In 2019, attendance nearly doubled to about 450 people.

Conclusion

Changing healthy behaviors isn't easy, especially for vulnerable populations that may be facing social disparities that make it hard to prioritize healthy behaviors. Using an adaptive process that proactively identified candidates, WHCHC offered options such as DPP, CCP, and wellness programs that addressed social and environmental factors, effectively improving the lives of their community members impacted by chronic health issues. WHCHC will continue to build on the work that they started in this grant and help their patients and the community make healthy lifestyle changes.

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Maui

Hāna Health

"We have the benefit of teaching each other. It's much easier to learn from your peers than someone who's regarded as an authority figure. So that's what we're learning together — how to teach each other. I realized the success of the program was not me. It was how those folks supported and taught each other. We stay overtime, so you know we're having a good time. I love to see people do better. I've seen huge successes in the past and I just want to see it in the present. That's what makes me want to do it."

- Hāna Health physician referring to the Living Pono program

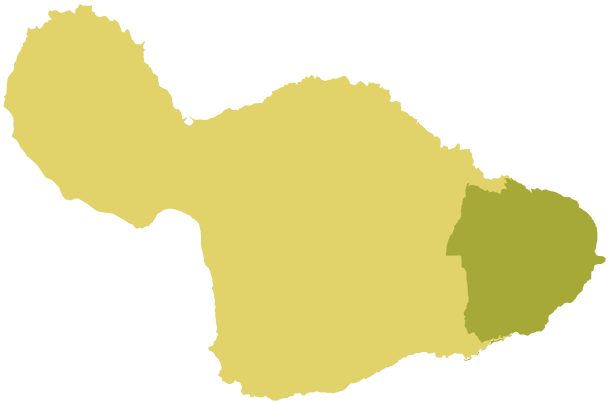
"I love to see people do better."

Photo courtesy Hāna Health

Hāna Health at a glance

Mission Improve the quality of life for Hāna residents through initiatives that address health, social, and economic needs of the community.

History To improve health care for the remote population of Hāna, the state transferred operation of the Hāna Medical Center to Hāna Health in July 1997. Unlike most primary care clinics, Hāna Health provides urgent medical services seven days a week, 24 hours a day. It's the only health care provider in the district.



Maui

Service area

Hāna Health Community Program

Focusing on nutritious and healthy eating, Hāna Fresh includes a nutrition center, farm stand, and seven-acre farm behind the health center. Hāna Fresh's mission is to grow, prepare, and sell food that supports the health and self-sufficiency of Hāna. Proceeds from the food sales support Hāna Health's programs and services.

Demographic information 2018[1-2]

Total patients served:

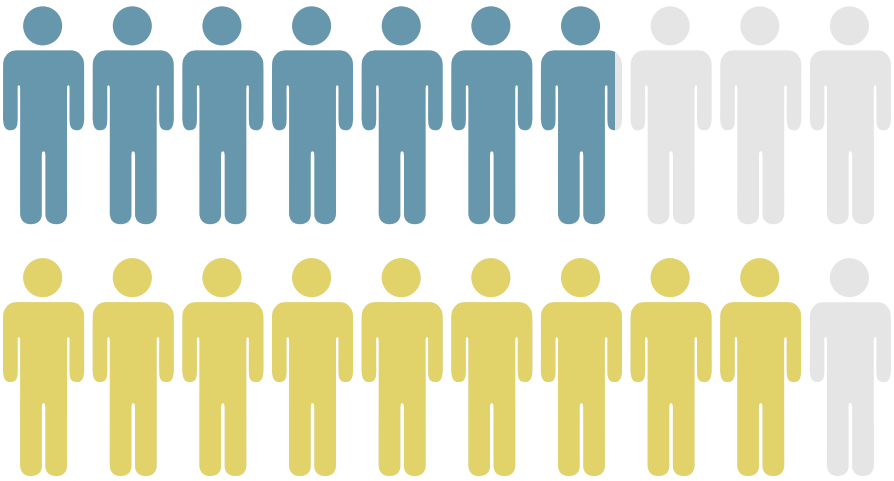
1,966

Best served in another language:

0.0%

Poverty Level

Hāna Health



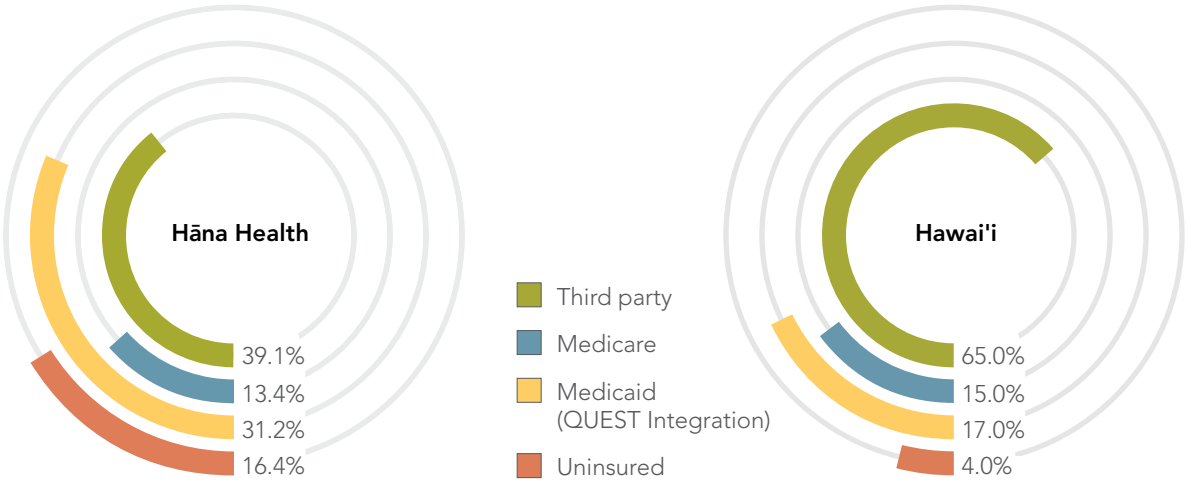
<100% federal poverty level

69.1%

<200% federal poverty level

89.7%

Insurance Type



HMSA Community Grant

Hāna Healthy Lifestyles

Grant Overview

Executive Grant Summary

As the nearest hospital is miles away, many residents in Hāna depend on Hāna Health for their health care needs. To improve the overall health of the community, Hāna Health initiated Hāna Healthy Lifestyles, a program with multiple interventions centered on various aspects of health, such as increased physical activity and chronic disease management and prevention, with a significant focus on healthier eating habits.

The health center took full advantage of Hāna Fresh, their on-site organic farm that grows, prepares, and sells food that supports the health and self-sufficiency of the Hāna community. Many components of the Hāna Healthy Lifestyles program used the farm's fresh fruits and vegetables to equip the community to improve their diets and live healthier lives. With each intervention, Hāna Health was able to help participants improve and invest in their own health.

Statement of Need

As a community with a high number of Native Hawaiians, Hāna faces a variety of health disparities that are less prevalent in other areas. Some of the increased risks this community faces are lower life expectancy and higher rates of cardiovascular disease and cardio-metabolic disorders such as obesity, diabetes, and hypertension. Hāna's many multigenerational households, 70% of which are Native Hawaiian, experience higher risks for these conditions and may normalize living with chronic disease for younger generations.

Other factors have also had a significant impact on the availability and accessibility of medical and nonmedical services. For example, Hāna's unique, isolated location creates a barrier to accessing healthy food options and ingredients. At Hāna High and Elementary School, most of the meals are pre-made and prepackaged. After school and during school breaks, students have had very few healthy food and snack options in their community.

Hāna's socioeconomic status, which is 43% lower than the state average, has also been a barrier to overcoming Hāna's health disparities. Seventy-six percent of Hāna High and Elementary School students participate in the National School Lunch Program and/or School Breakfast Program based on family size and income.

Intervention

Hāna Health implemented the Hāna Healthy Lifestyles program to address community health issues. The program consisted of four interventions:

- The Walk It to Win It Challenge: As a joint program between the health center and Hāna High and Elementary School, this challenge promoted physical exercise for elementary and middle school students. Two sessions a week were held for students to walk, skip, or run around the school's ballpark. The program also included a variety of supplemental activities like frisbee, hula hoop, dodge ball, and jump rope. Participating students received a pedometer to keep track of their steps and were offered fresh fruit and other healthy snacks.
- Rx for Good Health: Following the completion of a wellness exam or health screening, QUEST Integration (QI) members in this program received a "prescription" (i.e., voucher) for fresh produce and prepared salads redeemable at the Hāna Fresh farm stand.
- Mai e 'Ai (Come Let's Eat): This dinner program brought families together and served nutritious and culturally centered meals weekly. Each meal was accompanied by a presentation on a variety of topics such as the role of fitness in maintaining health, how to shop and prepare healthy meals on a budget, and the cultural aspects of wellness. Food boxes and recipes were distributed at the end of the presentations so that families could prepare and enjoy two healthy dinners.
- Living Pono: This 180-day program used a holistic approach to help prevent and reduce chronic disease. The program included case management, an organized walking program, prepared meals, stress management techniques, and peer support groups. Due to participant feedback, the program was revised several times during the grant period.

Hāna Health was awarded a supplemental grant to further their initiatives. In partnership with Hāna High and Elementary School and Hāna Youth Center, Hāna Health implemented the following programs to improve the food environment for students. The goal of the program was to promote good dietary choices and further reinforce healthy lifestyle principles.

- School salad bar: A salad bar was established at Hāna High and Elementary School so students could access fresh fruits and vegetables at lunch.
- Hāna Youth Center snack menu: Hāna Health provided free healthy snacks for the students who stayed at the center after school.

HMSA Community Grant

Hāna Healthy Lifestyles

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

Hāna Health initiated various programs to improve the health of their community.

To instill healthy habits at a young age, Hāna Health introduced the Walk It to Win It Challenge that focused on getting students physically active at school.

Walk It to Win It Challenge

	No.
Student participants (grades 3-8)	66
Group walks	54
Miles walked	790
Healthy snacks distributed	1,702

To encourage the health center's QI members to complete their wellness exams, the Rx for Good Health program rewarded them with a healthy incentive. After patients completed the necessary exam(s), they were given a "prescription" (i.e., voucher) to redeem for fresh produce or prepared salads from Hāna Fresh.

Rx for Good Health

	No.
"Prescriptions" distributed	249
Patients who completed their dental exam	167
Patients who completed a quality measure	82

To promote healthy eating habits, Hāna Health's Mai e 'Ai program brought families together for nutritious meals. Over the course of five family dinner events, Hāna Health reached many families and provided them with a healthy meal and well-being presentations. Through supplemental funding from a private organization, families also received healthy food boxes and recipes to take home.

Photo courtesy Hāna Health

Mai e 'Ai Program

	No.
Participants	165
Families	34
Meals prepared	631
Food boxes provided	240

Based on participant feedback, Hāna Health made many revisions to the Living Pono program to better support and improve the experience and health outcomes for future participants. Though the program varied slightly throughout the grant period, the program's general outputs were encouraging.

Living Pono

	No.
Unique participants	39
Organized walks	76
Prepared meals	5,853 (58 boxes of produce)
Peer support groups	45
Participants who lost weight and reduced their BMI	28
Participants who achieved a healthy systolic blood pressure range	42
Participants who achieved a healthy diastolic blood pressure range	35
Participants who lowered their A1c	12
Participants who lowered their cholesterol	8

HMSA Community Grant

Hāna Healthy Lifestyles

Photo courtesy Hāna Health

With the supplemental grant, Hāna Health was able to further their efforts to instill healthy habits in students with the introduction of a salad bar at school and healthier snack options at the youth center.

Hāna High and Elementary School Salad Bar

	No.
Salad bars provided	55
Meals served	5,529
People who accessed the salad bar	120
Students	107
Teachers	13

Hāna Youth Center Snack Bar

	No.
Healthy snacks prepared/delivered to the center	1,254
Healthy snacks sold	1,107
Children who selected a healthy option	15/day average

Intellectual Capital

Several focus groups were conducted to get feedback on the various initiatives that Hāna Health implemented.

Although the Walk it to Win It Challenge was ultimately discontinued, Hāna Health learned various lessons about youth health. The elementary school students were enthusiastic about the program, while middle school students had little interest in it. Two significant barriers in participation were transportation and weather. Given the logistics of the Hāna district, many students were on a fixed schedule — they either took the bus or were dropped off by parents at scheduled times, which made it difficult for them to participate in the before-school program. Frequent rainy weather also caused the program to be canceled often, which resulted in frustration among students who showed up to participate.

Hāna Health received a lot of positive feedback about the Mai e 'Ai program and learned that participants especially enjoyed the group camaraderie and information sharing. Most of the participants reported learning about the importance of good nutrition as it relates to living a long, healthy life. They also reported that due to what they learned in the program, they started establishing changes in their family's eating habits at home.

The Living Pono program was revised based on feedback and scaled back several times to better accommodate participants' needs. For example, the program's initial 180-day duration was later broken down into six one-month tracks to give participants greater flexibility. After completing each track, participants could continue to the next one if they wished. This eased worries and enabled participants to more confidently commit to the program. Much of the program's success could be attributed to the support that participants received from each other.

"Coming here and eating a meal has really helped and changed my way of eating. I'm thankful for the food. It's helping me. And I get support from everybody – from the doctors, everybody. I look forward to these nights. The support group is working really well. I go home happy."

- Living Pono participant

The school salad bar generally received positive feedback from students, some of whom said it was the best thing about eating at the cafeteria. Not all students had access to three meals a day, so school lunch was a guaranteed source of food. Despite this, many students expressed that the school lunch was not very good. Students opted to skip lunch rather than eat what was offered at the cafeteria. The fresh fruits and vegetables at the salad bar provided them with a healthy alternative.

The healthy options that Hāna Health provided at the Hāna Youth Center snack bar were generally well received by the students, although some wished that the unhealthier options, like pizza pockets, would return. Most understood that the new snacks were better for their health, although they didn't fully understand what made food "good" or "bad." The feedback uncovered a gap in understanding that Hāna Health could potentially fill with health education.

Human Capital

During the course of Hāna Health's various initiatives, participants learned how to prevent and manage their health conditions. The Mai e 'Ai program, for example, used interactive health presentations to teach participants a variety of wellness topics. Most learned about the importance of good nutrition and carried these lessons into their meals at home.

Many participants in the Living Pono program were able to lose weight, lower their blood pressure, and lower their hemoglobin A1c. Many participants said that learning to read food labels was a valuable lesson. Taking the time to see exactly what was in each product and knowing specifically what to look for really helped them while grocery shopping and preparing meals. One participant noticed a significant change in their health after they began reading the labels.

Social Capital

During the grant period, Hāna Health developed a working relationship with Abbott Pharmaceuticals, which offered Living Pono program participants the opportunity to use the Freestyle Libre, a continuous glucose monitoring (CGM) device. According to Hāna Health, research has shown that patients with diabetes who use CGM devices are able to better manage and understand their diabetes with minimal finger sticks. Although no participants have yet requested the device, Hāna will continue to work with Abbott Pharmaceuticals for when they do.

Hāna Health also strengthened its relationship with Hāna High and Elementary School and the Hāna Youth Center to extend healthy eating options and promote healthy eating behavior. Both the school and youth center are important community institutions, particularly for the youth, providing a place to gather and opportunities to encourage and promote healthy living.

Conclusion

As a community strongly centered around family and multigenerational living, Hāna Health focused their programs to address all generations. Whether it was instilling healthy habits in Hāna's youth or continually striving to improve the chronic disease management program for adults and kupuna, Hāna Health always had their community at top of mind. Moving forward, Hāna Health will continue to look at ways to provide nourishment and increase healthy lifestyle knowledge for the Hāna community.

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2. Kaiser Family Foundation. (2020). Health Insurance Coverage of the Total Population: Hawaii. The Henry J. Kaiser Family Foundation. Retrieved from https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22hawaii%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Photo courtesy Hāna Health

Mālama I Ke Ola Health Center

"I want people to see value in someone being able to really connect the patient with their provider. They go and they care for other people just because they're part of their community, not necessarily because they're blood-related family. You know, if you have the right people and they're doing the right things to help everyone have access to resources and education, you can change the community. It makes me feel better to know that there's still love in this world."

- Community Engagement program manager

"If you have the right people and they're doing the right things to help everyone have access to resources and education, you can change the community."

Photo courtesy Mālama I Ke Ola Health Center

Mālama I Ke Ola Health Center at a glance

Mission To provide culturally sensitive, coordinated primary care services emphasizing education, prevention, and advocacy regardless of one's ability to pay at the time of visit.

History Community Clinic of Maui Inc., dba Mālama I Ke Ola Health Center, was founded in 1993 to meet the community's demand for health services for the homeless, poor, and underserved. Since its beginning, Mālama has implemented comprehensive primary care medical services for all life cycles, ranging from preventive care to acute and chronic disease services. Mālama also serves patients who have health issues as a result of substance abuse. The health center is a safety net primary care provider for Maui's underserved residents.

Maui

Service area

Mālama I Ke Ola Health Center Community Program

Mālama's transgender primary care clinic, Transcend Maui, is available to transgender and gender nonconforming patients. The health center believes that everyone in Maui County deserves access to competent and compassionate health care that includes medical care, hormonal therapy, and behavioral health services to address issues with gender dysphoria and more.

Demographic information 2018[1-2]

Total patients served:

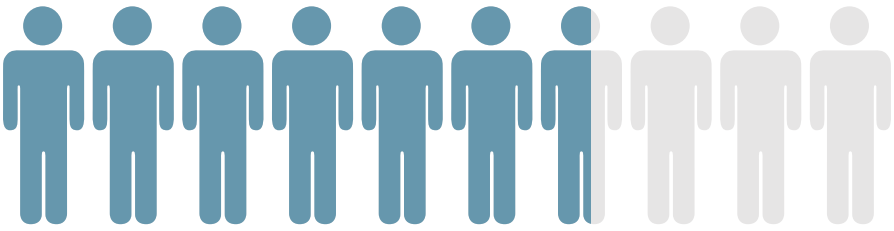
11,807

Best served in another language:

17.7%

Poverty Level

Mālama I Ke Ola Health Center



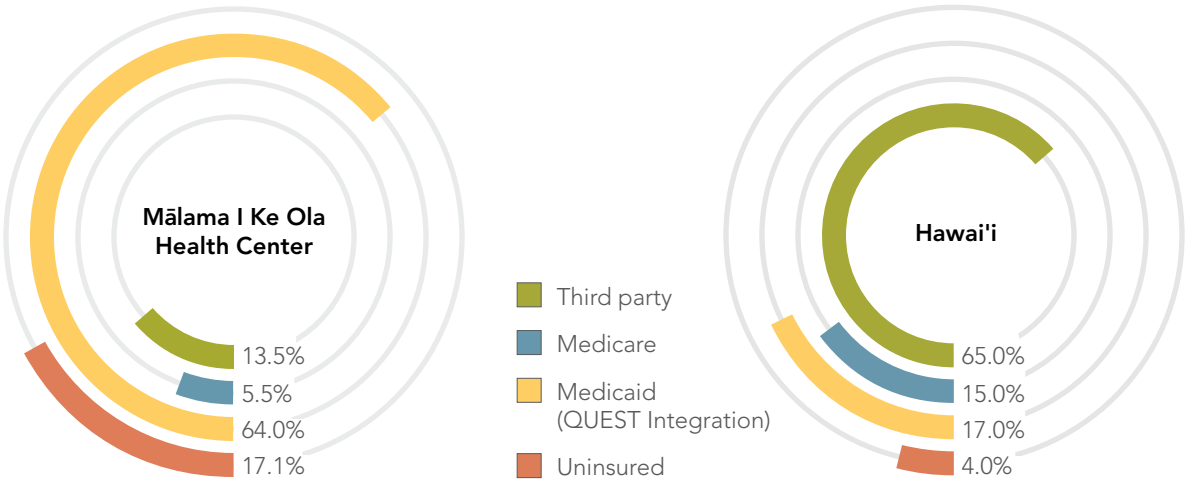
<100% federal poverty level

66.1%

<200% federal poverty level

91.7%

Insurance Type



HMSA Community Grant

Healthy Community Program

Grant Overview

Executive Grant Summary

Mālama strived to solve a prominent problem in their community. Quality of health indicators for hypertension and diabetes in their patients were lower than the state and national averages. Both chronic diseases, if left unaddressed, have been shown to lead to higher rates of cardiovascular disease and/or premature death. Also, factors such as low income, educational barriers, and underutilization of health care services contributed to the low quality of health indicators.

To address these issues, Mālama:

- Developed a community health worker (CHW) program to connect patients to health care services to help manage their chronic disease.
- Incorporated traditional medicine and complementary and alternative therapies to aid in treatment.
- Established a farmers market to increase access to fresh fruits and vegetables.

These interventions enabled Mālama to encourage their patients to invest in their own health by providing them with individual support, education, and increased access to alternative care. As a result, the number of patients with uncontrolled diabetes dropped 30% and the number of patients with controlled hypertension increased 45%.*

Statement of Need

Due to low income, barriers to education, underutilization of health care services, and other social determinants of health conditions, Mālama's quality of health indicators for hypertension and diabetes are lower than the state and national averages. During the grant period, Mālama targeted patients who had uncontrolled diabetes (HbA1c measure greater than 9) and/or those with poorly controlled hypertension (blood pressure consistently reading at or above 140/90).

*Uniform Data System report of patients Jan. 1, 2018, to May 31, 2020.

Intervention

To improve the health center's quality of care indicators for diabetes and hypertension, Mālama initiated three interventions:

1. A CHW program: Mālama hired CHWs to connect patients with health care services focusing on chronic disease management. Mālama specifically hired CHWs from their community because of their ability to gain trust and advocate for those who encounter challenges in the health and social service sectors. These CHWs have a better understanding of their community's needs, solutions, and culture. Their responsibilities included medical translation services at provider appointments, helping patients fill out health-related forms and, when applicable, traveling with patients to appointments with specialists on a Neighbor Island.

   CHWs also administered and implemented the Pacific Islander Diabetes Prevention Program, which is similar to the Centers for Disease Control and Prevention's program but with a focus on the challenges, successes, and needs of the Pacific Islander population.

2. Traditional medicine and complementary and alternative therapies: Mālama partnered with traditional medicine and complementary and alternative medicine providers to increase their patients' access to different services. These relationships enabled Mālama to implement a system that allowed patients to receive these services free of charge using a voucher.

3. A farmers market: In partnership with Oko'a Farms, Mālama launched a weekly farmers market that gave patients convenient access to the fresh, nutritious food they needed to manage their condition. Mālama also offered their patients vouchers to relieve some of the cost to purchase the food.

Photo courtesy Mālama I Ke Ola Health Center

Russell Park

Photo courtesy Mālama I Ke Ola Health Center

HMSA Community Grant

Healthy Community Program

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

Mālama's main goal was to offer their patients different ways to help them control their diabetes and hypertension. Their interventions resulted in the following clinical outcomes.

Diabetes and Hypertension Control

	Percentage
Patients with uncontrolled blood pressure	30% (reduced from 45% in 2017)
Patients with controlled blood pressure	45% (increased from 40% in 2017)

The CHW program was an important factor in achieving the clinical outcomes. Hiring culturally sensitive people from their community enabled Mālama to engage more of their patients in improving their health.

Community Health Worker Program

	No.
CHWs hired	13**
Unduplicated patients seen by CHWs	165*
Patient encounters with CHWs	1,676*
Patients enrolled in the CHW's diabetes prevention program	113

* CHW outcomes include patients served by currently employed CHWs as of March 2020 due to a system tracking error.

** Throughout the grant period, on average, five CHWs were employed at the health center.

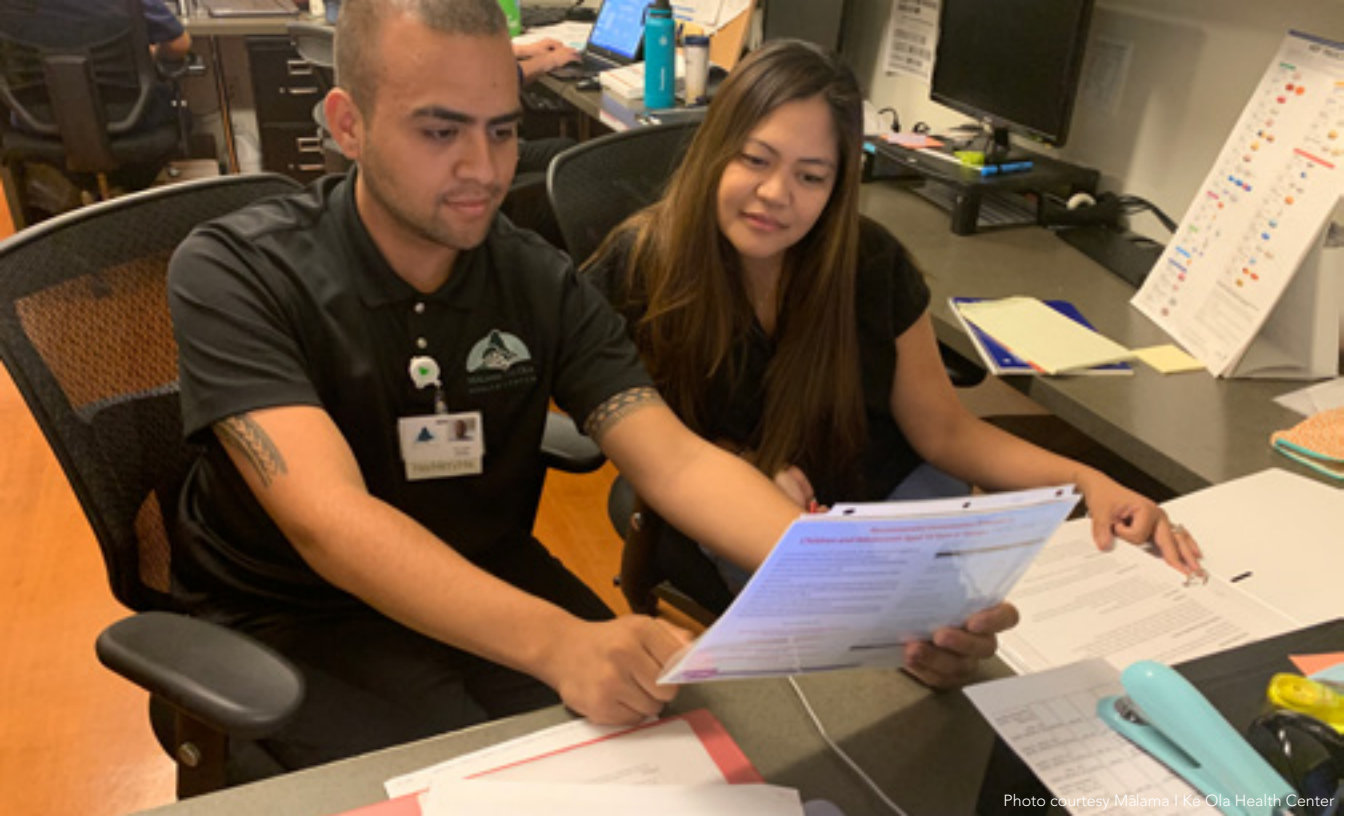


Photo courtesy Mālama I Kō Ola Health Center

Although not used as much as expected, patients were able to receive additional care through traditional medicine and complementary and alternative therapies.

Traditional Medicine

Patients who received lomilomi massage from University of Hawai'i Maui College students	7 patients, 21 sessions

Complementary and Alternative Therapies

Patients who received massage therapy from Maui Academy of Healing Arts	6 patients, 19 sessions
Patients who received acupuncture from a community provider	8 patients, 29 sessions

To increase patient access to fresh, nutritious foods, Mālama launched a weekly farmers market that featured produce from a local farm.

Farmers Market

	No.
Farmers markets held	48
Vouchers distributed	319
Patients who used the vouchers	300

In addition to the CHWs who were funded through this grant, Mālama hired a program manager and a director to head the newly formed Community Engagement department.

HMSA Community Grant

Healthy Community Program

Photo courtesy Mālama I Ke Ola Health Center

Intellectual Capital

With help from Mālama's director of clinical operations, the CHW program integrated with clinical services to form the health center's Community Engagement department. The CHW program established communication, booking, and documentation protocols with clinical services and solidified policies and procedures, such as allowing CHWs to accompany patients to off-island appointments. As a result, other Mālama departments, such as Women, Infants, and Children and ob-gyn, asked for assistance. In response, the CHW team conducted training sessions for clinic staff about CHWs' role and scope of practice.

Mālama learned many lessons from their interventions.

- Despite offering vouchers for complementary and alternative medicine, the health center discovered their patients were not interested in these services.
- Patients often requested individual support to make lifestyle changes and help with self-management goals set with their primary care provider.
- Mālama recognized that a three-pronged approach of education, demonstration, and application may be more successful when engaging patients to try these services.
- It was evident that not only was it important to educate patients about the benefits of these alternative forms of care but it was equally important to educate providers at the health center to recommend those forms of care.
- Being able to show patients and providers what these services look like and demystifying any thoughts and unfamiliarity of these forms of care would lead to more referrals and patient engagement.

The farmers market showed similar results. Mālama noticed that even with the vouchers, patients expressed that some items were expensive. They also observed that despite the farmer bringing a variety of produce, most patients purchased only common items such as onions, tomatoes, and lettuce. Educating the community on the variety of produce available and using the produce in cooking demonstrations are ways that Mālama will further engage and improve the health of their community.

Although each intervention provided some form of care on its own, the need to integrate the three programs in a family-centered approach is a lesson that the Community Engagement department will carry with them to future projects and programs. The three programs in this grant predominately addressed the health of the individual, however, families and social support networks are also strong influences on health. Educational sessions and goal setting targeted to involve the family might be a way to improve health outcomes for everyone.

Human Capital

To build their skills to work with patients, CHWs were trained on topics such as core competencies, happy and healthy for life curriculum, benefits of acupuncture, and massage therapy for people with diabetes and hypertension. The CHWs also attended the CHW Leadership Conference to gain more knowledge, skills, and resources. Integrating the CHW program with clinical services enabled the CHWs to learn about Mālama's electronic medical record system.

Mālama's CHWs educated 120 patients on diabetes management and hypertension control. Of those patients, 50% reduced their weight by 5%. Assessing clinical measures allowed Mālama to determine that the improved health outcomes were partially due to increased patient knowledge.

"I love myself. I am so thankful to be part of this program. It really did have a great impact on my life. It changed many things. It built up my confidence and helped me to be careful about what I'm eating. Controlling my diet and making walking a part of my daily activities pushed me to be even more active. It gave me new strength. I loved it."

– Pacific Islander Diabetes Prevention Program participant

HMSA Community Grant

Healthy Community Program

In addition to educating their patients, the CHWs conducted outreach services to help community members access various resources and navigate the health care system. Outreach events included health fairs to provide health screenings and education to assisting the broader community with connecting individuals and families to a provider or enrolling someone in a Mālama program. The CHWs also established a travel companion program that allowed them to travel with and help patients who have appointments on O'ahu while providing key services through medical interpretation, ground travel accommodations, and social support.

"A patient returned to the health center for paperwork to have a procedure done on a sore on his foot. He also complained of leg pain. Our provider asked our Marshallese CHW to explain that his problems are the result of his uncontrolled diabetes and that he must see an endocrinologist right away. The CHW walked with the patient to the referral department to get information for travel to the endocrinologist on O'ahu. There was some concern that no one would be able to contact the patient once the arrangements were made. The CHW knew where the patient lived [through family] and would be able to go to his home to deliver a message if his phone were to be disconnected again. The CHW was also scheduled to interpret for the patient's follow-up appointments."

– Community Engagement department program manager

Finally, the Community Engagement staff presented a variety of topics as panelists at webinars that focused on the importance of community engagement in the continuum of care for people with diabetes, management preparedness during the COVID-19 pandemic for Pacific Islander communities, and the CHWs' role in addressing COVID-19 for the Native Hawaiian and Pacific Islander communities.

Social Capital

To prepare for their various interventions, Mālama spent a lot of time building relationships with their program partners. For their complementary and alternative medicine intervention, Mālama worked with Hui No Ke Ola Pono and the University of Hawai'i Maui College to implement a pilot program allowing cohort students to practice lomi lomi on patients to fulfill certification hours. Mālama also worked with an acupuncture and massage therapy provider to provide alternative options for their patients.

Mālama's farmers market would not have been possible without partnering with a local farmer who provided the produce and set up and staffed the market.

Conclusion

From the creation of their Community Engagement department to hiring staff from the communities it serves, Mālama continues to listen and learn to increase their knowledge and develop community-centered programs. The Community Engagement department's dedication, creativity, and adaptability allowed them to respond quickly and effectively to care for their patients beyond programs that were established from the grant. Mālama's efforts exemplify the crucial role that community-centered programs play in improving the health of their communities.

Works Cited

1. HRSA Health Center Program. (2020) 2018 Community Clinic of Maui, Inc Health Center Program Awardee Data. Retrieved from https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=096040&state=HI&year=2018.

2. Kaiser Family Foundation. (2020). Health Insurance Coverage of the Total Population: Hawaii. The Henry J. Kaiser Family Foundation. Retrieved from https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22hawaii%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Lāna'i

Lāna'i Community Health Center

"I think it's the friendships. I really feel at home there [at Lāna'i Community Health Center]. I don't feel at home a lot of times in my own home. I get that feeling of love from these two ladies [LCHC's community health workers]."

– LCHC patient

"I really feel at home there"

"I was worried because she lost her loved one. I didn't want her to be by herself. I didn't want her to stay home because of her sudden loss. I was constantly like, 'OK Auntie, we gotta do something.' She would always go walking with her sister and then there was a sudden absence, so I was like, 'we go.' I gotta do something to keep them motivated and not feel that loss. I'm trying to figure out how we can all stay connected."

– Community health worker

Photo courtesy Lana'i Community Health Center

Lāna'i Community Health Center at a glance

Mission

The Lāna'i Community Health Center's (LCHC) mission is to take care of the Lāna'i community. A 501(c)(3) nonprofit organization, LCHC provides health care with a focus on physical, mental, emotional, intellectual, and spiritual welfare and by enriching and empowering lives to help build healthy families in a supportive environment.

To carry out its mission, LCHC:

1. Provides comprehensive health and wellness services.
2. Collaborates with partners to provide services for individuals of all ages, ethnicities, and genders.

Lāna'i

Service area

History

The Lāna'i Women's Center was established in 2002 with an award from the Hawaii Community Foundation. Three years later, the center was granted 501(c)(3) status and was soon awarded Federally Qualified Health Center 330e designation. Their name was legally changed to Lāna'i Community Health Center in 2009.

LCHC Community Program

LCHC has established many partnerships with other resources on the island to provide health care and outreach services to their patients and community.

Through their partnerships with Lāna'i High & Elementary School (LHES) and the LHES Foundation, LCHC has successfully provided health education to the students and staff. Furthermore, they provide outreach services to the two major employers on island, Four Seasons Resort Lāna'i and Pūlama Lāna'i, to ensure they reach as many individuals as possible. Through these partnerships, LCHC has successfully identified individuals who need health care and education.

Demographic information 2018[1-2]

Total patients served:

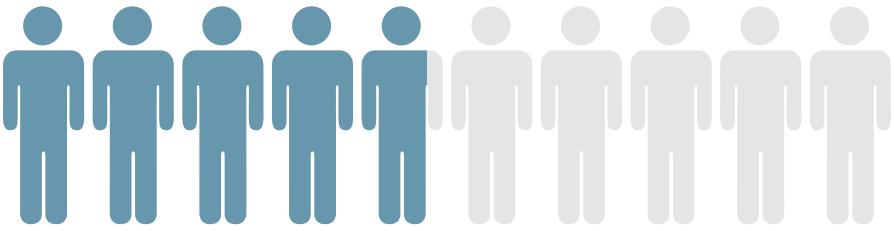
1,986

Best served in another language:

7.2%

Poverty Level

Lāna'i Community Health Center



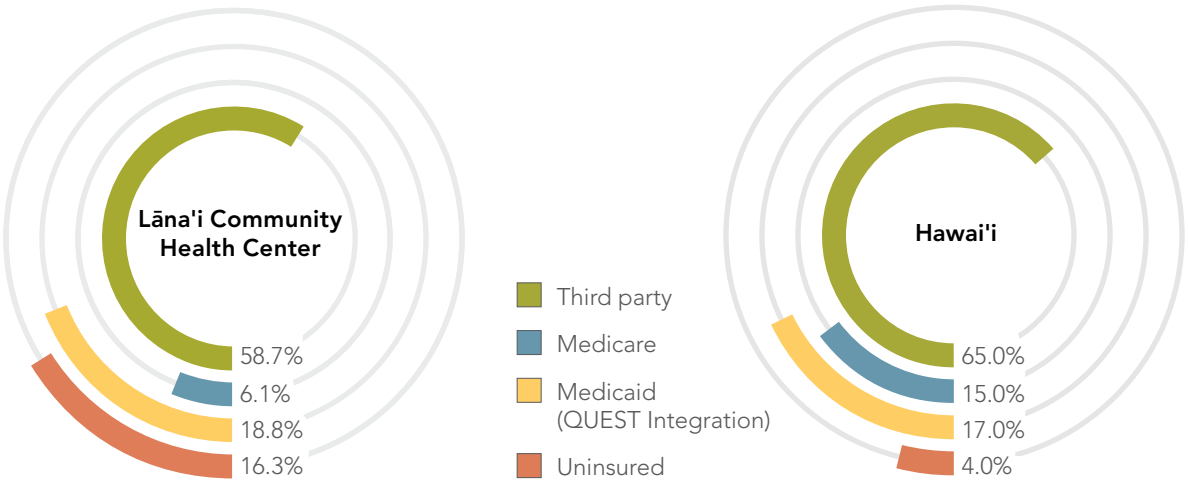
<100% poverty

47.4%

<200% poverty

77.3%

Insurance Type



HMSA Community Grant

Quality Rural Health Through Holistic Touch and Technology

Grant Overview

Executive Grant Summary

Lāna'i is home to a small rural community that's primarily employed in the service industry. The uniqueness of Lana'i's population and location has made accessing care and improving health and well-being a constant challenge. LCHC aimed to reduce barriers to care using enhanced technology and an expanded support team.

To positively impact the Lāna'i community, the health center increased participation in their home-based health monitoring program, expanded their care team with community health workers (CHWs) and off-island specialists via telehealth, added fitness programs to clinical care plans, included behavioral health in patient care teams through a new postdoctoral fellow, and expanded preventive services through partnerships with Lāna'i High and Elementary School and employer groups.

Statement of Need

The Lāna'i community has faced many challenges. According to the latest census and the Hawai'i Department of Health, 24% of residents are foreign born and 41% are in low-paying service jobs compared with 16% of the population in the rest of the state.[3] LCHC focuses on a holistic approach to improve the quality of care and health outcomes, but the health care system is still challenged by cultural norms and fragmentation that make it difficult for residents to access care.

Intervention

To address these challenges, LCHC created a more-integrated health care system using technology, expanded support teams, and the promotion of holistic health and well-being in partnership with schools and employers. The interventions that supported these goals are as follows:

- Access initiatives
  - Enhanced technology: To increase participation in the home-based health monitoring program, LCHC reduced the cost for patients and improved data capturing and sharing. The health center added a quality of life survey and stress questionnaire to the electronic medical record (EMR) workflows to enhance care.

- Expanded support teams: LCHC hired and trained a team of CHWs and fitness coaches to better engage and work with patients. The health center also expanded their services to an off-island obstetrician and pediatrician to provide telehealth services and consultations.

- Health and well-being initiatives
  - Integration of exercise: To increase participation in their exercise programs, LCHC added new classes and implemented the Lāna'i Integrative Functional Training Systems (LIFTS) to tailor programs to patients' functional status.
  - Improved chronic disease management programs: Recognizing the social and behavioral health component of disease management, LCHC brought in a behavioral health postdoctoral fellow to support patients who had a chronic disease. The health center also launched a diabetes prevention program modeled on the PILI 'Ohana Partnership, a nine-month culturally congruent, community-placed health promotion program for Native Hawaiian and Pacific Islanders who are overweight or obese. (PILI 'Ohana is an initiative of the Department of Native Hawaiian Health at the University of Hawai'i at Mānoa John A. Burns School of Medicine.)
  - Strengthened school and employer-based partnerships: LCHC expanded their health education and health promotion programs to Lāna'i High and Elementary School and employers.

Photos courtesy Lāna'i Community Health Center

HMSA Community Grant

Quality Rural Health Through Holistic Touch and Technology

Outcomes

Financial Capital

While measuring financial capital was not a focus of this grant, the integration of obstetric support through telehealth would likely have resulted in a measurable financial outcome.

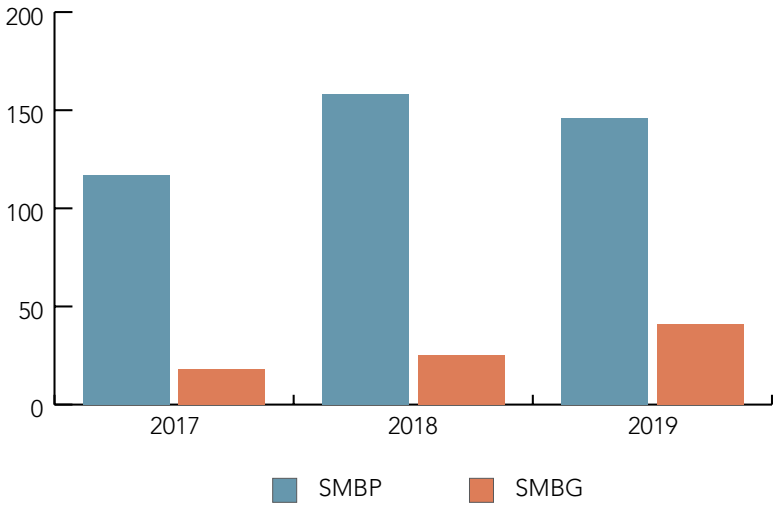
Historically, typical pregnancies involve two ultrasound visits and three to six obstetric visits that require travel to a Neighbor Island. While visits for ultrasound and obstetrics are ideally scheduled together, privately insured patients are often unable to afford the travel. As of September 2019, 21 of the health center's 33 obstetric patients have participated in at least one telehealth visit. Further evaluation is needed to determine the financial capital results, though the health center anticipated savings due to lower travel costs and fewer lost work hours.

Manufactured Capital

The health center's interventions to improve access to care resulted in the creation of many tangible products.

Overall, the health center saw an increase in new patients by 7% between 2017 - 2019 and reported that 72% of patients received more than one service from LCHC, a 2% increase from the baseline. This was attributed to interventions such as the Self-monitoring Blood Pressure (SMBP) program and the Self-monitoring Blood Glucose (SMBG) program. The SMBP program saw a 25% increase in participation, while the SMBG saw a 128% increase in participation over the grant period.

Participation Count



LCHC also defined quality metrics focused on lowering morbidity and mortality through improved medical management. However, the elderly, people with significant disability, and those with chronic mental health problems may be better served by measuring quality of life. Therefore, LCHC integrated the quality of life screener into the EMR. This required a new interface with OPTUM to use the SF12 assessment. Following the grant period, a staff psychologist will train the staff to administer the SF12 quality of life metric. With shared decision-making, the care team designs interventions with the patient to focus on improving quality of life in addition and managing their condition.

Manufactured capital was also achieved through health and well-being initiatives. During the grant period, a prediabetes program was created with support from Anne Leake, A.P.R.N., C.D.E., via telemedicine; four Introduction to Prediabetes classes were held; and a group program modeled on PILI 'Ohana was launched with eight participants.

LCHC also continually expanded their fitness program from year to year in response to their community's interest and allowed community members to volunteer as instructors. As of December 2019, the fitness program offered 31 different classes, including youth gymnastics, volleyball, and wrestling, and logged 352 unique participants and 11,407 total participants. In 2018, there were 19 classes, 351 unique participants, and 9,606 total participants. In addition, LCHC staff provided health and physical education to LHES students in grades K-5 and reproductive health education to seventh and eighth graders.

Additionally, LCHC implemented LIFTS, a modified version of the Functional Movement System™, to tailor the needs of their patients' functional movement. Due to financial capacity challenges, the LIFTS program was put on hold. But classes taught by the wellness coaches and support from CHWs are still being provided to patients to strengthen their functional movement and flexibility. The health center also launched the E Ola Kino Project, a research project that seeks to establish a comprehensive, intensive, school-based weight management program and introduce healthy eating and living habits to students.

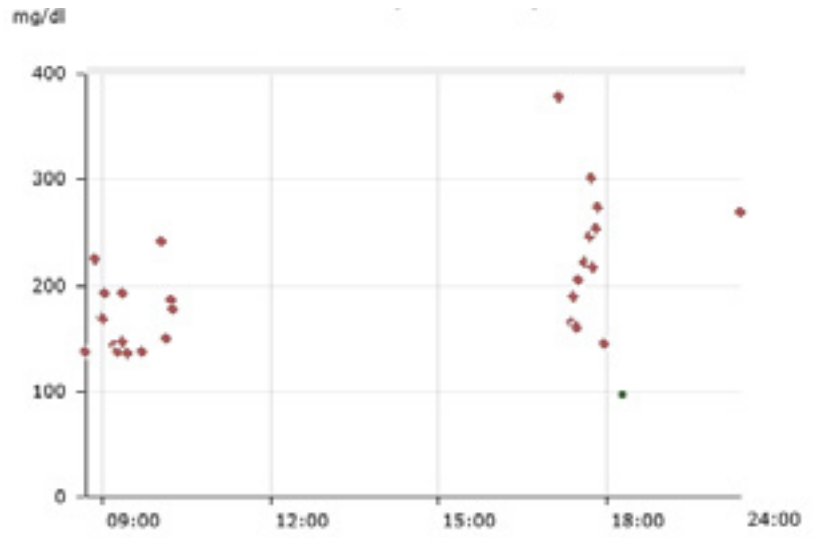
Finally, LCHC hired and trained a team of CHWs, including fitness coaches and a community dental assistant, to better engage and work with patients and the overall Lāna'i community.

Intellectual Capital

One of the goals of the SMBP and SMBG programs was to streamline the process to share data collected in the home with direct upload to the EMR to allow providers to monitor and discuss the values with patients. During the grant period, LCHC learned that the technology vendor for the remote monitoring had an exclusive contract with EPIC, which meant that it wasn't possible to directly integrate data with the LCHC EMR.

LCHC tried workarounds such as requesting a download function to manually update the files, but it was suspected that this wasn't a priority for the vendor given the small size of the health center. Eventually, the health center developed their own solution that involved uploading patient information that the care management staff emailed to them. The images represent the integration of home-based data into the EMR.

Glucose by Time of Day



Aside from their main duties with patient care and health education, two CHWs were also involved in WIC. Twice a month, one CHW provided assistance as a nutrition aide while the other provided translation services to WIC clients who primarily spoke Kosraean.

Human Capital

LCHC supported staff certification to provide the best care to their community. Their three CHWs received tuition assistance to complete their CHW certification program at University of Hawai'i Maui College. At the close of the grant, two were in their third semester while the third was in her first semester. One CHW renewed her certificate in functional movement systems. All LCHC's wellness coaches were certified in the foundations of SilverSneakers® Fitness Program with selected staff certified in Boom Move It (a high-intensity dance class), stability and "splash" classes, fall prevention, and tai chi.

Social Capital

To increase participation in the SMBP and SMBG programs, LCHC helped reduce financial barriers to participation. They partnered with HMSA's Pharmacy Benefits team to arrange with CVS Caremark® for a discount on remote monitoring blood pressure cuffs, which are now $39 per unit. Also, HMSA health plans now cover LifeScan meters and Verio Strips at nearly 100% of the cost.

To expand services to provide telehealth visits and consultations with new specialists, LCHC partnered with Cori Hirai, M.D., of University Health Partners of Hawai'i for obstetric services and Jessun Nam, M.D., M.P.H., for pediatric services.

Behavioral health was identified as a key component to support chronic disease management. To meet the need for behavioral health care services, the health center partnered with I Ola Lāhui to bring a postdoctoral fellow on staff. Jon Cisneros, Psy.D., provided services at LCHC twice a week for a year. As of September 2019, he passed his licensing exam and has joined the LCHC staff as a part-time psychologist. LCHC has continued to partner with I Ola Lāhui and has a new resident, Danny Rodrigues, Psy.D., who will provide services two days a week for the next year.

HMSA Community Grant

Quality Rural Health Through Holistic Touch and Technology

LCHC also strengthened their partnership with LHES to provide wellness activities and health education to students, such as leading physical education classes, providing reproductive health education, and introducing initiatives to promote healthy eating and active living. In addition, LCHC collaborated with the LHES Foundation, the Hawai'i Public Health Institute, and other community-based organizations to provide health and wellness activities for students such as the Teen Expo – Back to School Bash and Walk and Roll Wednesday initiative.

Finally, through partnerships with Four Seasons Resort Lāna'i and Pūlama Lāna'i, the two major employers on the island, LCHC was able to provide many outreach services throughout the year. LCHC staff hosted flu shot clinics, annual health fairs, oral health screening, smoking cessation services, behavioral health care, and nutrition consultations and education.

Photo courtesy Lāna'i Community Health Center

Conclusion

The use of technology, expansion of care teams, integration of exercise programs and chronic disease management programs with clinic workflows, and early interventions at Lāna'i High and Elementary School enabled the health center to improve access to care and the health and well-being of their community. LCHC aims to continue to build on their successes and partnerships to create a more-comprehensive health system for Lāna'i residents.

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Moloka'i

Molokai Community Health Center

"My health is my wealth! Taking care of myself gives me wealth to take care those I love. Mahalo for the 'Ai Pono workshops for new healthy eating ideas, lomi lomi for my mom, and the cultural workshops for my spiritual mind. It's the circle of life!"

– 'Ai Pono participant

"Taking care of myself gives me wealth to take care those I love. "

Photo courtesy Molokai Community Health Center

Molokai Community Health Center at a glance

Mission To provide and promote accessible comprehensive individual and community health care to the people of Moloka'i with respect and aloha.

History In 2002, Molokai Ohana Health Care, doing business as Molokai Community Health Center (MCHC), was created by community volunteers and residents in response to the need for expanded primary health care services. MCHC received funding to establish a centrally located community health center serving residents and visitors islandwide starting in March 2004.

Moloka'i

Service area

MCHC Community Program

MCHC's Lifestyle Health & Wellness department is an integrated unit that provides behavioral health, health coaching, and prevention services and culturally related health care services. Programs range from diabetes prevention and individual and group therapy to practices around la'au lapa'au, 'ai pono, lomi lomi, and ho'oponopono.

Demographic information 2018[1-2]

Total patients served:

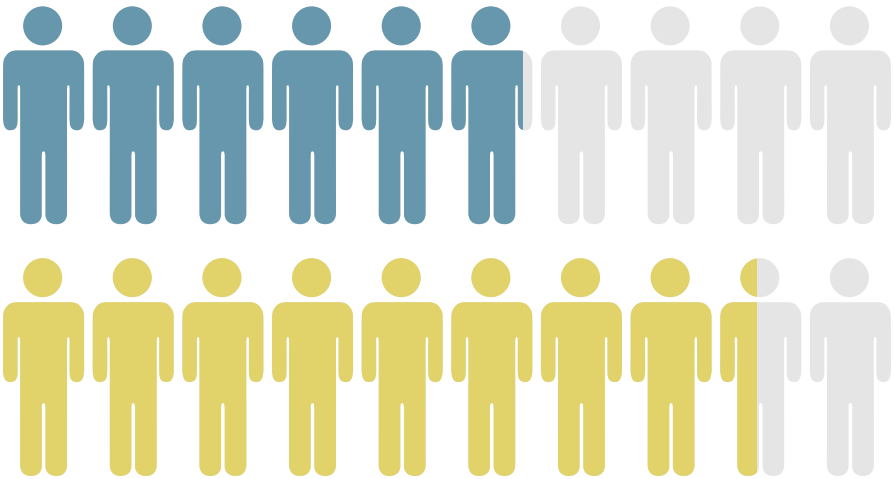
2,321

Best served in another language:

0.0%

Poverty Level

Molokai Community Health Center



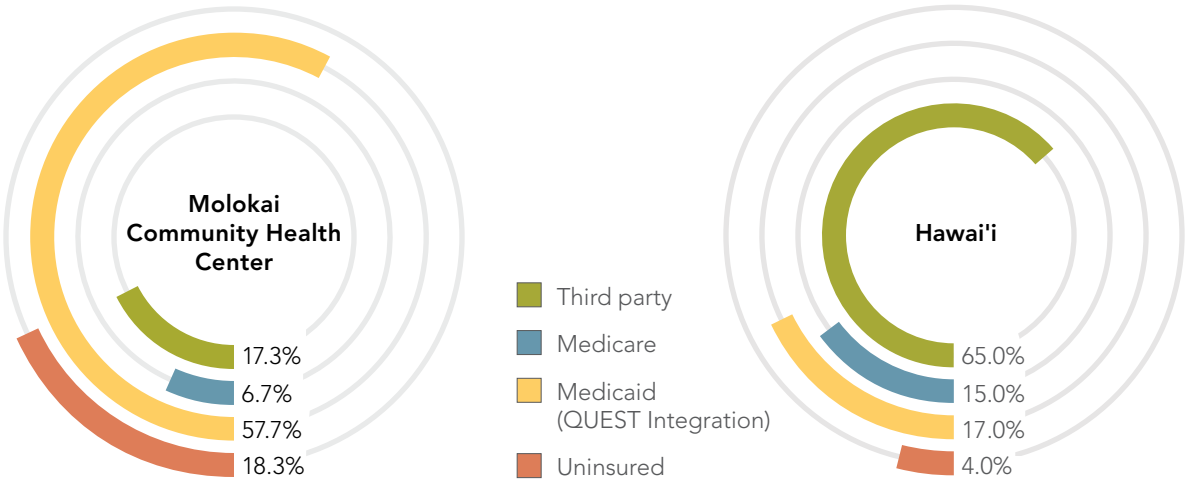
<100% federal poverty level

58.4%

<200% federal poverty level

84.8%

Insurance Type



HMSA Community Grant

Ka Hana Pono

Grant Overview

Executive Grant Summary

Using data collected from their 2016 Community Health Needs Assessment (CHNA), MCHC identified the need for nutrition and health education as well as social and economic development as key community health concerns. Using this and MCHC's connection to 'āina, culture, and relationships, MCHC implemented a two-pronged program. First, MCHC introduced a series of nutrition and health education programs that included story-sharing sessions about ancestral nutrition, a food prescription program, and Native Hawaiian healing practices. Secondly, MCHC implemented programs and services that included connecting students to work development opportunities through career days and 'āina-based health initiatives. Collectively, MCHC invested in programs and services that were important to their community while addressing health and well-being.

Statement of Need

As a community strongly connected to 'āina, culture, and relationships, MCHC recognized the importance of these factors' influence on health and well-being. Using CHNA data, the health center identified two key SDOH that would help them improve the health and well-being of their island: nutrition and health education and social and economic development.

Based on the CHNA, 61.3% identified nutrition and health education as one of the three prioritized health concerns of their community. This was further supported by the volume of MCHC patients with common chronic conditions such as diabetes, hypertension, high cholesterol, and obesity. Residents also noted that unemployment was a significant challenge for the community. Although the unemployment rate declined from 8.7% to 6.7% in the last three years, the rate is still the highest in the state. As SDOH became evident in communities, health centers have taken on a greater role in supporting their patients from a holistic perspective.

Intervention

To address SDOH and work toward an integrated model of care while emphasizing connection to cultural values, practices, and community customs, MCHC incorporated their programs of food, nutrition, the environment, and social support groups with clinical care services such as traditional medicine, counseling, and motivation services. MCHC also partnered with community stakeholders to build more connections.

As a result, integrated services and programs focused on nutrition and health education and social and economic development were created. They included:

- Facilitating food story-sharing sessions, called 'Ai Pono, with ketogenic and low-carb cooking demonstrations. Sessions shared how the prepared dishes impact emotional, spiritual, cultural, and physical health.
- Implementing 'āina Rx, a multistep food prescription program to help patients manage or mitigate chronic diseases or conditions such as diabetes, hypertension, obesity, cardiovascular disease, and asthma.
- Offering classes on la'au lapa'au.
- Partnering with lomi lomi therapists and an acupuncturist to care for patients with prediabetes, hypertension, and high cholesterol.
- Connecting students to workforce development and health education opportunities through career days, mock job interviews, and 'āina-based health initiatives at schools.

MCHC also used grant funds for the COVID-19 pandemic response.

Photos courtesy Moloka'i Community Health Center

HMSA Community Grant

Ka Hana Pono

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

Nutrition and Health Education

	No.
'Ai Pono participants	125
'Ai Pono sessions	14
Ketogenic/low-carb eating session participants	185
'Āina Rx patients served	15
Cultural practitioners engaged	4 lomi lomi therapists 3 la'au lapa'au practitioners 1 acupuncturist 10 alternative care and Native Hawaiian traditional healing practitioners
Lomi lomi and acupuncture patients	43

Social and Economic Development

	No.
Health fairs hosted	7
Health fair participants	Average 162
Community events	28
School-based community council meetings attended	10
Workforce development activities	4
Workforce development students served	210
Kilo Hā – Youth Planter Box Program students served	45

MCHC hired a community coordinator and a cultural coordinator to partner, lead, and create programs and services to address SDOH identified in the CHNA and to collaborate with the community to look for opportunities to integrate care and promote health and wellness.

Intellectual Capital

In the beginning and throughout the grant period, recruitment, retention of qualified health care practitioners, and capacity were challenges for MCHC. It was difficult to find individuals who were qualified to work with the community. When preparing to provide lomi lomi services, for example, interested practitioners were young women who were licensed in massage therapy. Most either held other full-time jobs or traveled off the island to work. This limited the time they'd be available to provide care.

The availability of cultural practitioners continues to remain limited and practitioners who are currently participating preferred an educational format to share their knowledge. In response, MCHC began to offer cultural workshops, Halawai Ho'onui'ike, where practitioners could share their practices. The workshops freed patients and the community from signing up for a structured program or service but allowed them to participate with others in a fun and engaging space.

Aiming toward an integrated model of care with community-based programs and services, nutrition programs such as 'āina Rx, a food prescription program, included access to food packages with healthy, local produce and grass-fed beef from Sustainable Molokai and Molokai Meatery & Goods. Participants attended food demos through the 'Ai Pono program to help them make the best use of their food packages when they cooked at home.

MCHC did not have a full-time registered dietitian and had to outsource nutrition education, which increased collaboration with other community organizations. Lessons learned from this program included a need for a more defined and controlled nutrition plan through more thorough and frequent check-ins with the dietitian, having a stronger on-campus nutrition education component, and having a care management tool to improve communication among the participant's care team.

As MCHC began their provider insurance credentialing in massage therapy and acupuncture, the health center learned that health insurance companies began offering alternative healing options to their members. As these services become billable, MCHC was able to further integrate their cultural and alternative healing services and practices with clinical care.

MCHC also had the opportunity to learn from Waianae Coast Comprehensive Health Center's traditional healer and licensed massage therapist and discussed potential models of care and strategies to connect with local practitioners and integrate their work with the health center.

HMSA Community Grant

Ka Hana Pono

To conduct their CHNA in 2019, MCHC gathered updated information and feedback from patients and the community, including demographics, health-related data, and feedback on how the health center can better support and care for the community. Results are being aggregated and analyzed.

The COVID-19 pandemic also provided challenges for MCHC. However, the health center adapted their programs and created plans to continue providing key services. For example, 'Ai Pono and lomi lomi and la'au lapa'au sharing sessions were moved to a virtual HIPAA-compliant platform in April 2020.

Human Capital

The health center partnered with Na Pu'uwai, Sustainable Molokai, and Milestones to develop 'Ai Pono. The program provided monthly and bimonthly sessions on clinical and nutritional education and support through food story sharing around ketogenic food choices that corresponded with the Native Hawaiian diet. 'Ai Pono participants continued to learn about nutrition and culture as it relates to food.

In addition, 15 patients from MCHC's diabetes management cohort enrolled in the 'Āina Rx program. They participated in food demos and learned how to cook healthy dishes using their food package while learning more about nutrition.

The health center met with Alu Like's Kupuna Program for 16 group sessions with 10 - 20 kupuna to learn and preserve lessons, life experiences, and knowledge. MCHC also met with Na Pu'uwai's Kupuna Council to discuss ways to learn more about various Native Hawaiian healing practices.

Two partnerships were established with community organizations to help implement Na Hopena A'o, a learning framework in collaboration with the Hawai'i Department of Education. This framework incorporates social-emotional learning through a sustainability component that observes the Native Hawaiian moon calendar.

Forty-five students at Ho'omana Hou High School and Liliuokalani Trust's Pili Mai youth program participated in the Kilo Hā – Youth Planter Box Program and learned how to plant crops with intention, support aloha 'āina advocacy, and explore entrepreneurial opportunities in growing food. There were themes for each semester such as community advocacy around sustainable farming practices and supporting local farmers. Students in the program constructed five planter boxes for a community food garden. The program also hosted a ho'ike with 60 community members in attendance.

Photo courtesy Molokai Community Health Center

Social Capital

MCHC's community integration and partnerships were a highlight of the program. The health center established and strengthened partnerships with 29 agencies and organizations including Seed of Love, Educational Opportunity Center, Educational Talent Search, Institute of Native Pacific Education and Culture, Molokai Child Abuse Prevention Pathways, Molokai Youth Center, Molokai Livestock & Cooperative, Molokai Arts Center, Ainacology, Papa Hana Kualoa, Punana Leo O Molokai, Sungentics LLC, Ka Hua Waiwai, and Chef Coach Hawaii.

The health center collaborated with Kaunakakai Elementary School, Maunaloa Elementary School, Kilohana Elementary School, Ho'omana Hou High School, and Kualapu'u Public Conversion Charter School. School activities included Future Fest, where students could learn about various fields in health and work opportunities; high school seniors could participate in mock job interviews.

MCHC partnered with the Dental Hygiene School at the University of Hawai'i (UH) Maui College to enact the In-Classroom Toothbrushing program that included oral exams by a dental hygienist and fluoride applications for about 215 students at the various schools MCHC partnered with. MCHC also created an annual community educational initiative and joined forces with Molokai Education through UH – Maui College and UH – John A. Burns School of Medicine to host a Teen Health Camp, which allowed students to practice skills such as suturing, infectious disease control, and lomi lomi with 45 students attending in 2018 and 60 in 2019.

HMSA Community Grant

Ka Hana Pono

Conclusion

As a community strongly connected to 'āina, culture, and relationships, MCHC recognizes the importance of these factors' influence on health and well-being. MCHC continues to move forward in embracing the work to improve health by addressing SDOH that are significant to the community. Using an integrated approach that includes partnering with local organizations, MCHC continues to work toward their vision and belief that a person's health is intrinsically connected to community and can be restored with a reconnection to ancestral knowledge, cultural practices, and community.

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O'ahu

Kalihi-Palama Health Center

"A patient with a history of post-methamphetamine-dependence hospital follow-up established care at Kalihi-Palama Health Center. The patient had behavioral health issues and a couple chronic health conditions and was connected to a care coordinator at the health center. The care coordinator referred the patient for dental and oral health care and partnered with the Queen's Care Coalition and an HMSA service coordinator to arrange for wound care and transportation services. The patient also received a mobile phone so that the care coordinator could keep in touch with them. Currently, the patient is staying at a sober living house, attends treatment, and is now compliant with their primary care provider and specialist appointments."

- Kalihi-Palama Health Center care coordinator

"Currently, the patient is staying at a sober living house, attends treatment, and is now compliant with their primary care provider and specialist appointments."

Photo courtesy Kalihi-Palama Health Center

Kalihi-Palama Health Center at a glance

Mission

To provide quality integrated health and social services to our community and all others in need of health care. Our focus is preventive primary health care provided in a respectful, caring, and culturally appropriate manner.

History

Kalihi-Palama Health Center (KPHC) grew out of a free walk-in clinic in the basement of Kaumakapili Church in 1975. As many new immigrants settled in the Kalihi and Chinatown areas of Honolulu, Rev. Richard Wong, Auntie Anne Kanahele, Uncle Henry A'arona, and other community leaders at the church recognized the need to provide primary care services. This would later include providing access to social services for food and housing and the ability to participate in community life.

In 1999, KPHC was recognized as a community health center and expanded their services to include behavioral health care and other services to address poverty and social isolation.

KPHC Community Program

Since 1988, the Health Care for the Homeless Project (HCHP) has provided accessible, quality services for individuals and families who are homeless or at risk for homelessness. Using a team-oriented, client-driven, and nonjudgmental approach, HCHP addresses the individuals' immediate needs and works to reintegrate them into the community. Services include the Ka'a'ahi Street Clinic, OHANA (Oahu Health Access and Network Association) Project, homeless outreach, case management, Shelter Plus Care, and the Homeless Prevention and Rapid Re-Housing Program.

Demographic information 2018[1-2]

Total patients served:

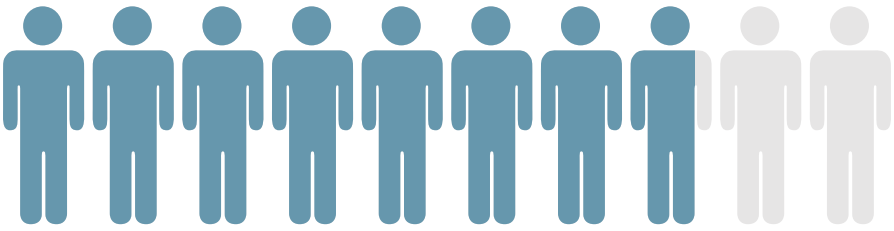
22,233

Best served in another language:

32.4%

Poverty Level

Kalihi-Palama Health Center



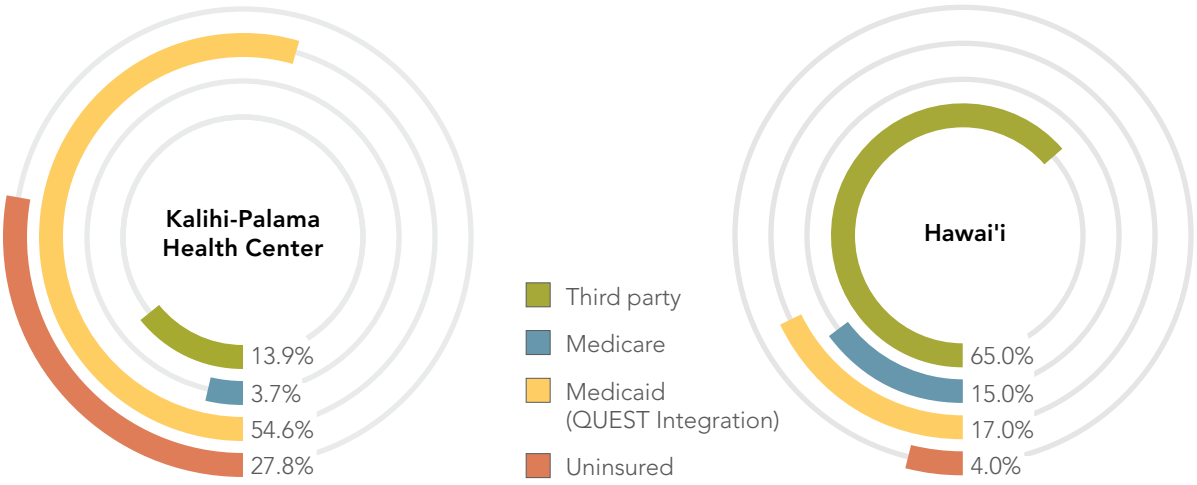
<100%
federal poverty level

77.9%

<200%
federal poverty level

87.4%

Insurance Type



HMSA Community Grant

Care Integration Program

Grant Overview

Executive Grant Summary

To engage HMSA QUEST Integration (QI) members, this grant expanded KPHC's Care Integration Program to this cohort. The program identifies a high risk and complex case cohort and aims to improve engagement with primary care. Faced with challenges using HMSA data to identify this cohort, KPHC partnered with Queen's Care Coalition (QCC) and HMSA's QI service coordination team to identify and engage with a similar cohort. This intervention allowed KPHC to continue to strengthen their work to address hospital overutilization while looking at opportunities and connections for their patients to access primary care.

Statement of Need

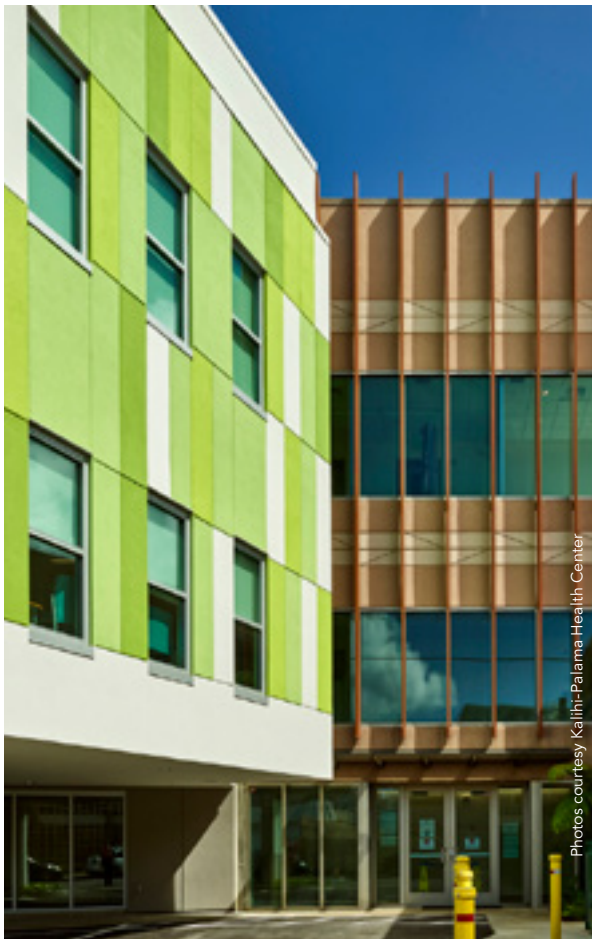
QI members who often delay or do not access primary care services at health centers such as KPHC often end up at the emergency room (ER) or in inpatient care. These individuals often experience unnecessary suffering, relatively poor clinical outcomes, more dissatisfaction with their providers, and significantly higher total costs of care.

Intervention

KPHC's Care Integration Program targeted HMSA QI members who were either newly assigned to the health center or were high-risk and/or complex patients who recently had an ER or inpatient visit to engage with the health center. The objective was to contact the patient to schedule an appointment for an evaluation and assessment of their health and social service needs within seven days.

Following the assessment, the patient and a member of the health center's care team, most commonly the care coordinator, worked with the patient to address their needs in a respectful and culturally appropriate manner. This included identifying other parties in the community who were involved in the patient's care, using motivational interviewing to engage the patient, and engaging with other teams in KPHC such as the Health Care for the Homeless Project staff to give patients access to social services. If KPHC was unable to contact the patient after three attempts, KPHC referred the patient to HMSA to determine alternative actions.

The program intended to use HMSA data to identify HMSA QI patients who met that criteria but faced challenges in obtaining the necessary data. KPHC leveraged their partnership with the QCC to identify patients who were often high utilizers of The Queen's Medical Center and who needed primary care services. HMSA and KPHC care teams also set up monthly meetings to discuss those patients and address any gaps in care.



Photos courtesy Kalihi-Palama Health Center

HMSA Community Grant

Care Integration Program

Outcomes

Financial Capital

There was no financial capital reported from this grant. However, there may be financial capital benefits if the partnership continues to grow and a study is conducted.

Manufactured Capital

Monthly meetings were established with the QCC and HMSA that included service coordination and Beacon Health Options® programs. During the meetings, the team reviewed cases and discussed the most effective ways to address the patients' needs.

To support newly assigned patients, patients with complex conditions, and high-risk patients, KPHC implemented activities and achieved the following results.

Manage Same-day Access to Care

	Target	Actual
Percentage of KPHC clinic visits that were same-day appointments	40%	74%
Percentage of HMSA members who requested and received a same- day appointment	n/a	90%

Manage Inpatient Care Transition

	Target	Actual
Percentage of patients discharged from inpatient care who were seen by a primary care provider/KPHC care team within seven calendar days of discharge	20%	40%
Percentage of HMSA members discharged from an inpatient stay who completed a follow-up visit within seven days	n/a	36.1%

Beacon Health Options® is an independent company providing behavioral health utilization management and quality improvement services on behalf of HMSA.

Photo courtesy Kalihi-Palama Health Center

Manage ER Visit Care Transitions

	Target	Actual
Percentage of patients discharged from ER visits who were seen by a primary care provider or KPHC care team within seven days of discharge	25%	57%
Percentage of HMSA members discharged from an inpatient stay and completed a follow-up visit within seven days	n/a	39.5%

Overall, this had the following impact on KPHC's quality metrics:

	2018	2019
Childhood immunizations	57.1%	60.3%
Cervical cancer screening	66.5%	67.5%
Diabetes >9% or no text	36.7%	34.3%
Hypertension controlled	64.0%	64.6%

KPHC hired additional staff to help provide and coordinate care for individuals who were identified as high risk and complex. New staff included additional care coordinators, community health workers, and a population management manager.

HMSA Community Grant

Care Integration Program

Photo courtesy Kalihi-Palama Health Center

Intellectual Capital

The partnership with the QCC allowed new processes to be tested to ensure care for patients before discharge. One pilot process provided a mobile phone loaded with 30-day access to patients who didn't have a reliable way for KPHC to contact them. The care navigators at the QCC helped patients activate the phone and made sure that patients knew how to contact KPHC and that KPHC knew how to contact the patients. At the patients' first visit to KPHC post discharge, KPHC extended the mobile phone plan for another 30 days. Patients could get up to 90 days of mobile phone access in monthly increments.

In response to creating a master list of members who were deemed high risk and complex and were receiving service coordination, workflows were established as a foundation to highlight the various ways KPHC care coordinators could contact HMSA service coordinators about issues such as travel requests and confirmations, confirmation of service coordination, and foster home placements. Later, phone numbers were exchanged once a patient was engaged with service coordination.

Human Capital

In-service presentations about HMSA's service coordination, Beacon Health Options, dual special needs plans, HMSA's hospital transitions team, and the HMSA Pregnancy and Postpartum Support Program were conducted to provide KPHC's care coordination and behavioral health care teams with information on HMSA's various resources for members.

The monthly case conferencing sync-ups provided opportunities for KPHC care coordinators and HMSA service coordinators to learn more about patients' health and social needs, other providers and organizations the member may have interacted with, and to see if other organizations can be contacted to assist. Having face-to-face meetings allowed KPHC and HMSA coordinators to establish a relationship that allowed them to contact each other freely.

Engagement efforts with KPHC patients resulted in their increased understanding about their health:

- 89% of patients demonstrated they knew how to check their blood sugar, log results, report the results to their care team, self-administer insulin, increase their physical activity, take medications as prescribed, and choose healthier diets with proper proportions.
- 92% of patients with diabetes were able to articulate potential complications and verbalize what to do in response.

Similarly, there was an overwhelming number of HMSA members who were motivated to participate in their own care and have a better understanding of their PCP's role and appropriate use of the ER. Also, roughly the same percentage of patients — 89% — recognized the importance of their providers' instructions, have shown improvement in managing their medications, and are involved in their own health care and wellness plans. This is also shown in the reduction in KPHC's no-show rate from 33% to 20% from 2017 to 2019.

Social Capital

KPHC established monthly meetings with the QCC to discuss patients who use the ER at The Queen's Medical Center most frequently in the past 90 days. QCC tracked patients who were able to transition their care to KPHC and notified KPHC about patients they needed to be aware of. KPHC care coordinators also had access to QCC's electronic health records to promptly get access to relevant clinical information and provide it to the clinical team to streamline transitions in care post discharge. These meetings helped the KPHC care coordinators establish close relationships with the QCC patient navigators who keep in contact with patients.

The case conferencing sync-ups with HMSA's health management teams allowed KPHC care coordination to strengthen their relationship with various direct service programs, primarily HMSA's service coordination and Beacon Health Options.

HMSA Community Grant

Care Integration Program

Conclusion

Overutilization and unnecessary use of our hospitals can have significant effects on the health care system. KPHC recognizes the important role they play in providing comprehensive primary and behavioral health services to their patients once they're discharged from the hospital to prevent recurring visits. Their partnership with the QCC and monthly meetings with HMSA's health management teams allowed greater communication and planning to help prevent patients from going back to the hospital and to improve health care engagement. KPHC is committed to continuing and expanding these partnerships to best care for their patients and community.

Photo courtesy Kalihi-Palama Health Center

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Kōkua Kalihi Valley

"Grace, one of our youth workers at the Kalihi Valley Instructional Bike Exchange (KVIBE), had befriended the Samoan/Chuukese family of one of the kids. The family was facing multiple challenges: a disabled father, lack of insurance, and food insecurity. Grace had begun visiting the family and buying them food with her own money. She was overwhelmed. Her supervisor encouraged her to pull back and instead of unilaterally attempting to meet the family's needs, pull in other staff to assist. However, the family was reluctant to go to Kōkua Kalihi Valley or meet with anyone except Grace.

"Anthony began helping the family understand the resources that were available to meet their needs."

"Through Pathways to Resilient Communities, Grace met Anthony, a Kōkua Kalihi Valley Chuukese eligibility worker. Grace approached Anthony, who agreed to go with her to visit the family. The dad agreed to talk with Anthony, but only at the front door. They spoke in Chuukese about life back home and their respective families and backgrounds. In time, on his own accord, the dad began sharing

Russell Park

about his condition. He was unable to work or even leave the house; without insurance, he was unable to see medical specialists. He was unaware of the process for establishing disability status, which would have made him eligible for health insurance from Med-QUEST (QUEST Integration).

"Anthony began helping the family understand the resources that were available to meet their needs. The dad later expressed surprise that Anthony 'wasn't an American and spoke Chuukese.' The mom subsequently decided to help other families on their block who had similar challenges. After Grace's and Anthony's visit with the family, Grace visited project staff to say how excited she was with the outcome and shared what she had learned through Anthony and the Pathways network."

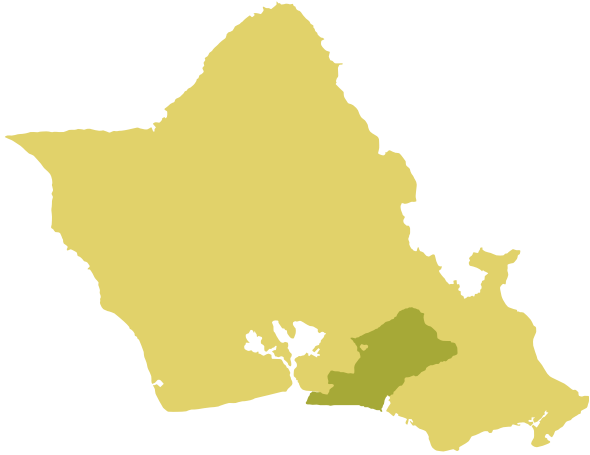
- Pathways Program facilitator

Kōkua Kalihi Valley at a glance

Mission Work toward healing, reconciliation, and the alleviation of suffering in Kalihi Valley through strong relationships that honor culture and foster health and harmony.

History Kōkua Kalihi Valley Comprehensive Family Services or Kōkua Kalihi Valley (KKV) was founded by community leaders in 1972 in response to a lack of health services for Kalihi's low-income, largely immigrant Asian and Pacific Island residents. Understanding health as well-being in the broadest sense, KKV pioneers holistic approaches to addressing the needs and aspiration of its economically marginalized yet culturally rich community.

The health center's 200 employees care for over 10,000 residents each year out of nine locations across the neighborhood, including a main health clinic, wellness center with a commercial kitchen/café, service sites in the largest public housing community in Hawai'i, an elder center, a municipal park, and a 100-acre nature and cultural preserve.



O'ahu

Service area

KKV Community Program

Roots Café & Market is one of more than a dozen KKV programs that provides access to care to the neighborhood's low-income, immigrant population. The café is a gathering place for the community to enjoy fresh, healthy food.

The program sells affordable plate lunches made with Hawai'i-grown produce, locally caught fish, and house-made sauces. The café operates their Farmacy, a mini-market full of fresh fruits, vegetables, and cultural products for the community to purchase. The café also supports many aspects of overall health and well-being, including education, economic stability, cultural connections, and more by hosting special events such as community food discussions, classes, and film nights.

Demographic information 2018[1-2]

Total patients served:

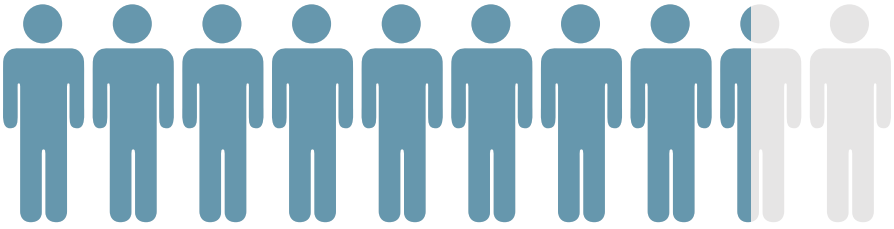
10,900

Best served in another language:

46.0%

Poverty Level

Kōkua Kalihi Valley



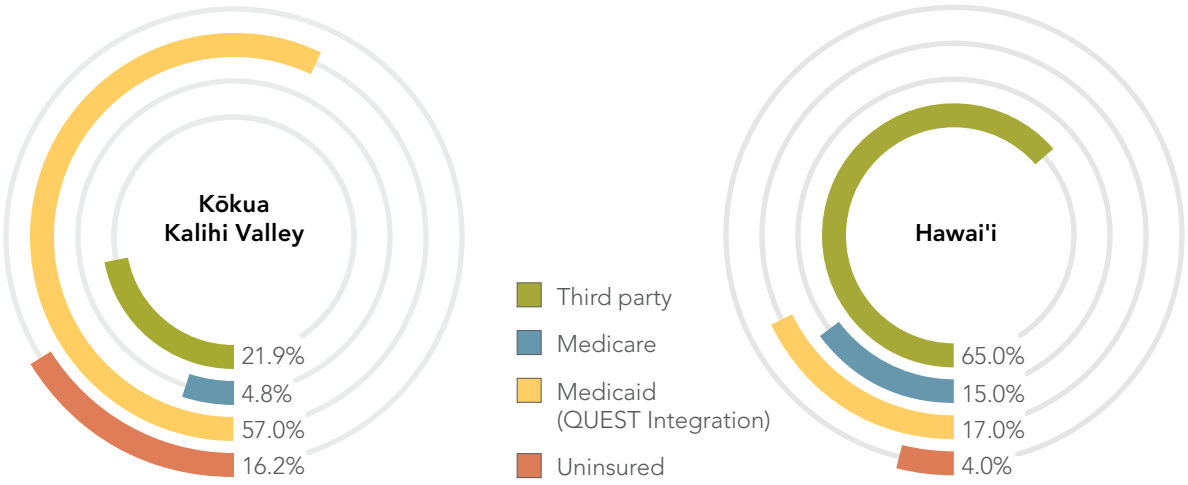
<100% federal poverty level

84.1%

<200% federal poverty level

96.0%

Insurance Type



HMSA Community Grant

Pilinahā Framework

Grant Overview

Executive Grant Summary

Health care providers typically prioritize downstream clinical interventions after patients have developed debilitating and expensive health conditions often exacerbated by drivers such as social determinants of health (SDOH). KKV's intervention aimed to establish opportunities for connection and healing in their patient population and community with the ultimate goal of restoring health as the community defines it.

To achieve this goal, KKV developed and applied a framework across the organization to improve internal referrals, links, and coordination of care while increasing the capacity of their SDOH programs. Outcomes included development and rollout of the framework, an organizationwide training, incorporation of the framework into human resources (HR) policies, and an increased number of patients in SDOH programs.

Statement of Need

SDOH is the primary driver of health outcomes for individuals in communities across the state. The social system opportunities we refer to as SDOH include access to education and economic opportunities, access to healthy food, neighborhood safety, access to exercise and movement opportunities, community cohesion, and cultural resilience. For Kalihi's populations, these determinants include historical trauma and alienation from land and tradition.

In response to this need and with support from Islander Institute, KKV and community stakeholders held a series of formal conversations to hear community perspectives on personal and collective health. Together, they created an indigenous Asian/Pacific Islander framework for health called the Four Connections, or Pilinahā, Framework. This framework explores the vital connections that support personal, familial, and community health.

The four components of the Pilinahā Framework are:

- Connection to place: To have a kinship with the land that feeds us.
- Connection to others: To love and be loved, to understand and be understood.
- Connection to past and present: To have responsibility, stewardship, and a purpose in the world.
- Connection to your better self: To find and know yourself.

KKV discovered that when patients talked about good health, they typically referred to feeling connected in one or more of the four ways. When sharing stories of bad health, they frequently spoke of momentary or chronic loss of one or more of those connections.

The purpose of this grant was to help re-establish these healing connections among KKV's patients and community to restore health.

Intervention

To foster health, resilience, and abundance among QUEST Integration (QI) patients and aligned with the Pilinahā Framework, KKV implemented the following interventions:

1. Increased QI patient access to KKV's SDOH programs through effective cross-referral, links, and service coordination among SDOH and clinical programs.

Photo courtesy Kōkua Kalihi Valley

- **Pathways Program**: In recognition of the need to integrate the Pilinahā Framework across the health paradigms of the community and of the health industry, KKV launched the Pathways Program. The program created cohorts of 15 to 25 KKV employees from across departments and took them through a six-part program that focused on breaking down department silos, creating connections using the Pilinahā Framework, and facilitating bidirectional referrals and coordination protocols. The following is a summary of each component:

Part 1: Welcome	Get to know each other in a fun and meaningful way.
Part 2: Speed Dating	Learn about KKV's programs, departments, and healing opportunities during a "speed dating" session with colleagues.
Part 3: Pilinahā	An orientation to the Pilinahā Framework through a series of layered story-sharing activities, beginning with an Aloha Circle that introduces participants through their name, home, and ancestors. Their stories of connection to self, others, place, and time allows them to explore the framework through different learning styles and look at the many ways that connections impact and inform our understanding of personal and community health. While the technology is intentionally kept simple, the impact is complex as the staff builds deep and meaningful connections and trust with one another, to their best selves, to their work, and to the community.
Part 4: Trauma and Resiliency Informed Care	The evidence of both trauma and resilience is pervasive in the communities that KKV serves and among their patients and staff. Participants learn about current research on trauma, the immediate and long-term physiological impact of individual and collective trauma, resources and approaches to identify and address trauma among those around us, and effective strategies for self-care and healing.
Part 5: Wai Wai Immersion	Similar to a practicum, this immersion allowed participants to witness the gifts of fellow staff and experience firsthand the healing opportunities of other programs. Each participant spent 12 hours in volunteer rotations in KKV programs or departments other than their own.
Part 6: Reflection and Reunions	Participants shared their experiences and ideas for the future of KKV.

Photo courtesy Kōkua Kalihi Valley

- **Modify HR policies:** Developed a comprehensive approach to integrate the Pilinahā Framework into KKV's HR policies including:
  - › Created core competencies and standards that align to the framework for each staff category such as frontline staff, coordinators, management, clinical, etc.
  - › Redefined staff recruitment strategies that effectively screen for Pilinahā alignment.
  - › Initiated training on the framework for all staff and new staff at orientation.

2. Increased the capacity of SDOH and clinical programs to foster transformative opportunities and space for QI patients to engage in the Pilinahā Framework.
   - KKV has many years of experience and demonstrated success of their diverse SDOH programs including their elder care program, Ho'oulu 'Āina Nature and Cultural Preserve, Roots Café, The Medical Legal Partnership; youth services including after school programs, tennis, and the Kalihi Valley Instructional Bike Exchange (KVIBE); a family literacy program; a pregnancy program; employment readiness programs; and a civic engagement program. To increase capacity, KKV provided funds to support these programs using an algorithm that aligns funding levels to each programs' needs and outcomes.
3. Implemented an indigenous evaluation methodology, Uluhōkū, across the organization. Uluhōkū uses a variety of qualitative and quantitative data sets to develop a composite picture of health among complex and multifactored interventions.

HMSA Community Grant

Pilinahā Framework

Photo courtesy Kōkua Kalihi Valley

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

To increase connection across KKV's clinical and SDOH programs, KKV successfully launched the Pathways Program that brought together staff across the health paradigms to achieve the following:

	No.
Participants	118 (52% of total staff)
Cohorts	8 (average size: 15)
Participants by department	
Medical/Clinical	67 (51%)
Administration	8 (32%)
SDOH	43 (63%)

Over the course of eight cohorts, participants created two tools that supported the goal of increasing connections among the departments. The first was a Healing Pathways calendar that included activities such as Ho'oulu 'Āina workdays, Roots Ehu'ola Dinners, and indigenous birthing classes as a resource for staff and their patients. The second was a referral protocol and cheat sheet of services for each program.

Additionally, KKV modified their HR policies to align with the Pilinahā Framework, which resulted in the following outcomes:

- Used the framework and concepts to organize annual staff retreats and trainings.
- Aggregated videos and readings online or in shared folders as a tool to orient new staff, students, and volunteers to KKV and Kalihi culture and values.
- Redesigned staff satisfaction surveys to assess strength of staff connection to KKV, their co-workers, their best self, and their kuleana. Results have helped staff identify strategies for more-tailored approaches to implementing the Pilinahā Framework.
- Recruited and mentored two project staff members under the Pathways Program who have now assumed lead management positions including the director of Maternal and Child Health and HR manager. These staff members now play a key role in infusing the culture of Pathways into the organizational fabric of KKV.
- Piloted a new approach to hiring that builds on existing community relations of more than a thousand students who cycle through KKV annually including volunteers, AmeriCorps VISTAs, and former staff, students, and supports. The pilot recruits cohorts of 10 individuals who participate in a program similar to Pathways. They're assigned as assistants to various programs and collectively tasked with a common project or initiative that benefits the community. Select individuals are invited to continue in future cohorts or apply for positions in the organization depending on KKV's firsthand understanding of their gifts, fit, and aspirations. KKV is currently recruiting its third cohort.

KKV also successfully increased capacity of their SDOH program, surpassing their target of 3,520 QI patients to serve 4,157 QI patients in 2019. The following table shows the unduplicated participation by program.

Programs 2019

	Individuals Served	QI Patients Served
Land and Cultural Stewardship	8,934	1,515+
Community Food Systems Development	2,466	764
All Youth Services	329	206
Legal Services	469	98
Early Childhood Education and Parenting Support	1,094	612
Elderly Services	1,430	962
Total	14,722	4,157

Finally, to implement KKV's Uluhōkū indigenous evaluation methodology across the organization, a project team was formed to develop metrics for the Pilinahā Framework. This group also created tools to capture data aligned to those metrics including provider "burnout" surveys, employee satisfaction surveys, program surveys, and Pathways Program pre- and post-evaluations.

Ho'oulu 'Āina and Roots Café also collaborated on a database to track program participation in ways that facilitated clustering and links to the clinical electronic health record. Each data element required careful assessment for its personal and social impact on program participants and for noninvasive collection strategies. At the end of the grant period, KKV completed the training of the methodology of 10 clinical and SDOH programs, four of which completed an Uluhōkū evaluation.

Intellectual Capital

The Pathways Program was designed, modified, and owned by the participants of the program. Originally, KKV discussed hiring a case manager or in-reach coordinators who would serve as point people to facilitate links among SDOH and clinical programs. However, KKV decided that the institutionalization of the Pilinahā Framework would be better served by intensively grooming and mentoring at least one individual in each program in the protocols and procedures of bidirectional referrals among all programs. The individual could then groom and mentor other staff in their program to grow the competency.

There were many lessons learned in implementing the Pathways Program over the two-year grant period, including:

- Secure full buy-in from executive management who understands, believes, and regularly communicates support for the approach.
- Engage front-line staff as leaders and curriculum developers. KKV recruited front-line staff who were connectors and leaders in their departments for the first Pathways cohort. The staff was empowered to develop objectives, test and refine curriculum, and design their approach. The first cohort spent nearly 70 hours piloting and refining the Pathways curriculum, which was reduced to 32 hours for subsequent cohorts. These leaders shared their experience with their programs, which played a significant role in garnering interest in subsequent cohorts. In retrospect, the initiative would likely have failed if front-line staff had not been given space to design, lead, and advise, especially since a larger proportion of KKV's front-line staff are from the communities KKV serves and hold the mana and kuleana of Kalihi.
- When starting, expect to invest significant time in the participants of the first cohort. Meet one on one regularly to foster engagement, interest, and feedback. Cultivate buy-in and identify good candidates in each area of the organization.
- Expect resistance or at least confusion. A relatively small number of people fully understood and supported the approach before experiencing it. This is consistent with KKV's understanding of staff learning styles and the tendency of programs to focus more narrowly on their programmatic outcomes. The health center often heard stories of staff expressing how bewildered they were about "what this Pathways is about;" later, many of these individuals became strong advocates for the Pathways approach. Clinicians were among the most challenging to recruit into Pathways because of the cost and productivity demands of clinical work. Yet KKV's participating clinicians are now among KKV's most ardent believers in the approach.
- Organizational protocols and practices, plus sharing of food, helped generate an environment more conducive to empathy, listening, and bridging. Project staff prioritized "hosting" cohorts through welcoming and closing protocols (e.g., Aloha Circles and Mahalo Circles) and provided good food that helped participants feel cared for.

- Expect a clinical and community/indigenous divide, but work to find opportunities to collaborate and find connection. For example, the Trauma Informed Care Module was jointly developed by the clinical staff who provided perspectives of clinical science and community staff who addressed cultural and historical trauma.
- Operationally, scheduling was a challenge particularly for the clinical staff. KKV learned to be flexible, schedule many months in advance, and offer makeup classes for those who may have missed key modules. When clinical staffing was at a low point, project staff delayed the next Pathways cohort by two months rather than proceed without clinical participation.

Human Capital

Implementation of the Pilinahā Framework via the Pathways Program, integration in HR policies, and expansion of SDOH programs enabled KKV to achieve the following employee satisfaction survey results modeled on the same framework.

Pilinahā Framework - Employee Satisfaction Survey

In the past year, I felt connected ...	Greatly Disagree	Disagree	Agree	Greatly Agree
To KKV	0	1	52	61
To co-workers	1	5	51	57
To my best self	2	4	52	56
To my culture	0	6	60	47
To my kuleana	0	6	54	54

The following testimonials from KKV staff illustrate the impact of the Pathways Program.

"Pathways was probably the highlight of my experience at KKV last year before my temporary departure (and definitely laid the foundation for my return). It created a sense of community in the organization for me. I wasn't just a medical provider clocking in and clocking out. I was part of a greater whole, an actual family, with a mission and goals for the community at large, which helped to direct the care I provided to my patients.

"When I spoke to Laura about coming back to KKV this year, it felt like a homecoming, not changing from one job to another. But KKV probably would have felt like any other employer had it not been for Pathways instilling that sense of family and community in me and I probably wouldn't view KKV in such a loving lens. And it probably wouldn't have been the first place I thought of when I decided to move back to Oahu. My time on Kauai felt like a sabbatical of sorts and helped me to realize that money isn't everything and shouldn't determine where you work.

"When I returned to KKV, it felt like I hadn't even left and I think a part of that was due to the relationships I developed with both individuals and the organization as a whole during my time in Pathways. I took a $24,000 pay cut returning to KKV, but it was totally worth it and I would do it all over again because I was coming home to my family, which is something I probably wouldn't feel if it hadn't been for Pathways."

-KKV staff member

"Healing comes from within us before we can heal our patients. Like with Phil and his program. It's healing me because I know he's there and I feel more confident to refer. Connection has been healing to me. I feel the energy to absorb more resources and information for patients and community. KKV is like when you hear something good, you want to tell everyone. I'm telling all my relatives to move to 96819. I thank everyone who's in the class; you are a part of me."

-KKV staff member

Social Capital

KKV elevates the voice and agency of front-line staff who are often more representative of the community than executive, management, and clinical staff. KKV places a high priority on hiring from the community and has gathered multidisciplinary staff across programs such as Pathways to take the lead on redesigning clinical intakes in ways that are more responsive to the community.

Conclusion

Building on KKV's historical emphasis on relationships and the inherent resiliencies of staff and community, the grant fostered understanding, agency, and connection among clinical and community programs in both direct and subtle ways. This has resulted in a growth in QI patients benefiting from more SDOH and clinical pathways to healing. Looking forward, KKV hopes to evaluate the impact of various SDOH interventions on clinical outcomes, cost, and service utilization.

Carving our stories into each other
the sayings of our grandmothers
nurturing us
The ease of hearing what we desire
when our own mouths utter the words
We are enough
We belong
on this edge of profound silence
a place who nourishes, loves, and forgives us
Words of healing
wrapping around protecting us in the future
Finding strength in the challenge
Hands held in deep gratitude
acknowledging that enduring in silence
no longer suits us
understanding these connections
are the most important
to acknowledge
to create
to aim for

- Poem by Cohort 5

Photo courtesy Kōkua Kalihi Valley

Works Cited

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2. Kaiser Family Foundation. (2020). Health Insurance Coverage of the Total Population: Hawaii. The Henry J. Kaiser Family Foundation. Retrieved from https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22hawaii%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Ko'olauloa Health Center

"A client struggled with behavioral health and substance abuse issues. She also struggled after the loss of her children to the state. After being homeless for a year, she came to me for help. We assessed her situation and developed a plan that would help her become more self-sufficient. First, we created a trusting relationship with her before initiating the coordination of services. Second, we worked on housing support.

"We created a trusting relationship with her before initiating the coordination of services."

"After completing a Vulnerability Index – Service Prioritization Decision Assistance Tool assessment [the state's designated homelessness assessment], she was referred for a permanent housing voucher through the Shelter Plus Care Program. Taking the housing-first approach with her helped her get her own place in four months. During that housing transition period, she received behavioral health and substance abuse services that led her to becoming sober.

Photo courtesy Ko'olauloa Health Center

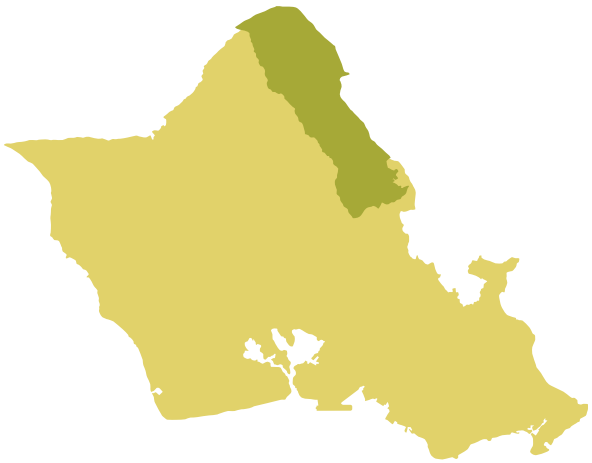
"I'm happy to report that six months later, she and her two daughters are reunited. They now enjoy spending time together as a family including going to the beach and attending church every week. She and her family are seen frequently at the Hawaii Foodbank and in the clinic, accessing health care and additional resources to keep them healthy."

– Outreach Eligibility Coordinator

Ko'olauloa Health Center at a glance

Mission Responsive to community needs. Promoting health and wellness in Ko'olauloa. Imua!

History The Ko'olauloa Health Center (KHC) has been serving its community for nearly 15 years. At the time of incorporation, KHC provided health care with two providers out of a trailer at the Kahuku Sugar Mill. Since then, it has grown into the full-service, multi-site, 16-provider, comprehensive health center it is today.



O'ahu

Service area

KHC Community Program

KHC's behavioral health department provides an array of services such as child, adolescent, and adult psychiatry; medication-assisted therapy; medication management; and treatment for substance use disorder and opioid use disorder. The health center also provides individual and group therapy sessions for psychotherapy and counseling, relationship and family counseling, substance abuse treatment, help to reduce or quit tobacco, anger management, bereavement/other loss, and life changes.

Demographic information 2018[1-2]

Total patients served:

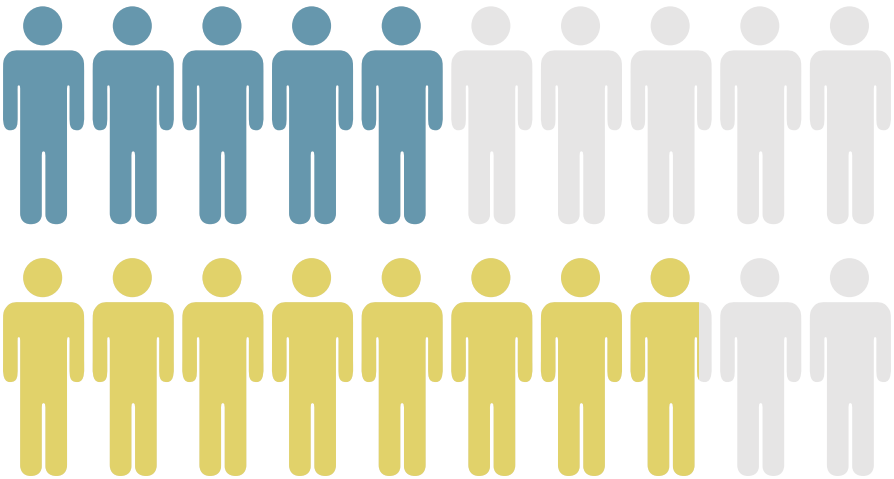
6,363

Best served in another language:

5.7%

Poverty Level

Ko'olauloa Health Center



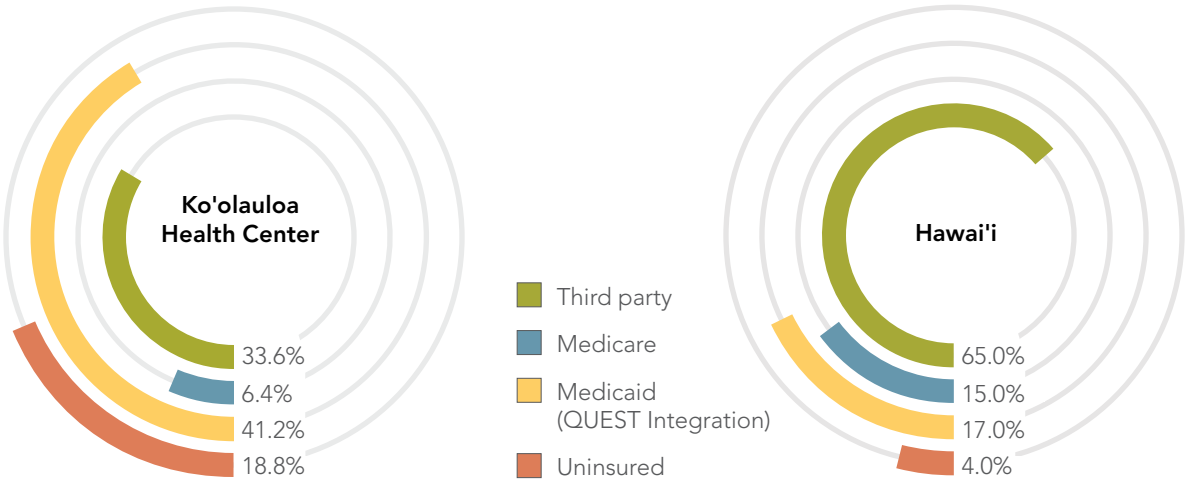
<100% federal poverty level

50.4%

<200% federal poverty level

79.5%

Insurance Type



HMSA Community Grant

Lifestyle Enhancement Program

Grant Overview

Executive Grant Summary

KHC's service area has experienced disproportionate social-economic, cultural, geographic, and health-related disparities that necessitate an approach that looks beyond individual interventions to care for their community. In response, KHC launched three efforts: 1) the Lifestyle Enhancement Course that used Prevent T2 coursework from the Centers for Disease Control and Prevention (CDC) to address individuals with prediabetes, 2) a new farmers market to address access to healthy and affordable produce, and 3) various community engagement initiatives under the Moku to Hale Social Determinants of Health Strategy. From developing and improving existing programs, KHC positively impacted the health of the Ko'olauloa community on many levels.

Statement of Need

The residents of KHC's service area have been disproportionately affected by unique social-economic, cultural, geographic, and health-related disparities that have impacted the way health care is received and accessed. The cost of living is an estimated 10-15% higher than the City and County of Honolulu overall, requiring a livable wage equivalent to more than three full-time jobs paid at minimum wage.[3]

This has been multiplied by the limited employment opportunities in the area, requiring commutes of sometimes more than an hour each way. The service area's unemployment rate has been estimated to be four times higher than the state's rate.[4,5] This was further supported in KHC's recent Community Health Needs Assessment (CHNA) in 2016 that reported 20.5% of survey participants were unemployed.[6]

In addition, the cost of fresh fruits and vegetables has been 25-30% higher than in neighboring Kāne'ohe and Temple Valley. These factors have contributed to the higher rate of mortality for heart disease and cancer and a higher hospital admission rate overall due to substance use disorders compared with the City and County Honolulu.

Historically, strategies to improve access and health outcomes have emphasized a focus on traditional health care systems and processes. However, targeted individual, family/group, and community approaches that address social determinants of health can have a profound effect on overall health and equity. Unfortunately, there were no active efforts in the service area that addressed social determinants of health to improve health outcomes and status.

Intervention

KHC launched the Ho'opi'i Ola Pono (striving to change, living well) Lifestyle Enhancement Program (LSEP) that included three main components: a Lifestyle Enhancement Course, a new farmers market, and the Moku to Hale Social Determinants of Health Strategy.

- The Lifestyle Enhancement Course was adapted from the CDC's Prevent T2 curriculum that incorporated support from a community health worker and a registered dietitian with a culturally based lens and harm-reduction approach. The program incorporated nontraditional methods of increasing activity like fishing, gardening, and yard work and focused on the nutritional value of foods. The program also provided tools such as home scales, blood pressure monitoring kits, exercise bands, and materials for a mini home herb garden. In the second year of the program, a diabetes self-management program was added in partnership with the National Kidney Foundation of Hawai'i to further support people with diabetes in the LSEP program.
- KHC established the Ko'olauloa Farmers Market to bring affordable, whole, and healthy foods from local agricultural businesses and partners to the Punalu'u community. During the grant period, the market was open every second and fourth Saturday of each month from 8:30 a.m. to 1:30 p.m. The market accepted Supplemental Nutrition Assistance Program (SNAP) and EBT Double Bucks Program benefits.
- The Moku to Hale strategy aimed to provide residents with necessary tools to improve quality of life and health status through social determinant of health interventions. A team from the Outreach Eligibility department reached out to individual community members and organizations, attended events, and organized value-added services such as nutrition counseling with the health center's dietitian.

Earl Yoshii

HMSA Community Grant

Lifestyle Enhancement Program

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

KHC successfully designed and launched the Lifestyle Enhancement Course and Diabetes Self-Management Education Classes to tailor the CDC's T2 Diabetes Prevention Program to meet the needs of their community. The following tables show the outcomes that were achieved.

Diabetes Prevention Program

	No.
Participants	73
Total weight lost	483 lbs.
Average weight lost	6.6 lbs.

Diabetes Self-Management Education Classes

	No.
Participants	12

KHC launched a farmers market to the Punalu'u community in March 2019 and achieved the following outcomes.

Ko'olauloa Farmers Market

	No.
Farmers markets	12
Attendees	50-80 average (250 at the first market)
Vendors	9-15

KHC actively connected with their community to achieve the following outcomes.

Moku to Hale

	No.
Community events attended or hosted	35+
Individuals reached through community events	50-800 per event
Families and individuals assisted (e.g., helped with applications and renewals for QUEST Integration, SNAP, and Supplemental Security Income and helped submit documents to maintain social support services)	750

Intellectual Capital

Using the CDC's T2 curriculum as a framework for the Lifestyles Enhancement Course, the health center continually improved the prediabetes course during the two-year grant period in response to the community's interests and values. In the first year of the Lifestyle Enhancement Course, 80% of the participants were engaged in healthy eating and physical activities and met their weekly action plan goals. However, there was a 50% drop-off in the last half of the program. After learning from participants that a year-long program was too much of a time commitment, the health center shortened the program to six months.

The health center also learned that the CDC's T2 curriculum lacked diabetes-specific education that was needed to further improve health outcomes. As a result, other components were added in the second year of the grant, such as caregiver training on decision making, self-care behaviors, and problem solving and active collaboration with the Lifestyles Enhancement Course team. Culturally appropriate nutrition classes, cooking demonstrations, integrated diabetes self-management education, and hypertension monitoring were also added. Finally, a certified diabetes prevention lifestyle coach was contracted to help facilitate the program and bring more energy to it.

Overall, these interventions highlighted the importance of health education, which the health center deemed highly critical and necessary. Facilitators and coaches who were passionate about serving the community were invaluable to the education effort while the health center searched for creative ways to incorporate the dietitian and nutrition education into the program.

HMSA Community Grant

Lifestyle Enhancement Program

To bring healthy, local produce and other foods to the communities in Ko'olauloa, KHC partnered with Kamehameha Schools to establish a farmers market. Although the grand opening attracted more than 250 attendees, subsequent attendance was hard to sustain. Therefore, KHC implemented a number of continuous improvement activities including redeveloping marketing materials and replanning community outreach, rescheduling the farmers market to dates and hours that coincided with pay periods and the timing of SNAP benefits, optimizing the vendors' time and commitment, and inviting vendors who could provide fresh produce that can be used in a variety of ways.

Finally, KHC conducted a CHNA in 2018 to provide the health center with a snapshot of the demographic and health of the Ko'olauloa community, challenges the community faces, and future opportunities and recommendations for the health center. The CHNA was distributed via paper and online with a response rate of 116 community members. Key results included: 66% of households had an annual household income of $75,000 or less; patients felt that healthier food options and access to recreational facilities, a nutritionist, and wellness services (e.g., diabetes, nutrition, and exercise) were important to their health; and the health center should focus on obesity, homelessness, illegal drug use, and diet and nutrition.

Human Capital

The Lifestyle Enhancement Course hired a dietitian to provide nutrition education and food demonstrations. The course added a component highlighting the importance of blood pressure management and monitoring. The last two cohorts could access a fitness coach who provided more thorough individual support through weekly phone calls. At the end of the grant period, participants' knowledge increased with 85% reported to have increased their consumption of healthier foods and increased physical activity.

Similarly, the Diabetes Self-Management Education program impacted participants through the use of a Stanford University curriculum via the National Kidney Foundation. The program was tailored to be culturally relevant and community focused. One-on-one appointments with the dietitian were provided to discuss food journals, modifications in diet, and nutritional intake and personal physical activity goals.


Earl Yoshii

"There were five of us participating in the program — Mom, Dad, Grandma, and two sons. Two out of the five achieved the 5% weight loss goal. This program has been beneficial, in different ways, to each family member. We might not have made huge strides but are making good progress, accountable successes, and steps motivating us to take personal responsibility for our own health, being healthier individuals, and a healthier family. As a family, we feel better, have more energy, and are more active. Our moods seem better, too … less grumpy and more smiles."

– Lifestyle Enhancement Course participant

Social Capital

Partnering with various community organizations to provide more services to the Ko'olauloa community was an important goal for the health center. KHC worked with the National Kidney Foundation to promote healthy eating and lifestyle changes in their Lifestyle Enhancement Course's Diabetes Self-Management Program. The health center also collaborated with the Hau'ula Community Association to access free permanent space at the Hau'ula Civic Center to stage programs. For the diabetes prevention program, Farm to Table 808 held cooking demonstrations for every class.

HMSA Community Grant

Lifestyle Enhancement Program

The health center worked with a land asset manager at Kamehameha Schools to implement a farmers market at the health center. The land asset manager recruited farmers; constructed tables, displays, and other items to host the farmers market; and assisted with marketing, advertising, and promotional items. The farmers market team networked with Waianae Coast Comprehensive Health Center (WCCHC) to learn more about implementing a farmers market as WCCHC currently runs their own.

To address their Moku to Hale strategy, the community eligibility and outreach team planned and executed various community events while collaborating with Hui O Hau'ula to start an Outreach Service Center at their local food bank. The Outreach Service Center provided a variety of services to address social determinants of health that impact the Hau'ula community by assisting individuals and families with signing up for health insurance, finding housing, and obtaining other social service benefits.

Finally, KHC's community relations director met with individuals and other community-based organizations in the Ko'olauloa service area to start an interagency group to establish community partnerships. This group worked on sustainability, integration, and addressing needs of the community. KHC also participated with Project Reach's back-to-school bash and winter event at Kahuku High and Intermediate School, an 'ohana resource night hosted by Hau'ula Elementary, and an open house for parents at Kahuku High and Intermediate and Kahuku Elementary schools. In July 2019, KHC partnered with the Honolulu Community Action Program to explore opportunities to collaborate with other organizations such as Ke Ola Mamo and the Institute for Human Services to further help the Ko'olauloa community.

Photo courtesy Ko'olauloa Health Center

Conclusion

The Ko'olauloa community experiences disproportionate social-economic, cultural, geographic, and health-related disparities, requiring an approach that innovates on individual interventions and is community-based. KHC addressed this need by launching three initiatives that address health at an individual, family/group, and community levels. From developing and improving their existing programs to developing new community-centered activities, KHC positively impacted the health of the Ko'olauloa community by identifying resources in their own community, empowering their staff, and doing what is best for their patients.

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6. Community Health Needs Assessment, Ko'olauloa Health Center, August 2016.

Waianae Coast Comprehensive Health Center

"I've had back problems since I was 11, so for 20-something years I've been trying different things. It's already been explained to me that this is your body, this is what you were given. And we can't fix you, but we can sure help you have a better life. And I appreciate that. I still have bad days. I will always have pain every day, so I can accept that. The part that I wasn't willing to accept, when I realized I didn't have to, is that it doesn't have to be a bad day every day.

"I've had so many negative experiences with pain management because I think it's a semi-new idea. And so many times if you don't talk to someone who's knowledgeable, they think you're an addict

"She gave me hope. For the first time in a long time, I felt like somebody's listening to me"

or you just want pain meds. When I came in, I was a little apprehensive. Like, is this another doctor who's just going to tell me I need to be a little bit stronger? But she listened and by the end of it, I felt like she understood. She gave me hope. For the first time in a long time, I felt like somebody's listening to me and I might get better."

- Ho'okūola Hale patient

Photo courtesy Waianae Coast Comprehensive Health Center

Waianae Coast Comprehensive Health Center at a glance

Mission

Waianae Coast Comprehensive Health Center (WCCHC) is a healing center that provides accessible and affordable medical and traditional healing services with aloha.

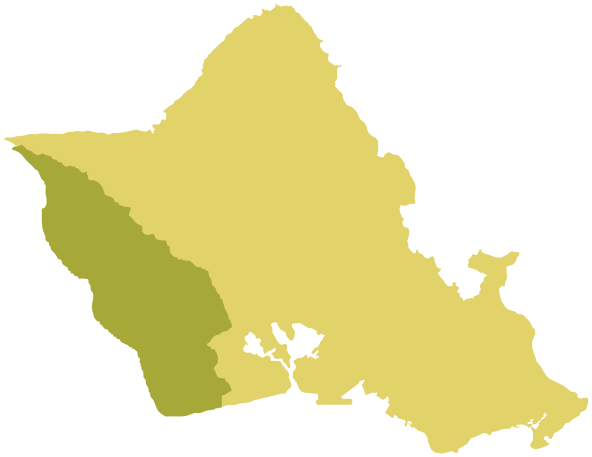
WCCHC is a learning center that offers health career training to ensure a better future for our community.

WCCHC is also an innovator, using leading-edge technology to deliver the highest quality medical services to our community.

History

In 1949, the Waianae Sugar Mill dispensary, which provided much of the health care on the Leeward coast, closed its doors. About 6,000 residents were left without medical care and were forced to go to Honolulu to see a doctor.

Concerned residents formed a health task force to create better health services and bring more doctors to the community. In 1972, construction of WCCHC began and it became the innovative health center it is today.



O'ahu

Service area

WCCHC Community Program

In partnership with the Hawaii Foodbank, WCCHC hosts 'Ohana Night, a nutritional outreach event for the Wai'anae community.

At 'Ohana Night, qualified families can pick up fresh, nutritious food free of charge. Families can also enjoy a free dinner and healthy cooking classes based on the food being distributed that night.

Demographic information 2018[1-2]

Total patients served:

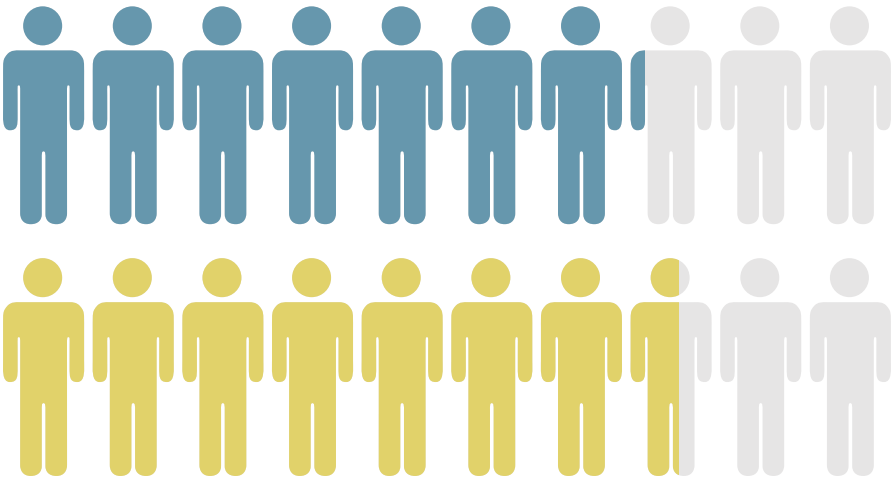
38,141

Best served in another language:

0.1%

Poverty Level

Waianae Coast Comprehensive Health Center



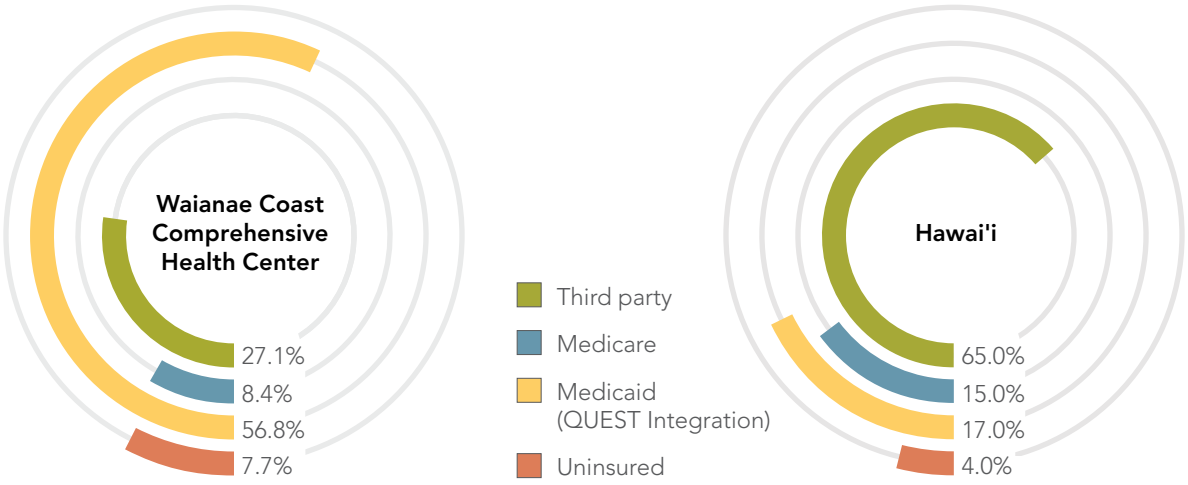
<100% federal poverty level

72.2%

<200% federal poverty level

76.0%

Insurance Type



HMSA Community Grant

Addressing Health Care Needs of Medically Complex Patients

Grant Overview

Executive Grant Summary

WCCHC recognized that addressing the needs of their community went beyond providing traditional medical care. New intervention strategies were needed. Two issues contributing to the prevalent complex medical conditions on the Leeward coast are behavioral health and substance abuse. To tackle the problem, WCCHC implemented the following initiatives:

- Clinical initiative: Establish a pain management clinic staffed with traditional and nontraditional providers and expand behavioral health services to their communty.
- Workforce initiative: Address behavioral health provider shortages in the workforce.

Focusing on the social determinants of health (SDOH) affecting many in their community was also crucial to creating change. WCCHC has been developing methods to assess SDOH needs in the community and have supplemented their efforts with the following initiatives:

- Community engagement initiative: Hold quarterly consumer-based leadership workshops to discuss issues of communities and health centers.
- Accountable care initiative: Ensure care coordination with new programs and establish performance-based dashboards to monitor WCCHC's ability to measure accountable care and quality metrics.

Through the grant, WCCHC established their pain management clinic, Ho'okūola Hale, which addressed chronic pain issues of 1,488 people. The program was later consolidated in the same space as their substance abuse program, which helped facilitate coordination of care between providers. Another clinic, Ewa West O'ahu Community Health Center, was opened to increase access to behavioral health services for that community. Ewa West provided services to 853 people and built partnerships with other community agencies.

WCCHC also helped facilitate AHARO Hawaii workshops, which led to the development of data aggregation between member agencies and the acquisition of a telehealth system. Lastly, a care coordinator was hired to focus on the coordination and assessment of their accountable care dashboards. These dashboards are updated nightly and identify areas of concern such as the health center's high-cost members. WCCHC facilitated 6,943 encounters with high-risk patients who were members of a QUEST Integration (QI) dual-eligible plan.

Statement of Need

The prominent adult QI population that WCCHC serves is medically complex with high rates of chronic disease frequently accompanied by behavioral or substance abuse conditions. The health center believes that these conditions have contributed to many of the problems affecting their community, which include opioid addiction and the overutilization of hospital emergency rooms.

Insufficient coordination of services, lack of treatment services in the area, and a shortage of behavioral health providers statewide have also been barriers for communities on the Leeward Coast. WCCHC acknowledges that long-term patient outcomes and changes in behavior can't be achieved without identifying and addressing the social determinants affecting their community.


Russell Park

Photo courtesy
Waianae Coast Comprehensive Health Center


Russell Park

HMSA Community Grant

Addressing Health Care Needs of Medically Complex Patients

Intervention

WCCHC implemented four initiatives to address their community's issues:

1. Clinical initiative: WCCHC developed an integrated approach to substance abuse treatment by addressing one of its root causes, chronic pain. Ho'okūola Hale, their new pain management clinic, integrated existing WCCHC medical and behavioral health staff and alternative care providers such as an acupuncturist, a physical therapy/exercise specialist, Native Hawaiian healers, and other traditional healers. These providers coordinated care to treat patients with traditional medicine as well as holistically to reduce the dosage of opioids.

   WCCHC also opened the Ewa West O'ahu Community Health Center in March 2018 to address the lack of behavioral health services in the area. The clinic is at the Child and Family Services complex that's also the site of several other social service agencies for domestic violence, alternative education, and community-based youth services.

2. Workforce initiative: Expanding services required more providers. As a result, WCCHC's nurse practitioner residency program requires their advanced practice nurse practitioners (APRNs) to complete rotations in their pain management clinic to train them in addressing pain management/opioid use. A provider from WCCHC also completed the Psychiatric Mental Health Nurse Practitioner certificate program at Johns Hopkins University and now provides services at their 'Ewa clinic. The program was expanded to other CHCs, allowing one nurse practitioner to complete their rotation at Waimānalo Health Center and another at Hāmākua-Kohala Health on Hawai'i Island.

3. Community engagement initiative: WCCHC helped facilitate quarterly workshops through AHARO Hawaii, a consortium of community-governed community health centers (CHCs). Workshops included discussions on accountable communities, addressing the SDOH and behavioral health/substance abuse integration, and other issues affecting their communities.

4. Accountable care initiative: WCCHC hired a care coordinator to focus on assessment, referral, and counseling services for the behavioral health and chronic pain cohort of patients. The health center also used their electronic health records to establish performance-based dashboards to monitor accountable care and quality metrics.

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

To address chronic pain using a nontraditional approach, Ho'okūola Hale hired providers such as an acupuncturist, a physical therapy/exercise specialist, Native Hawaiian healers, and other traditional healers. Working with medical and behavioral health staff, these providers were able to treat patients who were suffering from chronic pain in a more holistic way and reduce the amount of opioids taken. In addition, due to their increase in encounters and patients enrolled at the clinic, there was clearly a need for pain management services to help patients live a healthier and pain-free life. Since its inception, the program has accomplished the following:

Ho'okūola Hale

	No.
Patients (unduplicated)	1,444
Sessions (all providers)	15,421
Patients seen by provider type	7
Medical physician/mid-level provider	10,931
Acupuncturist	2,592
Exercise physiologist/physical therapist	512
Native Hawaiian/traditional healers	33
Behavioral health providers	1,353
Percentage of patients who were prescribed >50mg morphine equivalents	<15%
Percentage of patients who were prescribed <50mg morphine equivalents	<25%
Staff hired	15

Mālama Kū Ola is a new clinic that combined Ho'okūola Hale and Mālama Recovery Services, WCCHC's substance abuse program, under one roof. The clinic opened in September 2019 and provides behavioral health services for patients with chronic pain management needs as well as substance use disorder services for those who are at high risk for addiction. Bridging the two programs in the same clinic has facilitated coordinated care and integrated treatment planning between providers while increasing patient access to medication-assisted treatment services.

HMSA Community Grant

Addressing Health Care Needs of Medically Complex Patients

Photo courtesy Waianae Coast Comprehensive Health Center

Historically, providing medication-assisted treatment in rural settings presented challenges including lack of waivered buprenorphine providers, limited access to addiction expertise, persistent stigma associated with such treatment, and long travel times for patients. There are currently four waivered buprenorphine providers in three WCCHC clinics who can provide medication-assisted treatment services with direct referral to intensive outpatient substance use disorder treatment for additional education, structure, monitoring, and support when medically necessary.

Previously, many patients traveled more than 10 miles to get behavioral health services at the main WCCHC location in Wai'anae. To address this issue, WCCHC opened the Ewa West O'ahu Community Health Center in March 2018. The clinic has significantly improved access to behavioral health services, providing services to 27 discharged WCCHC emergency room patients. Sharing a location with Child and Family Services has resulted in numerous referrals from other social service agencies and primary care providers in the area while allowing them to quickly engage with patients discharged from The Queen's Medical Center – West O'ahu.

Ewa West O'ahu Community Health Center

	No.
Patients	853
Sessions	6,256
Staff hired	7

Intellectual Capital

The care coordinator collaborated with the electronic medical record department to start collecting baseline data for their pain management clinic, Ho'okūola Hale. The clinic received approval and is using the Mayo Clinic's Arizona Comprehensive Pain Evaluation to collect data and evaluate the program. Partnering with AHARO Hawaii, Ho'okūola Hale created dashboards to easily display and measure accountable care and quality metrics. Some of the dashboards include high-cost members, emergency room visits, inpatient follow-ups, and more.

WCCHC also sought to standardize their social needs assessment for patients through the PRAPARE project. The data gathered will be used to create a risk stratification tool for their care coordinators. The health center presented their current findings at an AHARO Hawaii workshop and several national conferences. The PRAPARE project enabled the health center to identify several other consumer-directed initiatives linked to SDOH. Initiatives focused on community engagement, cultural proficiency, workforce and economic development, and care enabling will be governed through WCCHC's Board Quality Committee.

Human Capital

WCCHC'S workforce initiative allowed one of their providers to earn a post-master's psychiatric mental health nurse practitioner certificate from Johns Hopkins University. The provider now sees patients at the 'Ewa center and oversees nurse practitioner residents for psychiatric mental health rotations.

WCCHC also focused on expanding their Nurse Practitioner Residency Program. Psychiatric mental health and primary care nurse practitioner residents completed buprenorphine waiver training and eight-week rotations in the pain management clinic. The training addressed pain management and treatment and responsible prescribing of opioids. The goal was to increase patients' early access to pain management to either prevent the initiation of opioid use or prescribe a shorter duration of use to prevent addiction. Residents also received cultural training through the Ha Ola Village Project to learn holistic pain treatment.

The Nurse Practitioner Residency Program was expanded to other CHCs. Two of their APRNs completed their rotations at different health centers, one at Waimānalo Health Center and the other at Hāmākua Health Center on Hawai'i Island. In March 2018, another graduate of the program moved off island to work at Hāmākua-Kohala Health.

HMSA Community Grant

Addressing Health Care Needs of Medically Complex Patients

Social Capital

With the creation of the Ewa West O'ahu Community Health Center, WCCHC developed a relationship with Child and Family Services and became widely known among residents. Ewa West receives many referrals from Child and Family Services, other nearby agencies, and primary care providers in the area. The clinic also built a relationship with The Queen's Medical Center – West O'ahu and can engage quickly with their patients when they're discharged.

Since 2017, Ho'okūola Hale has established positive and supportive relationships with community partners such as agencies that provide specialized treatment services and other resources in the community and throughout the state. This enables Ho'okūola Hale to refer and advocate for patients with needs that cannot be addressed in the organization to create a comprehensive continuum of care. Not only are Ho'okūola Hale patients referred to organizations and programs, the program receives referrals from these agencies for integrated chronic pain management care. Specifically, Ho'okūola Hale:

- Refers patients to residential substance abuse treatment services as needed and has developed collaborative relationships with many community substance use disorder providers such as Ho'omau Ke Ola, the Salvation Army, and Hina Mauka.
- Refers patients to recovery-based supervised living facilities when it's determined that a supportive, controlled environment is necessary for successful outpatient pain management treatment.
- Works closely with organizations that provide emergency and material assistance for families' basic needs. These organizations include the Hawaii Foodbank, Community Clearing House, Catholic Charities, Onelauena's emergency transitional housing, and several churches in the area that offer emergency food, clothing, and financial aid.
- Has a collaborative relationship with the Hawai'i Health and Harm Reduction Center (HHHRC) for naloxone training and medication provision. HHHRC also provides confidential HIV testing, counseling, and education.
- Works closely with Adult Client Services and the Hawai'i Department of Public Safety to accept referrals for patients with legal issues to receive integrated chronic pain management and substance use treatment services.
- Refers patients to the Hawai'i Division of Vocational Rehabilitation for vocational counseling, financial assistance, and support services.
- Employs providers who are active community members who promote awareness and involvement with resources and programs that support positive health outcomes related to chronic pain management.

Russell Park

To connect with others in the community, WCCHC facilitated workshops with AHARO Hawaii that led to:

- The development of data aggregation capabilities by the member agencies.
- The acquisition of a telehealth system.
- Improved engagement between their board and staff leaders.
- Successful fundraising efforts around joint purchasing and innovation.

These workshops were well attended and continued after the grant period.

HMSA Community Grant

Addressing Health Care Needs of Medically Complex Patients

Conclusion

WCCHC is a leader in addressing health care gaps through community-driven innovation and has made great strides in improving the health of their community on the Leeward coast. Ho'okūola Hale has been recognized by the Human Resources and Services Administration as a promising practice in pain management. WCCHC's commitment to addressing SDOH, access barriers, and provider shortages demonstrates that they're a significant part of the solution to health disparity in Hawai'i.

Photo courtesy Waianae Coast Comprehensive Health Center

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Waikiki Health

"I really didn't know what to expect. The experience was humbling, to say the least. I've had many different jobs in my life but this one is the most rewarding.

"One offender was wheelchair bound and could hardly use his writing hand. While helping him fill out some paperwork, I asked him what they were doing to help him. He said, 'Nothing. They don't care about anyone in here, especially when it comes to medical.' My heart sank and I assured him that we would help him.

"I've heard too many offenders say that no one cares about them or helps them in prison. They're human beings and, no matter why they're incarcerated, they deserve treatment and assistance.

" They're human beings and no matter why they're incarcerated, they deserve treatment and assistance."

"This program has changed me and has awakened me to the issues that these individuals face. It makes me want to break more barriers and do more for them. Giving people hope is one thing, but actually turning that hope into a reality is the biggest reward."

– Pu'uhonua Prison Program staff member

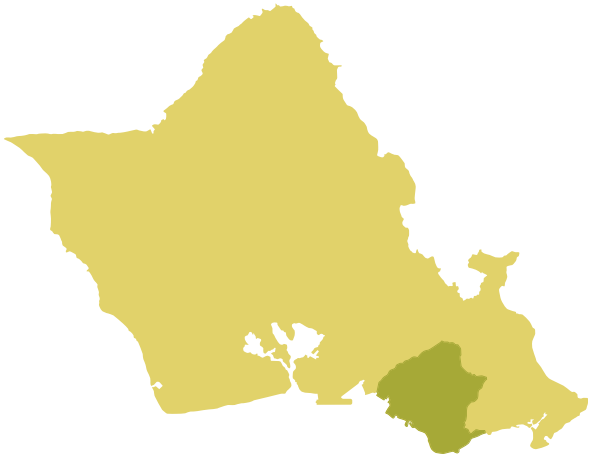
Photo courtesy Waikiki Health

Waikiki Health at a glance

Mission The mission of Waikiki Health (WH) is to provide quality medical and social services that are accessible and affordable for everyone regardless of ability to pay.

History In 1967, a handful of concerned community members decided to respond to the growing drug problem among Waikīkī's young people. They established the Waikiki Drug Clinic, which became the foundation for WH.

Since then, WH has provided quality medical care and social services targeting medically underserved populations across O'ahu with outreach services throughout the state. Today, WH is a multiservice, multisite, nonprofit agency that continues to focus on community needs.



O'ahu

Service area

Waikiki Health Community Program

WH's Youth Outreach (YO!) program welcomes homeless youth age 22 and under at the YO! Drop-in Center in Waikiki. The on-site Youth Clinic offers medical care and social services that address basic necessities, including food, clothing, shower and laundry facilities, and housing.

YO! staff provides nonjudgmental, culturally competent support and assists vulnerable youth in stabilizing their lives and making plans for a more secure future. To further create positive change, YO! offers health education sessions and empowerment opportunities, including job training and GED preparatory classes.

Demographic information 2018[1-2]

Total patients served:

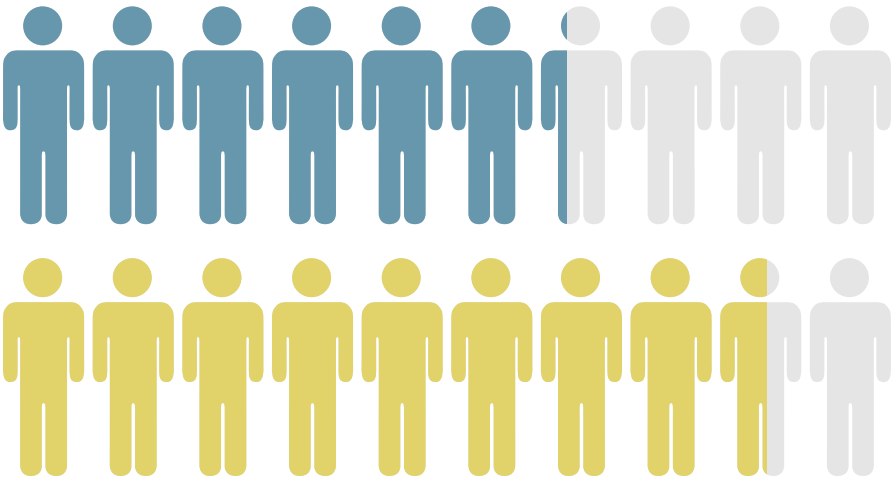
9,948

Best served in another language:

3.9%

Poverty Level

Waikiki Health



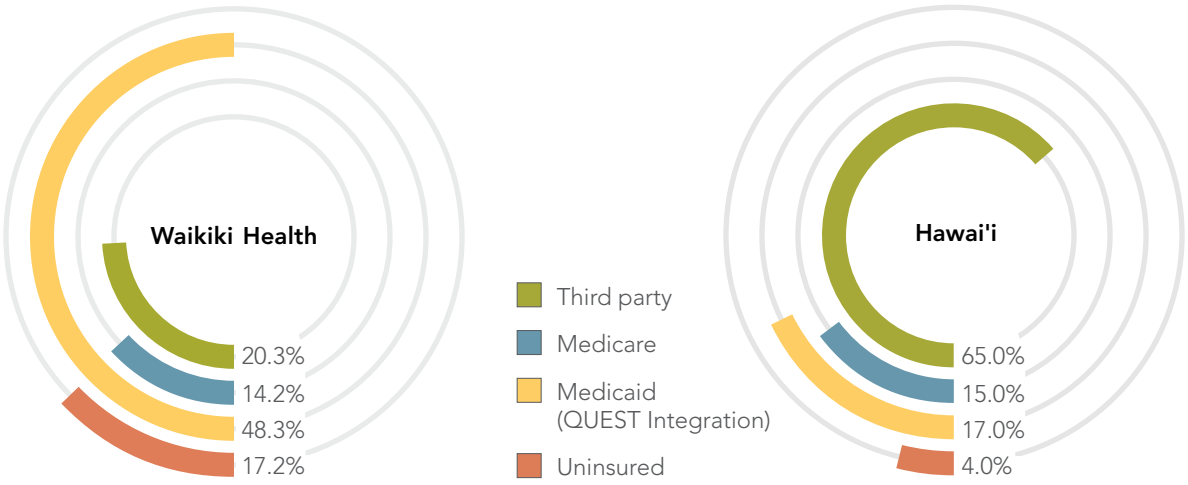
<100% federal poverty level

63.5%

<200% federal poverty level

86.5%

Insurance Type



HMSA Community Grant

Pu'uhonua Prison Program

Grant Overview

Executive Grant Summary

Historically, individuals of Native Hawaiian and Pacific Island descent have been disproportionately represented among offender populations. According to the 2010 U.S. Census, these ethnic communities accounted for about 39% of Hawai'i's total offenders. Social factors in the Native Hawaiian population, such as educational barriers and higher poverty rates, may have contributed to this disparity. Interviews with the formerly or currently incarcerated identify Hawaiian culture as the foundation for preventing recidivism.

To combat this issue, WH's Pu'uhonua Prison Program addresses the numerous health and social service needs of offenders to facilitate successful reintegration to the community. The program was developed and implemented by Francine ("Auntie Fran") Dudoit-Tagupa, the director of Native Hawaiian Healing at the center. The program is the first of its kind in the state and nationwide that provided re-entry assistance both pre- and post-release.

Four weeks before parolees and other offenders are released from incarceration, Auntie Fran and her team meet face-to-face with a pre-approved list of offenders to assess their needs and help them create a "Going Home Plan for Success" to follow when they're released. While the offenders are incarcerated, the Pu'uhonua team helps them fill out applications for QUEST Integration, Supplemental Nutrition Assistance Program (SNAP) and other financial assistance, TheBus disability passes, and other benefits, which Pu'uhonua staff submit immediately post-release.

Once released, individuals are provided with continued assistance in the form of referrals for housing/shelter, connections to clean and sober programs, transportation, clothing vouchers, support with family reunification, job opportunities with local businesses that have agreed to hire Pu'uhonua participants, a "medical home" at WH, and more.

Statement of Need

As of May 31, 2017, 5,296 Hawai'i offenders were incarcerated in-state or in Arizona. In 2017, Hawai'i spent $51,100 annually per inmate, or $140 per day.[3] Research has shown that social factors such as education, employment, and economic status are related to incarceration. According to the Hawai'i Department of Public Safety, offenders are caught in a cycle of incarceration and recidivism because they lack three essentials: a livable wage, a safe place to live, and healthy relationships.[4]

Initiatives to reduce incarceration and recidivism rates, such as WH's Pu'uhonua Prison Program, are needed to give Native Hawaiians, Pacific Islanders, and other individuals the opportunity to reintegrate to society. Providing cultural support and access to housing, job training, and other services can help ease the hardship that offenders experience post-release. Interviews with pa'ahao, or people who were formerly or are currently incarcerated, identified the strength of Hawaiian culture as the foundation for preventing recidivism. This could, in turn, enable the state government to direct more funds that are expended on the criminal justice system to other important needs.

"Our biggest contribution is offering incarcerated men and women a sound footing to re-enter the community. We assisted them so they could come out and move forward on making a better world for themselves."

- Francine Dudoit-Tagupa (Auntie Fran)
Pu'uhonua Prison Program director

Photos courtesy Waikiki Health

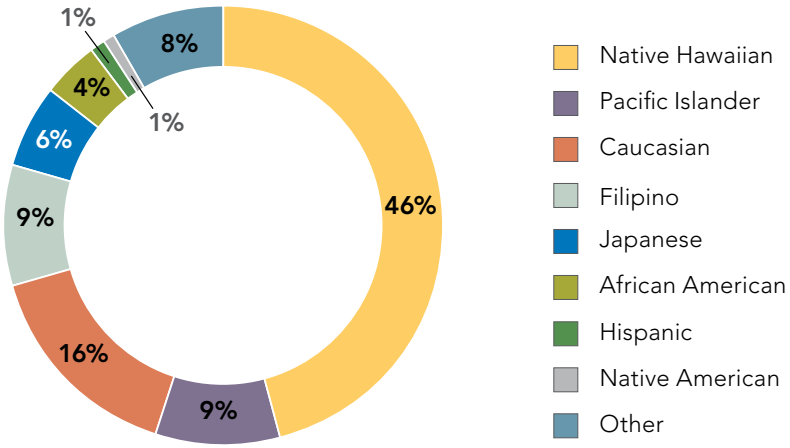
HMSA Community Grant

Pu'uhonua Prison Program

Intervention

The Pu'uhonua Prison Program, or "a safe place of healing," served as a support system of information, services, and encouragement for those who are incarcerated before and after they're released. The program primarily targeted Native Hawaiians and Pacific Islanders who were incarcerated in Oahu Community Correctional Center, Halawa Prison, Waiawa Correctional Facility, and the Women's Community Correctional Center. While the program is presented in a cultural framework, it's designed to engage, motivate, and benefit any inmate (see graph below).

Breakdown of Pu'uhonua Program participants



With the grant, WH was able to start a more-comprehensive Pu'uhonua Prison Program with new services:

- A mobile medical team assisted furloughed individuals and provided them with physical exams and tuberculosis testing to help them secure jobs and housing after release.
- Housing was offered at the Next Step Shelter for two months post-release. The Pu'uhonua Prison Program paid the fee for the first two months to prevent released offenders from becoming homeless. The program also helped with transition to permanent housing.
- Taxi vouchers were distributed to take released individuals directly to the Next Step Shelter to prevent re-establishing unhealthy relationships and reducing opportunities for recidivism.
- Clothing vouchers and bus passes were distributed to help participants prepare for job interviews and employment.

Photo courtesy Waikiki Health

- Staff helped participants obtain vital documents required for employment and other services.
- The program emphasized ho'oponopono, the Native Hawaiian healing practice that includes intervention for reconciliation with self and others. It focuses on integration of the spirit, mind, body, and emotion; connection to community and kuleana (responsibility); and self-care strategies.

Four weeks before their release, preapproved groups of offenders met regularly with Auntie Fran and her staff to get help with their medical and social service needs and learn about community resources. These conversations invoked reflections on what post-release may look like to the offender and helped create a personalized plan based on their needs. One important service that the Pu'uhonua staff provided was helping individuals fill out QUEST Integration health insurance applications that were submitted immediately when they were released.

After their release, Pu'uhonua participants received help with various needs, many of which WH provided. Bus passes, medical visits, clothing vouchers, and Next Step Shelter referrals were among the most-used services. Some unique services, such as WH's medical providers writing letters that confirmed participants' identity, were crucial to helping participants obtain identification cards and birth certificates that were destroyed while they were incarcerated.

HMSA Community Grant

Pu'uhonua Prison Program

Outcomes

Financial Capital

According to a 2018 report from the Hawai'i House of Representatives Concurrent Resolution 85 Task Force on Prison Reform, Hawai'i's overall recidivism rate was over 50%.[3] The Pu'uhonua Prison Program's recidivism rate was drastically lower at 9%. Of the 9%, most of the individuals returned to prison not because of a new crime, but for parole or probation violations.

In 2018, it cost an average of $66,439 a year to house an individual in prison.[4] Through the grant period, the Pu'uhonua Prison Program touched 2,299 offenders, which may have saved up to $152,743,261 annually.

With funds remaining at the end of the designated grant period, the Pu'uhonua Prison Program was allowed to operate until Jan. 30, 2020.

Manufactured Capital

WH prepared to achieve four main deliverables throughout the grant period to support program participants in their journey to reintegration.

Pu'uhonua Prison Program Outcomes

	No.
Offenders who received service and support during Social Service Days.	2,299
Assessments completed using the program's Social Determinants of Health Assessment tool.	224
Offenders who received help to apply for QUEST Integration health insurance.	1,444
Furloughed individuals who received mobile medical unit services.	427

Participants of the Pu'uhonua Prison Program also received the following services to help them reintegrate to the community:

Pu'uhonua Prison Program Services

	No.
Participants who designated Waikiki Health as their medical home.	1,060
Participants who visited WH for a medical appointment.	1,060
Behavioral health care visits at WH.	466
Referrals to the Next Step Shelter.	654
Participants who are currently living at the Next Step Shelter (as of 9/30/19).	16
Participants who secured employment (as of 9/30/19).	237
Participants who receive mail at Ohua Clinic address.	597
Bus passes issued.	1,570
Participants who received a Goodwill clothing voucher.	897
Participants who received letters from WH medical providers confirming their identity.	649
Participants who received Social Security card.	499
Participants who received SNAP/financial assistance.	609
Participants who received rehabilitation services.	383

WH hired a full-time program assistant, a part-time data entry and eligibility specialist, and a part-time eligibility specialist/patient service representative who joined Auntie Fran to help with the expanded Pu'uhonua Prison Program.

HMSA Community Grant

Pu'uhonua Prison Program

Intellectual Capital

Articles and editorials in the *Honolulu Star-Advertiser* and *Island Scene* magazine and news items on Hawaii News Now reflect the growing interest in the Pu'uhonua model. Throughout the grant period, Auntie Fran expanded her outreach activities to working with government agencies and nonprofit partners and schools to increase awareness about the goals and achievements of the Pu'uhonua Prison Program. Auntie Fran's outreach activities included:

- Meeting with health care providers on Maui, Hawai'i Island, and Kauai.
- Speaking to nursing students and faculty at Illinois Wesleyan University on ho'oponopono, the Native Hawaiian healing practice of reconciliation and forgiveness.
- Working with many universities and supervising field schools to show students that their kuleana involves demonstrating respect for the land and nature. Illinois Wesleyan University and the town of Mount Royal in Quebec, Canada, selected Auntie Fran to help with their native people programs.
- Presenting in Washington, D.C., at the U.S. Conference on AIDS on the topic, "Linking Incarcerated Native Hawaiians Living with HIV to Care Pre/Post Release."

Initially, WH's objective was to have a minimum of 360 individuals a year complete Pu'uhonua Prison Program's "Social Determinants of Health Assessment Tool," which was adapted from the National Association of Community Health Centers and Association of Asian Pacific Community Health Organization research tool. This survey included assessments of social, economic, and emotional factors of health and well-being.

Initial findings showed that program participants were either unable or uninterested in completing the assessment. Pu'uhonua staff simplified the survey, made it user friendly, and renamed it the "Going Home Plan for Success Questionnaire." However, this also proved too complicated and not useful for the target population. The Going Home Plan for Success Questionnaire was discontinued. Auntie Fran concluded that having friendly, supportive, one-on-one conversations with participants was far more effective in securing information and subsequently providing appropriate assistance than using any version of the questionnaire.

Human Capital

The additional Pu'uhonua staff was trained to process and help participants fill out QUEST Integration health insurance applications and navigate the health and social service system. The staff also gained knowledge while assisting and connecting their participants to various services and programs from other community-based resources. Auntie Fran, in particular, learned about the barriers and challenges associated with the various government agencies and the processes and workflows needed to assist the participants.

Social Capital

The Pu'uhonua Program worked with many community partners who provided additional support:

- The Transforming Lives Prison Ministry, run by Barbara Gatewood, is a faith-based program at Oahu Community Correctional Center. Participants are transitioned to WH to continue Native Hawaiian healing through ho'oponopono.
- First L.A.P. (Life After Prison) offered shelter, food, transportation (for Alcoholics Anonymous meetings, doctors' appointments, job interviews, etc.), and group counseling for men adjusting to life after incarceration.
- Chaminade University School of Nursing students assisted the medical unit at the Women's Community Correctional Center.
- Makiki Christian Church provided Skype family reunification visits between O'ahu families and their relatives incarcerated on the Mainland. The church also donated day passes for TheBus.
- The Hawaii Department of Public Safety and United Self-Help coordinated post-release services.
- Hawaii Paroling Authority partnered with the Pu'uhonua Prison Program to coordinate social services and other support services for offenders on parole. These services included acquiring housing, enrolling in treatment programs, and replacing legal documents.

HMSA Community Grant

Pu'uhonua Prison Program

Photo courtesy Waikiki Health

Other partnerships included Pū'ā Foundation, Fishers of Men Ministries, Mahoney Hale, Makana O Ke Akua, House of Blessing, Habilitat Rehabilitation, Salvation Army Adult Rehabilitation Center (ARC Treatment Center), Ho'omau Ke Ola, Po'ailani, Hina Mauka, Oxford House, Shelter of Wisdom, Hope Inc., Sand Island Treatment Center, Addiction Treatment Services, Honolulu County Offender Re-entry Program, CARE Hawaii, Epic 'Ohana Inc., Honolulu Community Action Program, Helping Hands, WorkHawaii, Islands Hospice, TheBus, Goodwill Industries, North Shore Mental Health, Hawai'i Health & Harm Reduction Center, and the Hawai'i State Judiciary. In addition, 51 employers in Hawai'i agreed to hire and train former offenders who now usually get a job within 30 days of release.

"It takes an army to raise this community."

- Francine Dudoit-Tagupa (Auntie Fran)
Pu'uhonua Prison Program director

Conclusion

Engaging the criminal justice system enabled WH's Pu'uhonua Prison Program to reach a population that previously received limited to almost no care and support once they were discharged back to the community. The Pu'uhonua Prision Program connected released offenders with health insurance, a medical home, treatment services, social service support, and other services they needed to get a new start in life.

Auntie Fran and her team continue to fill this gap in care and assistance to this population while leveraging their experience and partnerships by looking at opportunities to work more closely with the Hawai'i Department of Public Safety and the Hawaii Paroling Authority.

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Waimānalo Health Center

"Sometimes you go to the doctor and you think you're going to get fixed, but then you leave the doctor and you still feel horrible because they weren't able to treat you. They were just there to examine you. But when you come [here], you leave feeling fixed, you leave feeling well enough to continue your day. That makes a huge difference, to go into the doctor's office and come out feeling better than when you went in."

- Waimānalo Health Center patient

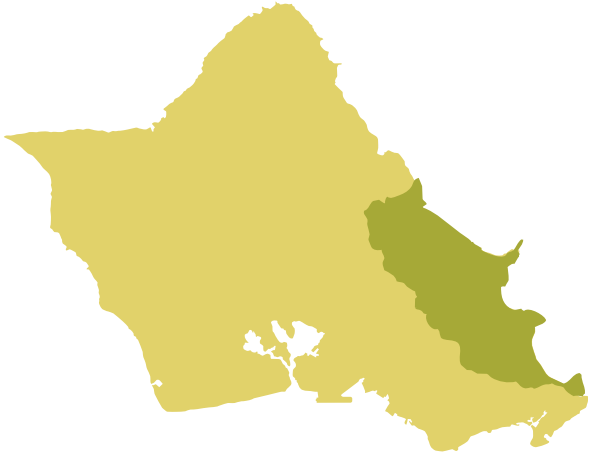
"When you come here, you leave feeling fixed, you leave feeling well enough to continue your day."

Photo Courtesy Waimānalo Health Center

Waimānalo Health Center at a glance

Mission Waimānalo Health Center (WHC) is committed to providing the highest level of primary and preventive health services with special attention to the needs of Native Hawaiians and the medically underserved and improving the health and wellness of individuals and their 'ohana regardless of their ability to pay.

History WHC was conceptualized by a group of women who led a health service committee in 1988. The group advocated for continued health services in Waimānalo after a Hawai'i Department of Health demonstration project was to end after 23 years. Founders Patricia Heu, Madi Silverman, Eve Anderson, Kawahine Kamakea-Ohelo, and Mabel Ann Spencer represented the community and advocated for a local health center. After incorporating in 1989, facility construction, and hiring professional staff, WHC saw its first patient in January 1992 and became a federally qualified health center in 1994. Since then, the health center has continued advocating for community health and expanded services to meet the needs of its patients.



O'ahu

Service area

WHC Community Program

WHC integrated Native Hawaiian healing practices into their primary care services. While other health centers also practice Native Hawaiian healing, WHC is unique because their cultural practitioner is in the examination room with the physician. The cultural practitioner is fully integrated into the system and attends daily meetings to discuss that day's patients.

Demographic information 2018[1-2]

Total patients served:

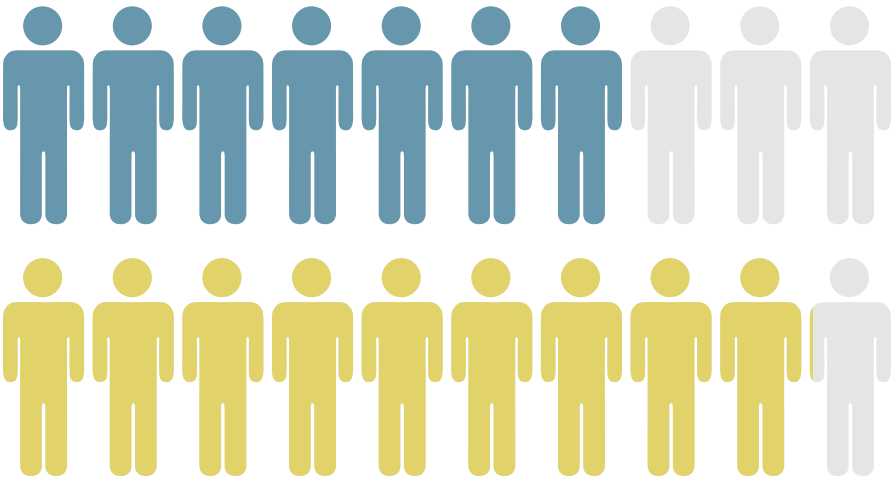
4,590

Best served in another language:

2.1%

Poverty Level

Waimānalo Health Center



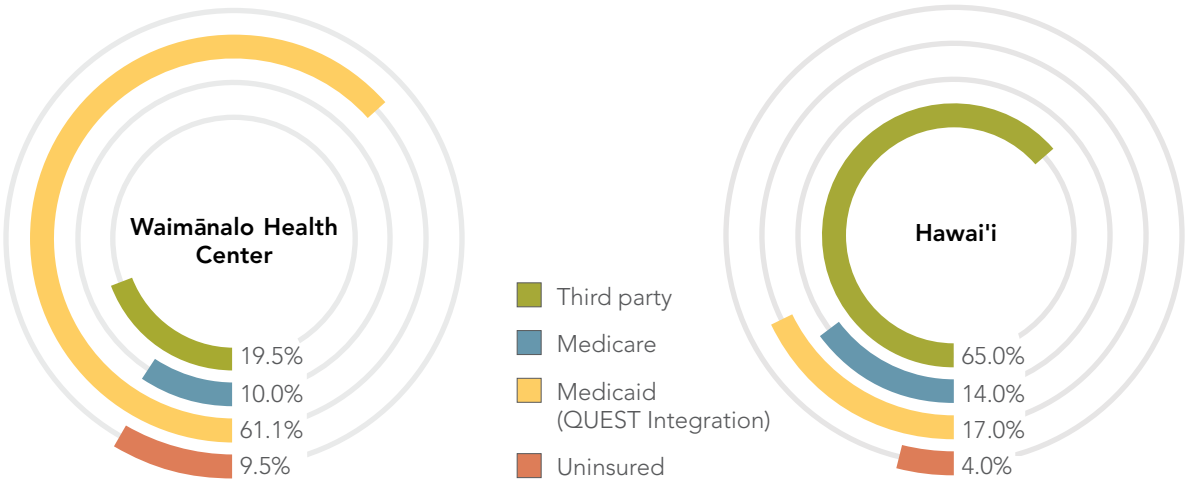
<100% federal poverty level

70.3%

<200% federal poverty level

90.9%

Insurance Type



HMSA Community Grant

Ho'oilina Pono A'e

Grant Overview

Executive Grant Summary

WHC believes that health disparities for Native Hawaiians are the result of a complex interaction between social determinants of health (SDOH), cultural and historical trauma, and a disconnect between culture and effective health services. To address these disparities, WHC focused on five social and environmental conditions: culture, education, economic self-sufficiency, and health care access through transportation and civil legal justice. Addressing conditions that affect the Waimānalo community enabled WHC to increase its understanding, outreach, and support to positively shape the health of the community it serves.

Statement of Need

SDOH affects communities on all levels. The World Health Organization defines SDOH as the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life. For Waimānalo, a community predominately comprised of individuals who identify as Native Hawaiians, health inequities remain constant despite improvements in health for the overall population in Hawai'i. Native Hawaiians have a higher mortality rate compared with Caucasians and a disproportionate prevalence of chronic medical conditions.[3]

In addition, according to the U.S. Census Bureau, about 8% of Waimānalo residents do not graduate from high school and only 13.5% have earned a bachelor's degree or higher, less than half of the state's average of 30.5%.[4]

WHC's patient no-show rate was about 18% due to a variety of barriers. Lack of accessible transportation was a common problem for many patients. The single highway that runs through the community was deemed unsafe by many residents. Very few chose to walk or bike because the area is prone to vehicle and pedestrian accidents. Public transportation such as the City and County of Honolulu's TheBus was available but cumbersome since its route is the same heavily trafficked highway.

Fifty-eight percent of those served through WHC live at or below the federal poverty level. According to the U.S. Census Bureau 2010-2014 American Community Survey 5-Year Estimates, 7% of Waimānalo households receive cash public assistance and 21% of households receive food stamp/SNAP benefits. Waimānalo has an unemployment rate of 8%.

Issues related to housing, utilities, income, insurance, education, legal status, veterans' affairs, employment, and personal and family stability affect the well-being of many Waimānalo residents.

According to WHC, 43% of patients seen through their medical-legal partnership required assistance with a civil legal issue; income support and insurance were identified as the most common issues.

Intervention

1. Mo'omeheu: Based on feedback from the community, WHC integrated Native Hawaiian healing practices into their primary care services. Embedded in the medical staff, their cultural practitioner was present in the examination room with a physician to offer an alternative to Western medicine. A study, Ho'oilina Pono A'e (Creating a Better and Just Legacy for the Next Generation), designed with a community advisory board, was conducted by WHC's cultural practitioner, chief executive officer, and a researcher from the University of Washington Indigenous Wellness Research Institute.

   Due to community demand, the cultural practitioner conducted lā'au lapa'au and lomilomi visits in the clinic and lā'au lapa'au classes, including a class called 7 Laws of Health that addressed health with a holistic approach. With continued feedback and interest from the community, WHC expanded their Native Hawaiian healing practices with the hiring of a kāko'o, an assistant to the cultural health practitioner, and formally defined their model and theory of change through qualitative community-based research.

2. Imi Na'auao: The Kū I Ka Mana (KIKM) program provided mentoring and tutoring services to middle school students from Waimānalo and Kailua. The program offered a safe space for school work, tutoring, health education, and intersession programs to help prepare them for postsecondary education. 'Ohana Nights were held during the intersession as a venue for students to showcase what they'd learned to their families.

3. Mauli Ola: WHC purchased a nine-passenger van to transport patients to and from their health care appointments. Based on the growing need, transportation was extended to patients' residences in Kāne'ohe and to sites that patients were referred to, such as Adventist Health Castle in Kailua.

4. Ho'okahua Waiwai: WHC partnered with Goodwill Industries of Hawaii, Inc., to deliver its evidence-based Employment Services Training to the community. When individuals expressed challenges to attend these sessions (e.g., time commitment, lack of child care, etc.), WHC and Goodwill began alternative "drop-in" sessions to increase attendance.

5. Pono Kaulike: WHC partnered with the Legal Aid Society of Hawai'i to have an attorney available to provide civil legal services in the pediatric clinic. Services included screening and identification of potential legal issues, interventions, and/or referrals to services based on clinic screenings. Health-harming legal needs were also screened, such as income support and insurance, veterans affairs, and personal and family stability.

HMSA Community Grant

Ho'oilina Pono A'e

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

The following results were achieved for the five conditions of the grant.

To guide the research, a community advisory board was established to provide feedback and support throughout the research project. The team interviewed participants ranging from WHC staff and providers to patients and community members.

Ho'oilina Pono A'e study

	No.
Community advisory board meetings	7
Research participants	28

In addition to the study, the cultural practitioner held sessions on Native Hawaiian healing practices such as lā'au lapa'au and the medicinal uses of limu.

Cultural Practitioner Courses

	No.
Lā'au lapa'au sessions	28
Lā'au lapa'au participants	85
7 Laws of Health class participants	38
Patients seen by the cultural practitioner	1,706

Photo courtesy Waimānalo Health Center

As education is a critical determinant of health, KIKM program partnered with Waimānalo Elementary and Intermediate School to provide mentoring and tutoring services to students with health-related services and classes. A popular event, 'Ohana Night, allowed students from Waimānalo and Kailua to showcase what they learned from KIKM's intersession program.

KIKM program

	No.
Students who received mentoring and coaching services	284
Students who received tutoring services	190
'Ohana Nights	10
'Ohana Night attendees (per night)	25-40
Students who received educational resources and incentives	268
Participants who received health education services	257

Similar to education, transportation to obtain health care is a critical determinant of health. Affordable and dependable transportation services can help overcome barriers to accessing care for individuals, particularly older adults and young families. With the purchase of a van, WHC was able to address their no-show and Pap smear screenings rates.

WHC Access and Preventive Screening Measures

	Pre-intervention	6-Month Results
No-show rate	18%	15%
Pap test rate	44%	70.7%

Transportation Services and Outreach

	No.
One-way trips via van	1,710
Patients transported	130
Encounters of outreach and engagement about van and health center services	8,555
Patients who were contacted with information about van and health center services	4,215

WHC partnered with Goodwill to provide their Employment Services Training to address individuals in the community who are unemployed or seeking employment.

Employment Services Training Program

	No.
Participants	22
Participants employed	8
Participants awaiting employment	6
Participants in further training	2
Participants in a training program	2
Participants continuing to work on resume/personal documents	2

In addition, WHC strengthened its partnership with the Legal Aid Society to continue providing health-harming screenings to their patients if a provider encountered a potential legal or outside issue that could be impacting the patient's health.

Health-harming screenings – Needs identified

	No.
Income and insurance	55
Housing and utilities	15
Education and employment support	2
Legal status and veterans affairs	5
Personal and family stability	40
Patients screened	130

Photo Courtesy Waimānalo Health Center

Intellectual Capital

Ho'oilina Pono A'e research project recruited and interviewed community residents, patients who received traditional healing services at WHC, staff and providers, and kupuna for a community-based participatory study focusing on the added value of integrating Native Hawaiian healing into primary care. Results indicated that Native Hawaiian healing:

- Provides an alternative to Western medicine.
- Can recall ancestral knowledge.
- Focuses on the whole person and addresses spirit.
- Generates increased disclosure and engagement leading to behavior change.
- Is central to a decolonizing process for the health centers, its patients, and for health care in general.

The findings from the study further strengthened the importance of the health center's integration of a cultural practitioner in the primary health care staff and the resulting positive patient outcomes.

"I feel it's really important not for us only to see the Western medical sense, but also know what was from our ancestors, what was brought and taught and I feel it's really important that people not only learn about it, but learn the actual background. And the only way you can do that is by sharing and bringing it out into the community. I'm so glad that Waimānalo Health Center provides that because if in your own family, if they don't share it with each other, how else would you get it?"

- Waimānalo community member

HMSA Community Grant

Ho'oilina Pono A'e

Due to positive feedback from patients on the transportation services, such as service availability and how they prefer riding with the van driver than with any other public transportation service, WHC is considering expanding services with an additional driver and possibly purchasing another van. Throughout the grant period, WHC expanded pickup and drop-off locations from Makapu'u to Kāne'ohe. The van also transported patients to pick up their prescriptions while the health center's pharmacy was under construction.

To help refine WHC's transportation services and broader services, the health center contracted with Hawai'i Public Health Institute to interview residents of Waimānalo and neighboring communities. The assessment identified barriers such as long wait times, short patient-doctor interactions, and lack of transportation. It also identified a high interest in cultural practices. These results reinforced the overall approach of the grant and engagement with communities while highlighting the important role that transportation plays in accessing medical care.

Because of lower-than-expected enrollment in Goodwill's Employment Services Training, WHC reevaluated its services with input from the community, participants, and staff. WHC learned that participant challenges included no child care, lack of transportation, and needing more-frequent training. After some brainstorming, WHC and Goodwill decided to move to a "drop-in" model that included evening hours and job training opportunities for youth.

WHC continues to meet with the Legal Aid Society to discuss progress and issues discovered in patient screenings for health-harming needs. A Legal Aid Society attorney and WHC's chief executive officer presented at two webinars in partnership with the National Center for Medical Legal Partnerships and Episcopal Health Foundation. The Legal Aid Society also presented at an AHARO Hawaii workshop hosted by WHC.

The Legal Aid Society identified challenges with increasing the number of individuals served at WHC's pediatrics department citing reasons such as a family's lack of understanding of civil legal services, parents wanting to speak to the attorney without the child present, and lack of time. WHC and the Legal Aid Society discussed these challenges and proposed distributing more information to families at the health center and speaking at 'Ohana Nights to educate families on the civil legal services available.

Human Capital

WHC's new kāko'o for the Native Hawaiian healing program enabled the expansion of outreach and education to the Waimānalo community. The kāko'o also gained knowledge from the cultural practitioner's mentorship.

Similarly, students who participated in KIKM's programs not only received mentoring and academic tutoring services, but also increased their knowledge of topics ranging from culture and ethnic identity, cultural differences, genealogies to career development, and financial literacy to civic engagement and volunteering.

Community members who participated in Goodwill's employment training learned job readiness through resume building, job searching, applying for a job, and interview skills. Peer mentors from KIKM were trained on youth job training readiness. The health center staff publicized the drop-in services through outreach events with other community partners and encouraged patients and community members to access these and other health center services.

Social Capital

WHC partnered with various individuals and organizations to expand services to engage individuals with the health system and provide services that benefit the health and well-being of their community. A new partnership was formed with Goodwill to deliver employment services training. WHC also worked with the Legal Aid Society to expand legal services for patients who were screened for a health-harming need (e.g., income, housing and utilities, legal status) and with Waimānalo Elementary and Intermediate School to provide tutoring services and health education sessions.

WHC also connected with local health plans, community health centers (CHCs), and community stakeholders by facilitating a workshop through AHARO Hawaii. This workshop consisted of multiple breakout sessions for:

- Clinical quality concerns and focus on specific metric improvements.
- Increasing interest and engagement of other stakeholders with AZARA, a data-sharing electronic platform.
- Opportunities for board members to strengthen their relationships and provide input on a CHC conference agenda in December 2018 hosted by Waianae Coast Comprehensive Health Center.

Photo Courtesy Waimānalo Health Center

Conclusion

Social determinants of health, cultural and historical trauma, and a disconnect between culture and effective health care services play critical roles in shaping the health and well-being for Native Hawaiians and the Waimānalo community. Holistically addressing the needs of their community through innovation and partnerships around culture, education, and health care access enabled WHC to positively impact the health of their community. WHC is committed to build on what they learned during the grant period to continue to improve the various conditions that influence the community.

Photo Courtesy Waimānalo Health Center

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Kaua'i

Ho'ola Lahui Hawai'i

Frannie Apilado was dealing with drug addiction when she arrived at the doors of Ho'ola Lahui Hawai'i. She was desperate to get treatment for some dental issues and drove all the way from the other side of Kaua'i to a place she'd heard about.

"They knew about my drug addiction, but that never changed how they treated me," she says. "They always treated me great."

She's had five teeth extracted and is preparing to receive a bridge and a partial denture. Apilado says that the center has also helped her overcome an eating disorder and taught her better oral hygiene.

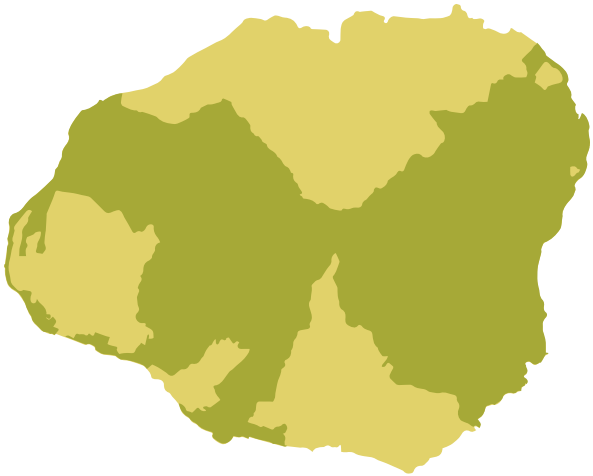
"They always treated me great."

Photo coutesy Ho'ola Lahui Hawai'i

Ho'ola Lahui Hawai'i at a glance

Mission To improve the health and well-being of our community.

History Ho'ola Lahui Hawai'i (HLH) was established in 1986 on the west side of Kaua'i. In addition to its designation as a federally qualified health center, HLH is the Native Hawaiian Health Care System for the county of Kaua'i selected by Papa Ola Lokahi.



Kaua'i

Service area

Ho'ola Lahui Hawai'i Community Program

Mālama I Na Pua is a health and wellness program for Native Hawaiian youth who attend a Hawaiian language charter school on the island. The purpose of the program is to raise health awareness and provide the tools to empower youth to make healthy lifestyle choices. The staff provides services to students and offers a variety of health and exercise classes.

Demographic information 2018[1-2]

Total patients served:

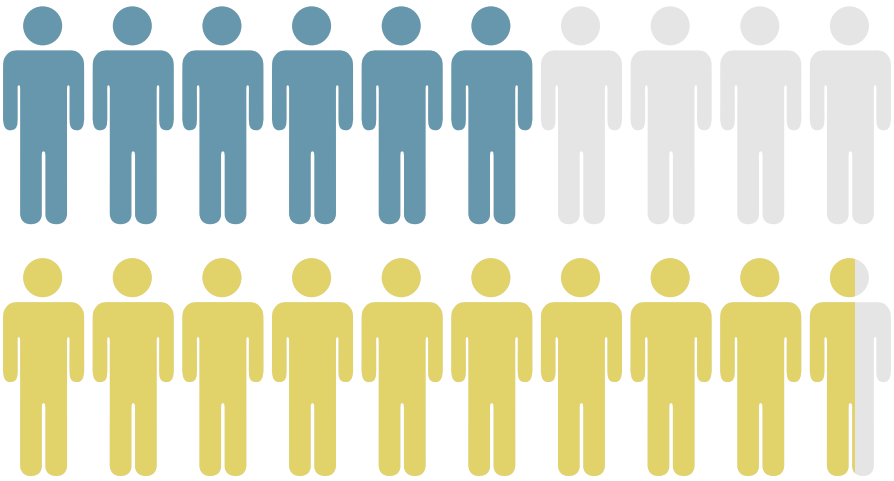
3,806

Best served in another language:

1.2%

Poverty Level

Ho'ola Lahui Hawai'i



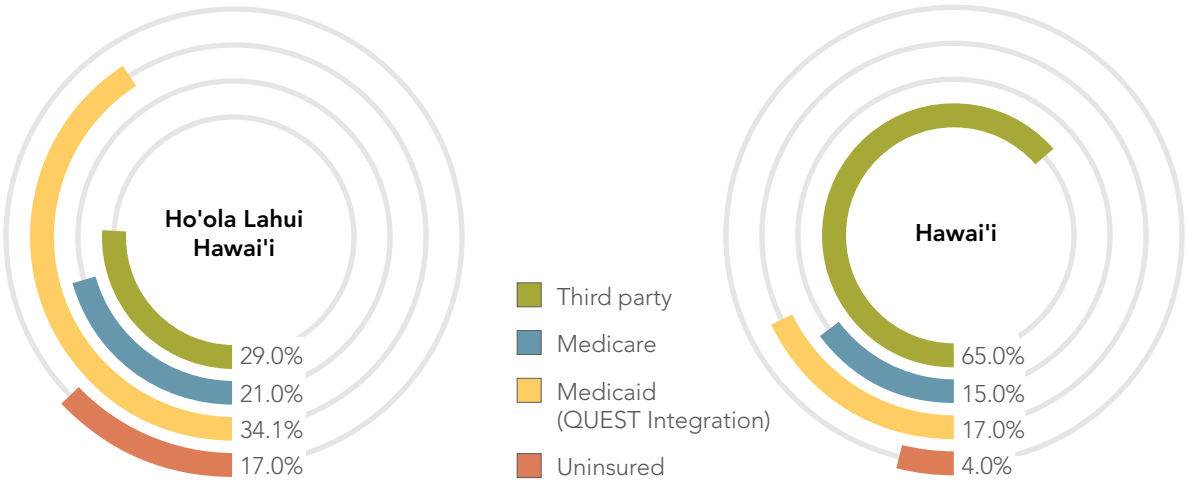
<100% federal poverty level

61.8%

<200% federal poverty level

95.9%

Insurance Type



HMSA Community Grant

Adult Dental Care

Grant Overview

Executive Grant Summary

In August 2009, a comprehensive dental benefit was terminated for adult members of QUEST Integration (QI) plans. Currently, only extractions or emergency visits to alleviate pain are covered. Through the grant, HLH temporarily reinstated the restorative dental benefit to selected adult patients for semi-annual cleaning and services such as fillings, crowns, and dentures. Over two years, HLH provided restorative services to 503 patients. These patients restored their oral health and reported gainful employment, improved self-esteem, and improved diet and nutrition. HLH plans to use these outcomes to continue to advocate with legislators and key stakeholders to reinstate adult dental benefits.

Statement of Need

Terminating the comprehensive dental benefit resulted in tooth decay, loss of teeth, and periodontal disease for adult QI members, all of whom have broader health implications such as poor diet due to inability to eat solid foods, low self-esteem, isolation, and employment issues.[3] Currently, only extractions or emergency visits to alleviate pain are covered.[4]

The elimination of the benefit resulted in an increase of emergency department (ED) visits, which don't provide dental care and can't do much more than send the patient home with pain medication. In 2012, Hawaii saw a 67% increase since 2006 in ED visits for preventable dental problems. This represented more than 3,000 ED visits that accounted for more than $8.5 million in hospital charges. Residents in QI plans accounted for more than half of the ED visits; most were adults 18 - 44 years of age.[5]

HLH offers dental services on a sliding fee scale, but currently has a six-month waiting list for new patients.

Earl Yoshii

Intervention

HLH provided full dental services at their clinics for adults who were enrolled in a QI plan that included semi-annual cleanings and restorative services (e.g., fillings, crowns, bridges, dentures, partials). Services were capped at $1,800 per program year per qualified recipient at no cost to the member.

In addition to restorative services, patients received an individual care plan, preventive dental education with materials to take home for their family, and referrals to other in-house services such as registered dietitians, medical care, case management, fitness support, behavioral health care, and substance abuse treatment. HLH leveraged their outreach staff to support cultural and language barriers with their mostly Native Hawaiian and Filipino populations.

While the primary goal of the intervention was to restore oral health, the secondary goal was to improve the diet of patients who were empowered to eat solid food, gain employment if physically able or of working age, and improve their appearance to promote improved self-esteem and social interactions.

HMSA Community Grant

Adult Dental Care

Outcomes

Financial Capital

Financial capital was not a focus of the outcomes that were measured for this grant.

Manufactured Capital

The main objective of the grant was to provide preventive and restorative dental treatment for adults over age 21 who were enrolled in a QI plan. The following is a breakdown of the services provided.

Adult Dental Care

	No.
Patients seen and received a treatment plan	503
Patients who completed the treatment plan	397
Dental hygiene instructions	688
Exams	250
X-rays	573
Prophylactic cleanings	495
Deep cleaning	128
Fluoride treatment	11
Crowns	224
Fillings	1,437
Root canals	21
Full dentures	40
Partial dentures	84
Adjustments	115
Added tooth/reline dentures	29
Extractions	32

Photo courtesy Hoʻōla Lāhui Hawai'i

Intellectual Capital

HLH's Adult Dental Care program, which provided free services, did not fit within their existing sliding fee scale infrastructure. An alternative process was needed, so HLH established a separate enrollment process with additional guidelines for program participants. The new process was successful in managing program enrollment and patients didn't mind the extra work and were more than willing to meet extra requirements that included education, developing a treatment plan, and completing surveys.

Once the program was established, HLH discovered that they needed to make other changes along the way. Originally, the program was designed with a strict $1,800 cap per person per year. During the grant period, however, the program cap was flexed as some patients didn't use their total allotment while others needed work beyond the cap. Not only did this flexible cap allow patients with greater needs to get the care they needed, but HLH was able to serve additional patients on their waiting list.

HLH also learned that some of their patients were unable to complete the program for various reasons such as unresponsiveness, moving off island, or other personal reasons. While this resulted in the removal of some patients from the program, it allowed the unused funds to be reinvested in others who needed services.

Despite these adjustments that allowed greater reach, HLH is still overwhelmed by the number of patients that need extensive dental services in their community. The incredibly high demand for services resulted in a six-month waiting list.

Another challenge that prevented HLH from completing planned treatments within the grant period was the clinic's capacity and facility space. In 2019, one part-time dentist retired and another reduced office hours from three days a week to two. In June 2020, another dentist took an extended leave for an undetermined period and the dental assistant staff at one HLH dental clinic resigned due to the COVID-19 pandemic.

This decrease in access to dental care coupled with the health center's limited facility space made it difficult for them to accommodate the larger need. As a result, HLH was not able to fulfill all services during the grant period but continues to work toward completing treatment for the remaining program participants.

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Human Capital

Initially, patients were required to take a pre- and post-dental survey about their oral health and how it impacted their lives. Though the post-dental survey was eventually discontinued due to difficulty in contacting patients after their dental visits were completed, patient testimonials from those who completed the program indicate a positive improvement in self-esteem and other aspects of their life.

The pre-survey questions were based on a standardized and validated testing study by Slade GD, ed., Measuring Oral Health and Quality of Life.[6] Patients received a treatment plan based on their input and assessment from the dental staff.

Pre-survey topic	Result
Appearance	55% of patients felt that problems with their teeth, mouth, or dentures had affected their appearance and 58% felt self-conscious.
Health	65% of patients found it uncomfortable to eat because of problems with their teeth, mouth, or dentures while 40% felt that their nutrition suffered because of it. About 38% of patients felt their general health had worsened while 38% felt like it hadn't.
Finances	Only 25% of patients reported that problems with their teeth, mouth, or dentures affected them financially. About 19% felt unable to work to their full capacity because of it. This may be because about 46% of the patients surveyed were 60 years of age and older.
Emotional	About 49% of patients reported that their dental problems made them feel miserable, while almost 44% had feelings of depression. About 46% of patients reported feeling tense or anxious due to problems with their teeth, mouth, or dentures.

Patients provided testimonials after receiving dental services:

A Walmart employee with multiple dental problems and poor oral hygiene lost all her natural teeth. After receiving treatment, she said, "I got lots of compliments from people, especially at work!" Her store manager told her that she received 100% positive comments on her performance as a greeter (via customer survey).

Earl Yoshii

Another patient originally came to the health center as an emergency walk-in due to a lot of pain from her multiple dental problems. She was from Hawai'i Island and traveled back and forth several times to receive treatment. On the day she received her dentures, she said, "I can't wait … I just want to be able to eat." That night, she was able to eat a full meal of fish and mashed potatoes.

Social Capital

HLH's outreach staff successfully spread awareness of the program through regular visits to food pantries. However, through strengthened relationships with existing partner organizations, such as Women in Need and Kauai Economic Opportunity, HLH found a prominent increase in participants through these referral sources.

Internally, HLH hired a case manager who spoke Hawaiian with the Ni'ihau dialect. The case manager accompanied patients from Ni'ihau to their appointments, served as an interpreter, and encouraged them to complete their treatment. The health center saw an increase in participation and outcomes from the Ni'ihau community.

Overall, HLH also saw an increase in patient satisfaction with the health center's services due to the additional dental service offerings during the grant period.

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Conclusion

HLH identified a need that not only impacts the island of Kaua'i, but the entire state. Their intervention temporarily reinstated the dental restoration benefit and provided much-needed preventive services for their QI patients. Improved oral health as a result of restorative procedures and care allowed patients to improve other aspects of their life such as mental health, healthier eating habits, and even employment. HLH will continue to advocate and inform legislators and key stakeholders in state government about the importance of this dental benefit for adult QI members.

HLH plans to use its final evaluation, output data, and patient testimonies to inform legislators and key stakeholders in state government to support the restoration of the adult dental benefit for QI members. A possible cost benefit analysis is recommended to show greater need and the importance of this benefit and overall return on investment for the state and taxpayers. Also, identifying alternatives to improve access to care for adult members in QI plans such as using technology in areas that have a shortage of providers, introducing incentives to encourage dentists to serve QI members, providing loan repayment models for dentists who provide care for them, and expanding scope of practice for other oral health professionals are potential interventions needed to address gaps in care for this population.

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Lessons Learned

Throughout the Community Grant Program, HMSA was able to learn with community health centers (CHCs) within the scope of the program and sometimes beyond. CHCs play a critical role in improving the health of communities; their approach to care is based on looking beyond the traditional scope of medical care to treat the root cause of the problem. The knowledge and experience shared with HMSA is invaluable and should be shared broadly. The following are key lessons and strategic implications for the broader health care ecosystem.

Health priorities in our community can be misaligned with health system priorities. Many QUEST Integration members may deal with health concerns such as chronic pain, mental health issues, dental complications, and many other conditions that reduce one's quality of life and affect long-term health outcomes. When a health system isn't accessible, some people in pain may turn to other behaviors to cope.

Barriers to health system access aren't just physical. In some communities, complex geographic and transportation barriers make it difficult or even impossible for patients to access a health center. However, CHCs understand that access to care means much more than simply removing those barriers. These include cultural barriers, stigma and discrimination, and enduring trauma from past interactions with the health system. These barriers are multifaceted and are compounded for certain populations.

Health systems must develop relationships with cultural ambassadors, community leaders, social service organizations, and other community voices to learn about the barriers their communities encounter and collaborate to create access "bridges."

Trauma is a root cause of health disparity. Some health centers have uncovered a pattern in their communities; past or ongoing trauma seems to be a precursor to multimorbid chronic disease, long-term homelessness, substance abuse, and mental illness. Some communities understand this as historical trauma. Some observe it as interpersonal violence and neglect in families.

In response, some CHCs are being trained in trauma-informed care that shifts the focus from "What's wrong with you?" to "What happened to you?" A trauma-informed approach to care acknowledges that health care organizations and care teams must have a complete picture of a patient's life situation — past and present — to provide effective health care services with a healing orientation.

Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes as well as provider and staff well-being. It can also help prevent unnecessary care and excess costs for both the health care and social service sectors.[1]

Community health workers (CHWs) change lives. A CHW has a passion to work with communities and people who face health and social access barriers. They are often individuals who have shared experiences and shared culture with those they serve. Embodying the core principles of trauma-informed care, CHWs:

- Create a safe space for their patients.
- Build trust through caring, transparency, and responsiveness over time.
- Collaborate with their patients on decisions.
- Recognize their patients' strengths, believe their patients are resilient, and know they have the ability to heal from trauma.
- Understand the trauma, discrimination, and microaggressions their patients face daily.

CHWs build bridges of trust between patients and providers. They advocate for community needs in their health centers to inform system change and program development to improve patient care. A health system that listens to its CHWs is a health system that's connected to its community.


Camille Rockett


Russell Park


Russell Park

Community health outcomes are intertwined with social determinants of health and ethnicity. Nationally, when it comes to important health outcomes, our ZIP code matters more than our genetic code. In Hawai'i, socioeconomic status and ethnicity can vary dramatically in a ZIP code; therefore, these factors are often the most important indicator of health outcomes in our state.

For example, the life expectancy of Native Hawaiian women is 15.7 years shorter than Chinese women in Hawai'i.[2] Native Hawaiians have the highest infant mortality rate in Hawai'i, 2.3 times greater than Caucasians. Forty-five percent of babies born before 28 weeks gestation in Hawai'i are born to Native Hawaiian mothers in low-income communities.[3] Micronesian health disparities are even greater; Micronesians are hospitalized for serious illness at significantly younger ages and with greater severity of illness than their Native Hawaiian counterparts.[4]

Social determinants of health such as income and educational attainment directly affect health-related social needs such as safe and stable housing, transportation, and access to food.

Disparities in social metrics are also aligned with ethnicity. In Hawai'i, Filipina and Native Hawaiian women have the lowest annual earnings ($33,000 and $37,000, respectively), which means that Filipina earn 63 cents and Native Hawaiian women earn 71 cents on the dollar that men in Hawai'i earn.[3] Bachelor's degree attainment differs dramatically based on ethnic group and disparities have remained steady over time.

CHCs take time to learn about the cultural composition and socioeconomic challenges in their service areas to develop approaches to care. The most important sources of data are their patients and community members.

If a certain cultural population has not engaged in care, CHCs will reach out to those communities to learn how to improve engagement. If high school graduation rates are low in their community, they will implement programs to improve engagement in school and college matriculation. To address a health disparity experienced by a local Marshallese community, a CHC may create a diabetes prevention program and hire a Marshallese community health educator to help adapt and facilitate curriculum and to ensure that the program addresses transportation, child care, and food, and to cultivate relationships with participants and community leaders.

Strong community relationships woven into programs like this help ensure continual quality improvement and create pathways to new collaborative, community-driven efforts that address inequity.

Community health centers transform community economies. Many CHCs see themselves as anchor institutions for their service areas. Anchor institutions are large organizations such as universities and hospitals that are part of their communities and have economic interests in the health and safety of their community.

CHCs in Hawai'i use a community wealth building approach that employs and builds on existing assets. This contributes to sustainable ecosystems that directly benefit community members and improve equity. The table below illustrates the impact of a community wealth building approach.[5]

Drivers	Community Wealth Building Approach
 **Place**	Develops under-utilized local assets of many kinds to benefit residents.
 **Ownership**	Promotes local, broad-based ownership as the foundation of a thriving local economy.
 **Multipliers**	Encourages institutional "buy local" strategies to keep money circulating locally.
 **Collaboration**	Brings many players to the table such as nonprofits, philanthropists, anchors, and cities.
 **Inclusion**	Aims to create inclusive, living wage jobs that help families enjoy economic security.
 **Workforce**	Links training to employment and focuses on jobs for those with barriers to employment.
 **System**	Develops institutions and supportive ecosystems to create a new normal of economic activity.

Note: Cited in Data on Community Wealth Building from Communities in Action (2018). [5]

Trusted reciprocal relationships are key. Relationships are foundational to community health. To see positive change in patients, in other community organizations, and even other health plans, we must foster human-to-human connection. The most effective relationships begin and are maintained with curiosity, listening, and empathy. Healthy relationships sustain healthy ecosystems.

An enduring commitment to a human relationship can repair what's broken, whether it's the physical body, trust in a provider, or even a community system of health. Established relationships with CHC employees, leaders, and community partners have helped us learn important lessons.

Every community is different — there will never be a one-size-fits-all solution to improving the health of Hawai'i. As HMSA continues to look at ways to improve the health of our communities, we must also expand our knowledge and understanding of what health means to the people of Hawai'i. As impactful institutions, each CHC's deep connections with the communities they serve are crucial. As the health of communities change, HMSA must also look at ways to adapt and learn.

It is with reverence and gratefulness that we dedicate these lessons learned to the special people who serve our community in Hawai'i's CHCs.

Camille Rockett

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Mahalo

Community health centers (CHCs) play a key role in advancing the health and well-being of the communities they serve. CHCs provide comprehensive and holistic health care and understand the unique needs of their communities and tailor programs and services to meet those needs.

We've learned some valuable lessons throughout the grant process. And one of the most important lessons is that we can't do this alone. It's vitally important to build relationships and collaborate with CHCs to improve the health and well-being of our families, our friends, and our communities.

Mahalo to the CHCs that have opened their doors to let us partner with, learn, and grow with you during the years of the grant. The lessons we learned from your reports, site visits, and talk-story moments are invaluable. We are truly excited to continue growing our partnership with each of you.

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