Kahua Ola Strategic Plan 2.0

NATIVE HAWAIIAN HEALTH

THE QUEEN'S HEALTH SYSTEMS

Kahua Ola (KO) FY23 Annual Report

July 1, 2022 to June 30, 2023

THE QUEEN'S HEALTH SYSTEMS

August 8, 2023

Table of Contents

NATIVE HAWAIIAN HEALTH
THE QUEEN'S HEALTH SYSTEMS

NATIVE HAWAIIAN HEALTH

THE QUEEN'S HEALTH SYSTEMS

SECTION

1

TRANSFORMING OUR NETWORK THROUGH KAHUA OLA

FY23 Ka ‘Ike Pono: Population Health Transformation

NATIVE HAWAIIAN HEALTH
THE QUEEN'S HEALTH SYSTEMS

		FY23 Q3		
	Q3 ACTUAL	THRESHOLD	TARGET	SUPERIOR
POPULATION HEALTH				
Native Hawaiian Health:		✓ Native Hawaiian Health Registry On-line (self-identified) ❑ Implement Kahua Ola 2.0 milestones on O‘ahu, Hawai‘i Island and Molokai communities	❑ 5% decrease no show/cancellation rates for Native Hawaiian (NH) participants in QEC, QWO & QNHCH programs ✓ 5% increase in total unique NH lives touched in FY23	❑ 15% decrease no show/cancellation rates for NH participants in QEC, QWO & QNHCH programs ✓ Achieve Hgb A1c levels of <8 or ❑ <9 in 60% of NHs with Hgb A1c ❑ levels 8 or higher ❑ 30% increase of NHs participating in NHH QEC, QWO, & QNHCH programs
% Decrease in No Show/Cancellation Rates (NHs)	0.2% Increase (Jul 22 vs Jun 23)			
% NHs with Hgb A1c levels of <8 or <9	87.3% improvement (Jun)			
% Increase of NHs in NHH programs	14.4% (N=366) (increase from Jun 22 vs Jun 23) in total # unique NH lives touched in			

	FY22	FY 23	FY 23 Q1	FY 23 Q2	FY 23 Q3	FY 23 Q4
Measure	**Baseline**	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**
Implement Kahua Ola 2.0 milestones on O‘ahu, Hawai‘i Island and Molokai communities	Native Hawaiian Registry Online (self-identified) Phase 1 of 3 Kahua Ola Program Scale-Up to All NH not started	Native Hawaiian Registry Online (self-identified) Phase 2 of 3 Kahua Ola Program Scale-Up In Progress	Phase 2 in progress Program assessment initiated	Phase 2 in progress Program assessment in progress	Phase 2 in progress Program assessment & reports complete	Phase 2 complete Process improvement & recruitment initiated
% Decrease in No-Show/ Cancellation Rates (NHs)	19.7%	0.2% increase	19.2%	21.5%	22.4%	19.9%
% NHs with Hgb A1c levels of <8 or <9	TBD	87.3%	84.7%	83%	84.4%	87.3%
% Increase of NHs in NHH programs	(320)	14.4% (366)	-3.4% (309)	-0.3% (319)	5.3% (336)	14.4% (366)

Source 1: Clarity Report Native Hawaiian Health_202304051305

Source 2: Clarity Report Ka ‘Ike Pono Patients-Encounters FY22 FY23 202307141950

Source 3: Navigator excel workbook: manual tracking

FY23 Ka ʻIke Pono: Transformation in Innovation, Research, & Education

	FY23			
	ACTUAL	THRESHOLD	TARGET	SUPERIOR
INNOVATION, RESEARCH, AND EDUCATION				
Academic Health System Development	TARGET MET	✓ Develop QHS Faculty Development, Graduate Medical Education (GME), Undergraduate Medical Education (UME), and other health professionals Education Strategic Plans	✓ Develop Caregiver Pathway Programs for: ❑ Clinical-Educator & Clinical-Academic faculty ❑ GME primary, specialty & subspecialty professional development & recruitment for QHS sites ❑ UME development & recruitment into JABSOM residency programs ❑ Recruitment-Scholarship programs at Community College, Undergraduate & Graduate Schools for QHS caregiver workforce.	❑ Develop an QHS interdisciplinary education, training & research plan that integrates Hawaii's Schools of Medicine, Nursing, Social Work, Public Health & Clinical Psychology to advance the QHS Aspirational Goals & core strategies ❑ Develop Plan for upstream employment and education, training, & recruitment of Middle and High School students in the health professions
Academic Health System & the Queen's University Research Institutes (QUeRI) to meet the QHS Aspirational Goals	TARGET & SUPERIOR MET	✓ Establish Queen's University Academic Affairs Committee (QUAAC) and associated work committees for faculty, GME/UME students education, and research	✓ Develop QUERI Strategic Research Plan that: 1. Creates a Research Engine to fund & sustain intra- & extra-mural research 2. Sets priorities for developing/ integrating basic, translational, clinical interventional, epidemiologic, & psychosocial research	✓ Genomics Institute – Approval of Capital Improvement Proposal to establish the Institute's 3 core centers & its team leaders for the: 1. Clinical Individualized Genetics Center (CIG-C) 2. Laboratory Genomics Diagnostic Center (LGD-C) 3. Applied Research Genomics Center (ARG-C)

NHHC FY23 Dashboard July 1, 2022 to June 30, 2023

KO PRIORITY	FOCUS		FY22 BASELINE	FY23 THRESHOLD	FY23 TARGET	FY23 SUPERIOR	FY23 ACTUAL	Q1 (July-Sept)	Q2 (Oct-Dec)	Q3 (Jan-March)	Q4 (April-June)
Priority 2: Empower Individuals and Families											
2.1	**Address holisitic needs & increase capacity for health maintenance** Improvement in comprehensive needs assessment (psycho social needs assessment/social determinants of health/pre-visit planning/wellness screens)			Develop & implement comprehensive screening tools & care plan tools, hire & train staff	increase # of meaningful encounters to address SDOH (e.g., transportation, food insecurity, housing) Measured by Assessment and Reassessment of SDOH in EPIC	increase # of meaningful encounters to address SDOH (e.g., transportation, food insecurity, housing) Measured by Assessment and Reassessment of SDOH in EPIC	Standardized Screening tool efforts initiated & Positions Pending Approval & QEC Kilolani 4,883 (Other reports in validation)	Program Assessment Initiated	Program Assessment in progress & SDOH for 1 program QEC Kilolani 3,875 (other reports in development)	Program Assessment complete & Process Improvement Initiated QEC Kilolani 4,508	Workflows Education Initiated with front line & Recruitment Process Initiated & QEC Kilolani 4,883

NOTE: Priority 1.1 & 1.2 are integrated into the QHS Population Health Ka ‘Ike Pono FY23 Goal. Refer to outcomes on pg. 4

NHHC FY23 Dashboard July 1, 2022 to June 30, 2023

KO PRIORITY	FOCUS	FY22 BASELINE	FY23 THRESHOLD	FY23 TARGET	FY23 SUPERIOR	FY23 ACTUAL	Q1 (July-Sept)	Q2 (Oct-Dec)	Q3 (Jan-March)	Q4 (April-June)
Priority 3: Deliver Culturally Responsive Care										
3.1	NHH Cultural Competency Training	N/A	Adapt existing cultural training to for key internal groups	Deploy curriculum to one priority internal group (e.g. System leadership)	Cultural certification developed and awarded to employees who completed training	3 adaptations completed and deployed & Contract Negotiations In Progress for System-Wide Cultural Curriculum, Competency, and Certificate Program	'Āina-based adaptation 1 Cohort of QEC Residents Attend 'āina-based learning & 1 Cohort of QEC Kīlolani Staff Attend 'āina-based training	Wahi Pana adaptation Pilot completed with Queen's Consultant	Wellness Adaptation (Lei Making & Wahi Pana) 1 Caregiver Cohort at Caregiver Wellness Retreat	Contract Negotiations Initiateds for System-Wide Cultural Curriculum, Competency, and Certificate Program & 1 Cohort of NH Service Staff Trained Internally
3.2	Enhance cultural awareness and cultural safety for caregivers	N/A	Hire Archivist/ Historical expert to review, digitize, and manage QHS archives for broader educational use	Develop digital platform(s) to educate staff on Queen's history, Mo'olelo, and Founder's values (e.g. Queen's Enrichment Program)	Develop and implement platform for staff feedback to inform on cultural safety considerations (LENS Board)	Archivist recruitment in progress for call-in position, awaiting applicants & Digital platform development, testing in progress & 3 videos complete	Archivist Job Description in development & Design contract approved. Project Charter initiated for Queen's Enrichment Program (QEP) to develop digital platform	Archivist Position Approval Process Initiated. Approval Pending. & Content development and recording of mo'olelo, history, & educational videos in development	Archivist position on hold, pending re-review in Q4 3 videos complete. Design development in progress of digital platform for Queen's Enrichment Program preliminary introduction to EVPs	Archivist position reclassified to Call-In & awaiting approval & Design development & testing of digital platform in progress

NHHC FY23 Dashboard July 1, 2022 to June 30, 2023

KO PRIORITY	FOCUS	FY22 BASELINE	FY23 THRESHOLD	FY23 TARGET	FY23 SUPERIOR	FY23 ACTUAL	Q1 (July-Sept)	Q2 (Oct-Dec)	Q3 (Jan-March)	Q4 (April-June)
Priority 4: Engaged Community										
4.1	Engage self-identified NH in the Data Registry to ensure data drives future decisions and engage NH in participation in such registry to drive trust and equitable access	107,747 unique Part-Hawaiians (over 3 years) via Epic NH flag identified and served through Queens (Phase 1)	Complete Phase 2 (engagement) of Native Hawaiian Health Registry On-line (self-identified) obtaining consent	Phase 3.1 Identify # of unique NH served in the last 3 years (location/region) and contact NH to obtain consent to use data	Complete methodology and contact of 5% of NHs within QHS to enroll in the NH Data Registry Program and participate in NH programs (retrospectively) (Prospectively) new patients would be enrolled at new contact/intake	113,616 (+5.45%) unique Hawaiians (over 3 years) Development of EPIC Registry & Analytics App in progress	Healthy Planet Project Scoping initiated for EPIC Registry Development & NH Data Qlik View Analytics App Scoping Started	in progress	Healthy Planet Project Scoping & Charter Completed - Epic Registry Development Initiated NH Data Qlik View App in Validation	113,616 (+5.45%) unique Hawaiians (over 3 years) Development of EPIC Registry & Analytics App in progress

Community Health Needs Assessment & Strategic Partnerships

CHNA PRIORITIES	QHS NATIVE HAWAIIAN HEALTH PRIORITIES
Financial Security	Improve Health and Well Being
Food Security	Empower Individuals and Families
Mental and Behavioral Health	Deliver Culturally Responsive Care
Housing	Engage Community
Trust and Equitable Access	

Native Hawaiian Community Partners

- Papa Ola Lōkahi & NH Health Care Centers
- Ke Kula Nui o Waimānalo
- Puʻuhonua o Waiʻanae
- Liliʻuokalani Trust
- Kamehameha Schools
- King Lunalilo Trust
- Office of Hawaiian Affairs
- Council for Native Hawaiian Advancement
- I Ola Lāhui
- Kula no nā Poʻe Hawaiʻi
- Ulu Network
- The Kohala Center
- Kanu o Ka ʻĀina New Century Public Charter School
- Nā Kālai Waʻa
- Hui Mālama i ke Ala ʻŪlili (HuiMAU)
- Kū-A-Kanaka

AHARO Virtual Accountable Care Organization (ACO)

- Waiʻanae Coast Comprehensive Health Center
- Waimānalo Health Center

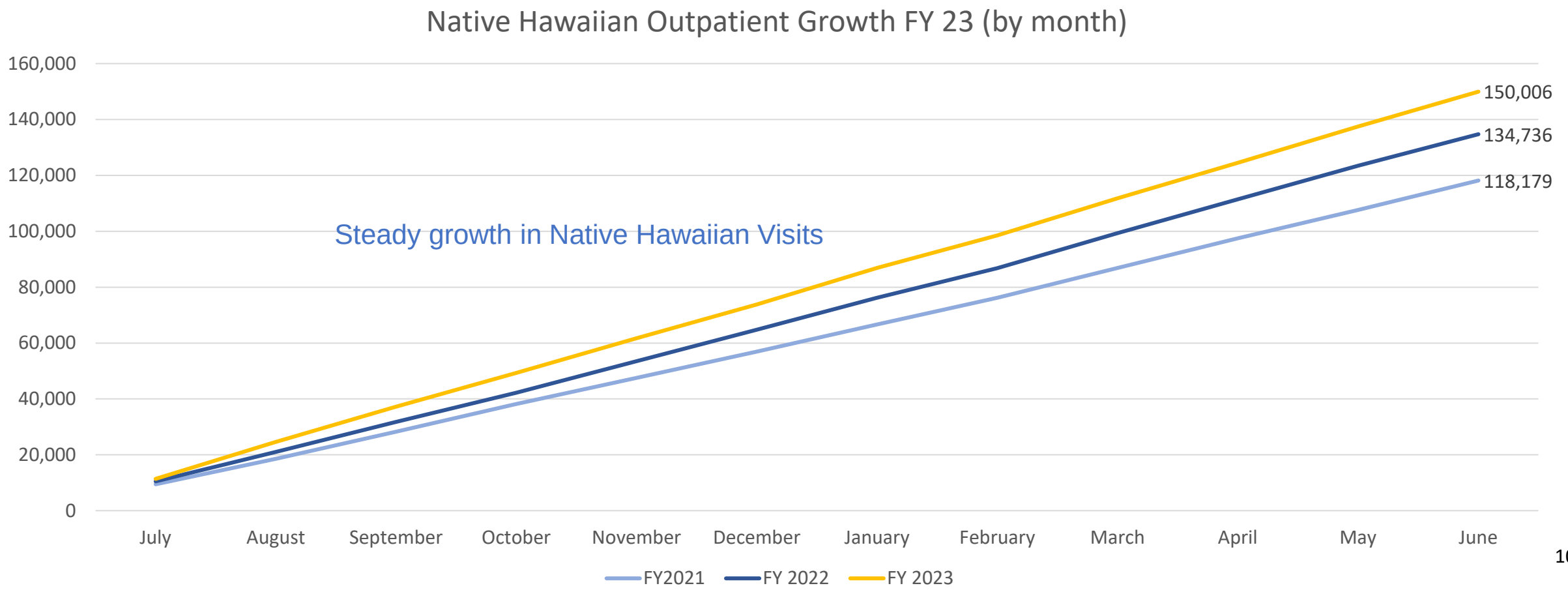
Other NH Serving Federally Qualified Health Centers

- Hawaiʻi Island Community Health Center
- Kōkua Kalihi Valley

Serving More Native Hawaiians Year-Over-Year in Ambulatory for Upstream Care

FY23 Native Hawaiian Outpatient Visit Growth Rate (Year-Over-Year Comparison)

	FY 19	FY23	FY 21	FY 22	FY 23
Measure	**Baseline**	**3 YR Increase**	**Actual**	**Actual**	**Actual**
Growth Rate in QHS NH Outpatient Visits	94,970	**58% (150,006)**	24.4% (118,179)	14% (134,736)	**11.3% (150,006)**

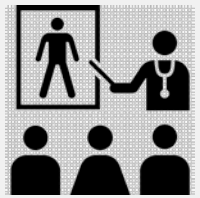


Following-Through on Recommendations from Native Hawaiian Studies & Reports

- **Disaggregated data and longitudinal tracking – in progress**
  - ✓ Papa Ola Lōkahi data sharing agreement executed
  - ❖ QHS data infrastructure development in progress
- **Virtual health access – in progress**
  - ❖ Remote Patient Monitoring in progress
  - ❖ DHHL telehealth grant in progress
- **Preventive care aimed at youth, younger adults, and older adults – in progress**
  - ✓ Ola Hou I Ka Hula (Hula For Hypertension) at EmPower Health
  - ❖ Scoping access opportunities for at-risk youth (Lili'uokalani Trust)
- **Integration of traditional Hawaiian practices – scope in progress**
  - ❖ Collating feedback from Native Hawaiian leaders meetings
- **Native Hawaiian primary care system – exploration in progress**
  - ❖ Expanding culturally responsive patient-centered medical home models for Primary Care
- **Community-based healthcare teams – in progress** in 2 programs, pending expansion for third
- **Address mental health stigma** – Successful behavioral health integration program at QNHCH, developing model for expansion
- ❑ **Place-based care in communities**

MEDICAL SERVICES

✓ Completed
❖ In Progress
❑ Not Started



HEALTHCARE WORKFORCE

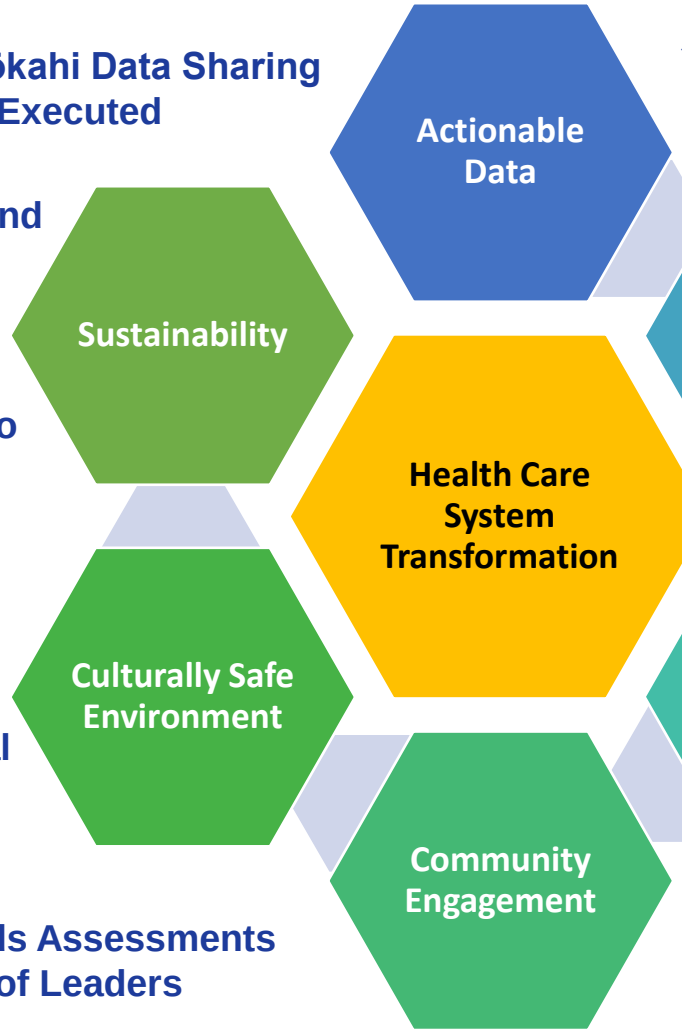
- **Cultural competency and culturally safe environments**
- **Providers trained in integrative approaches**
  - ❖ Lāhui o ka Pō Native Hawaiian birthing
- **Native Hawaiian workforce development –** internal and external
- **Behavioral health providers** – expansion in 1 program
- ▪ **Longitudinal tracking of Native Hawaiian workforce –** DEIJ CW Strategic Plan Roadmap
- ❑ **Improve quality of life, financial security, and resources for Native Hawaiian health workforce**

Source [1]: E Ola Mau a Mau Report; http://www.papaolalokahi.org/native-hawaiian-programs/native-hawaiian-health-needs-assessment.html

Source [2]: Expectations, Wants, and Needs of Native Hawaiian Patients and Communities, Keawe'aimoku Kaholokula, PhD, October 2021

Continuing to Develop the Population Health Infrastructure for Transformational Change

Key Initiatives in Progress to Support Health System Transformation for Health Equity to Achieve our Aspirational Goals

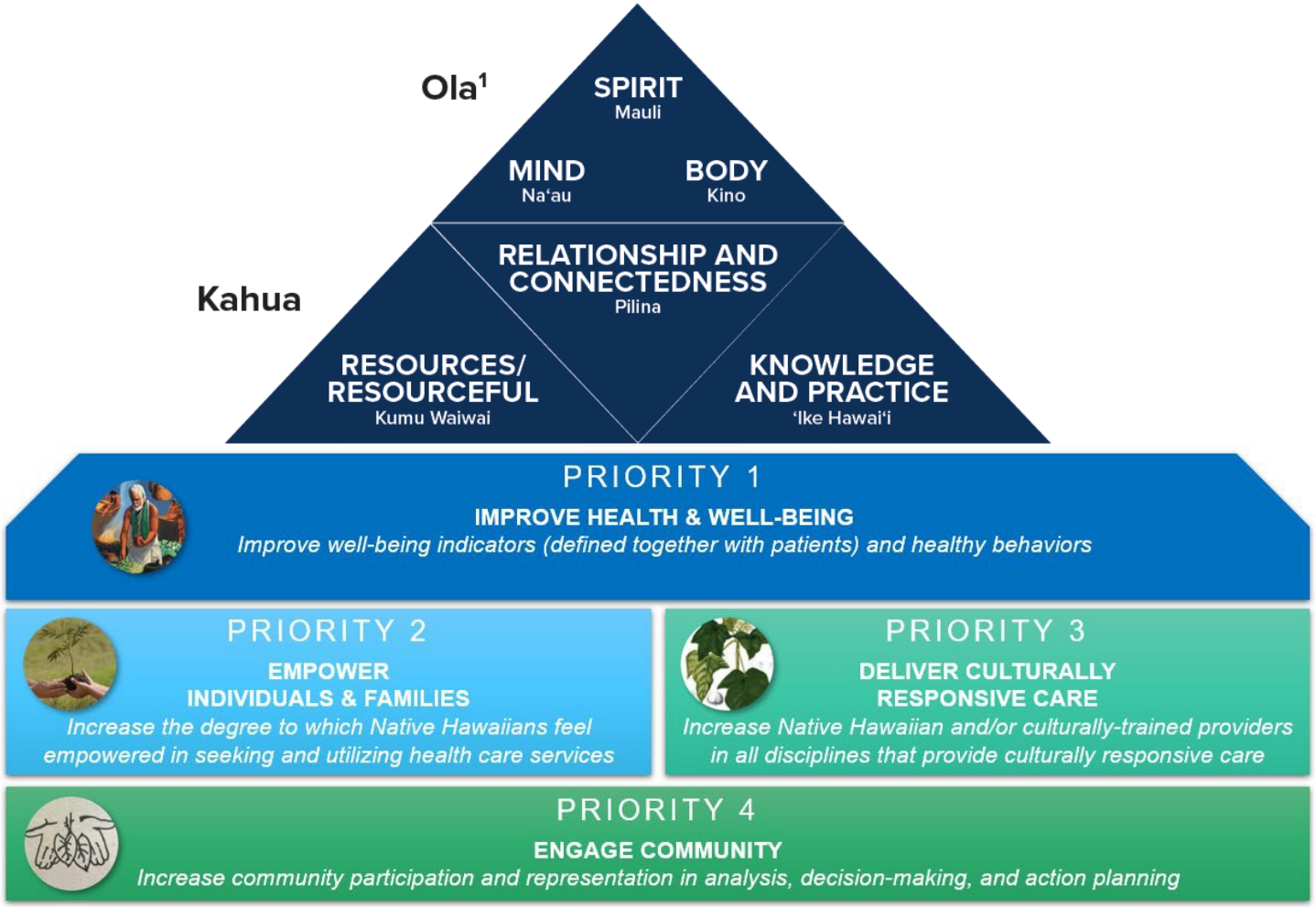


- ✓ Papa Ola Lōkahi Data Sharing Agreement Executed
- ❖ Healthy Planet Epic optimization (to Improve Data Collection)
- ❖ Development of robust outcomes reports
- ❖ Developing Grant and Research Core
- ✓ Kahua Ola program needs assessment complete
- ❖ Process improvement, workflow, and procedure development
- ❖ Contract negotiations started to develop cultural curriculum, competency, and certificate
- ✓ Native Hawaiian Health Federal Designation awarded
- ❖ Developing legislative plan and partnerships with aligned priorities
- ❖ Developing culturally grounded design experience standards focused on cultural and environmental stewardship
- ❖ Community Health Needs Assessments
- ❖ Community Convening of Leaders
- ❖ Evolving community engagement strategy

*** Data * People * Process * Partnerships**

NATIVE HAWAIIAN HEALTH
THE QUEEN'S HEALTH SYSTEMS

FY23 Summary & Highlights



GOAL 1

HEALTH CARE ACCESSIBILITY

Build trust and accessibility for Hawaiians in targeted communities

GOAL 2

COMMUNITY SERVICES SUPPORT NETWORK

Connect patients to resources in the community to address health-related social needs

GOAL 3

TRAINING AND EDUCATION

Promote and support training and education of culturally responsive approaches to care delivery

ACCOMPLISHMENTS

5

Culturally-safe Clinical Programs across the health system continue or expand

(primary and specialty care)

83

Community Partnerships

(SDOH, impact evaluation, research, cultural and spiritual connectedness, data, education/awareness, COVID, access to services)

224

Training & Learning Activities

(engagement with employee focus groups, cultural learning, spiritual and cultural connectedness, health education)

33

Health Care Scholarships

(awarded)

FY23 KO Priorities: Summary and Highlights

P1 IMPROVED HEALTH & WELLBEING

Webinars:

- Nutrition webinars (3 part series)
- Medicare webinar (3x)
- Hawaiian language and health (2 part series)
- Kī hōʻalu in person series (4 part series)
- Modern stroke management
- Gout

P2 EMPOWERED INDIVIDUALS & FAMILIES

Birthing a Nation Moku o Keawe

- Primary Audience – NH Families (N=8)
- Total of 6 classes, 9 topics

Participants shared:

- *"The big takeaway is that we have a right to our cultural practices and reigniting or sometimes creating some of those cultural traditions for our ʻohana will often start with our own ʻiʻini {desire)".*
- *"Tonightʻs class shared wonderful perspective about the link between our physical body and our deeper intellectual, emotional and spiritual bodies".*

P3 DELIVER CULTURALLY RESPONSIVE CARE

- LENS Board
- Queen's Enrichment Program
- ʻIolani Palace Tour
- Queen Emma's Birthday Commemoration
- King Kamehameha IV's Birthday Commemoration
- Prince Albert Edward's Birthday Commemoration
- JABSOM DNHH Contract Re-Negotiation
- Moʻoʻōlelo o nā Aliʻi for Leadership
- Weekly *He Momi* Language Articles

P4 ENGAGE COMMUNITY PARTNERS

Waimea Community Leaders Meetings

- "The ʻāina needs to be in the strategic plan. When the ʻāina thrives, we thrive."
- "Restoration is the intervention."
- "What is health? A community figuring it out for themselves and creating the mechanism."
- "Aloha is imperative for our social and emotional health."
- "When Natives thrive, everyone benefits."

NATIVE HAWAIIAN HEALTH
THE QUEEN'S HEALTH SYSTEMS

NATIVE HAWAIIAN HEALTH
THE QUEEN'S HEALTH SYSTEMS

Community Health Needs Assessment (CHNA)

KILOLANI STAFF MEANINGFUL ENCOUNTERS TO ADDRESS CHNA

FY 23 Encounters Ever= 4,628

FINANCIAL SECURITY	FOOD SECURITY	MENTAL & BEHAVIORAL HEALTH	HOUSING	TRUST & EQUITABLE ACCESS
TBD	170	574	172	3,712

[1] Source: EDS. Report 969 – 092 "…Patient with SDOH_Statistics CARE*link" Timeframe: FY23 YTD 04/01/2023

NATIVE HAWAIIAN HEALTH
THE QUEEN'S HEALTH SYSTEMS

Kahua Ola 10-Year Strategic Priorities

Kahua Ola II Plan Implementation Strategy	Progress
1. Population Health Programs	In Progress
A. Kilolani - Chronic Disease Management & Primary Care (Queen Emma Clinics) Scale-Up	In Progress
B. Kahu a Ola - Integrated Primary Care & Behavioral Health (QNHCH) Scale-Up	In Progress
C. Nā Pua Kaiona - Navigation, Wound Care & ~~Primary~~ Specialty Care (QMC WO) Scale-Up	In Progress
D. Workforce development plans for QNHCH, MGH, QMCM, QMCW	In Progress
E. Assess/Develop strategic approach to engage/care for NHs from birth throughout lifespan	In Progress
2. Native Hawaiian Health Registry	In Progress
A. Develop ethnicity metrics for data/strategic alignment w/ NH-serving organizations	In Progress
B. Design & test procedures for data collection for patients entering QHS facilities	In Progress
C. Develop IT markers for NH morbidity, mortality, and quality metrics & outcomes	In Progress
D. Test prototype design & refine final procedures/metrics	In Progress
E. Go Live for all QHS facilities and begin monthly CARE*Link data collection	Not Started

Kahua Ola 10-Year Strategic Priorities Continued

Kahua Ola II Plan Implementation Strategy	Progress
3. Native Hawaiian Community Engagement – at least 4 priority regions (e.g. North & West Hawai‘i, Waimānalo, West O‘ahu, Molokai	In Progress
A. Convening Native Hawaiian Placed-Based Leaders	In Progress
B. Identification of needs, expectations, preferences, and priorities respective of Kahua Ola strategic alignment	In Progress
C. Strategic partnership & alignment where applicable to achieve QHS aspirational goal	In Progress
4. Cultural Integrity, Assessment, Education & Training	In Progress
A. NH cultural assessment of entire system & develop action plan	Not Started
B. Hire archivist & historical librarian to review, digitize, & manage QHS mo‘olelo	In Progress
5. Grant Writing Core - build grant writing core	In Progress
6. Legislative Strategy & Aims	In Progress
7. Molokai Population Health Transformation - Community Assessment & Planning	On Hold
8. Oncology Education/ Engagement Program – Business Case, Pro-forma, Approval, Execute	On Hold
9. Population Health Scale Down or Revision of Community-based Programs	Complete
10. Genomics Institute	In Progress
11. Ambulatory Native Hawaiian Cultural Behavioral & Psychiatric Treatment Program	Not Started

SECTION

2

NATIVE HAWAIIAN HEALTH

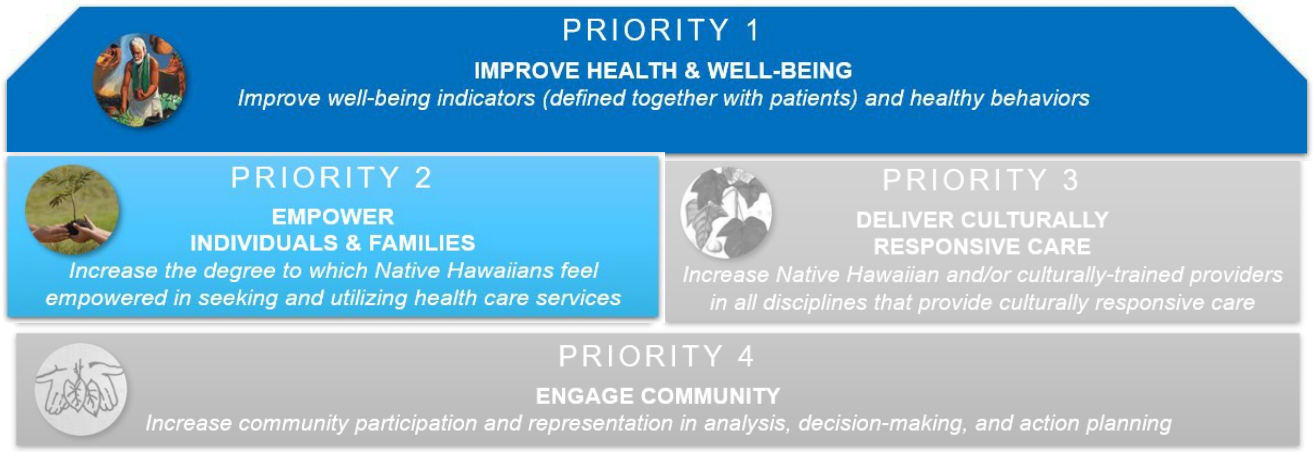
THE QUEEN'S HEALTH SYSTEMS

FY23 KAHUA OLA Performance Report

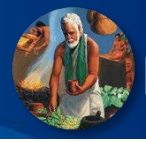
NATIVE HAWAIIAN HEALTH

THE QUEEN'S HEALTH SYSTEMS

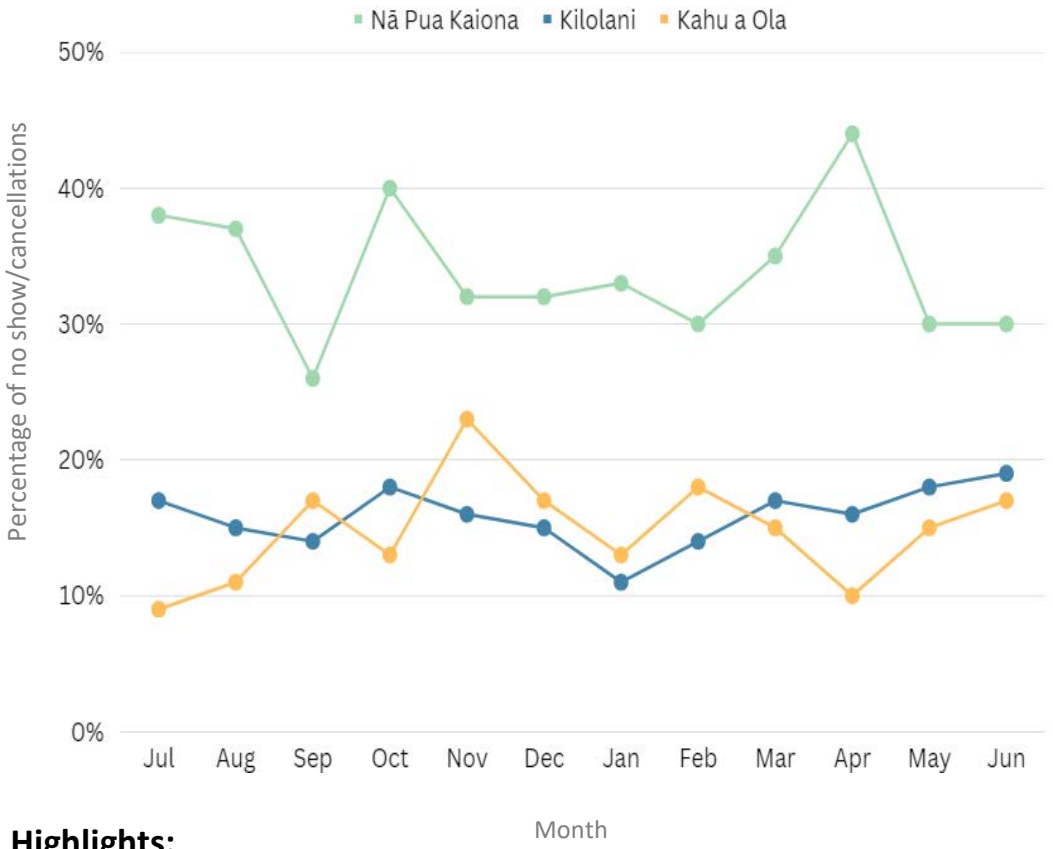
TRANSFORMATION IN CLINICAL CARE
Goal 1: Kumu Waiwai- Health Care Accessibility



Patient Access & Engagement: No Show/Cancellations



Month-to-Month No Show/Cancellations of Patients Who Did Not Reschedule in FY23 for ALL Programs

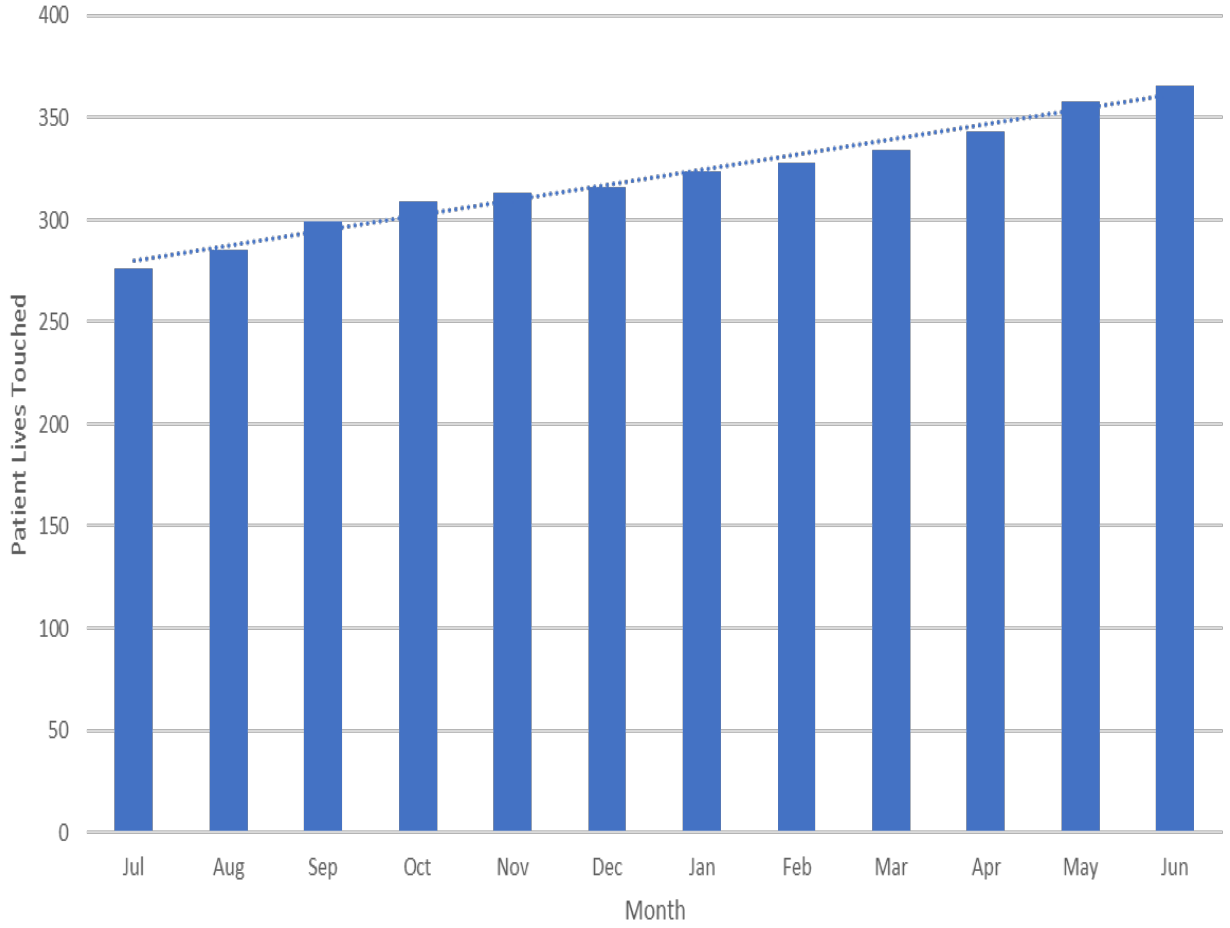


Highlights:

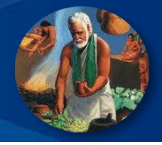
- **19.9%** overall no show/cancellation rate among patients who did not reschedule
- **15.1%** no show/cancellation rate in Kahu a Ola
- **15.9%** no show/cancellation in Kilolani
- **33.5%** no show/cancellation rate in Nā Pua Kaiona

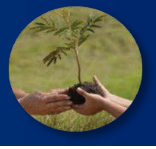
Steady Increase of the total # of new unique patients enrolled In NHH Programs

Despite Hiring Delays, Programs Continue to Serve New Patients



QEC Kilolani Ka ʻIke Pono Performance Report





KEY TAKEAWAY: Kilolani intervention patients were more engaged with care and saw better clinical outcomes than non-intervention group

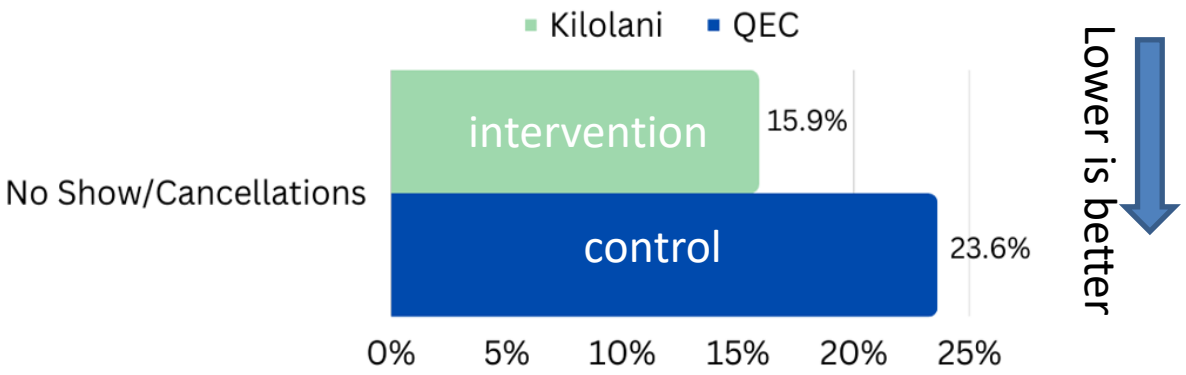
PROJECT UPDATE **Status** (✓ Completed ❖ In Process ☐ Not Started)

Scale-Up Progress ❖

- Program assessment complete
- Position requests submitted for interdisciplinary team staff (i.e., RN ops manager, 2 Navigators)
- Request approval from labor relations for approval of nurse and clinical support staff
- Healthy planet epic optimization underway to improve care delivery, data collection, quality and completeness
- Data registry and reports in development
- Process improvement strategies in development and workflow education for staff underway

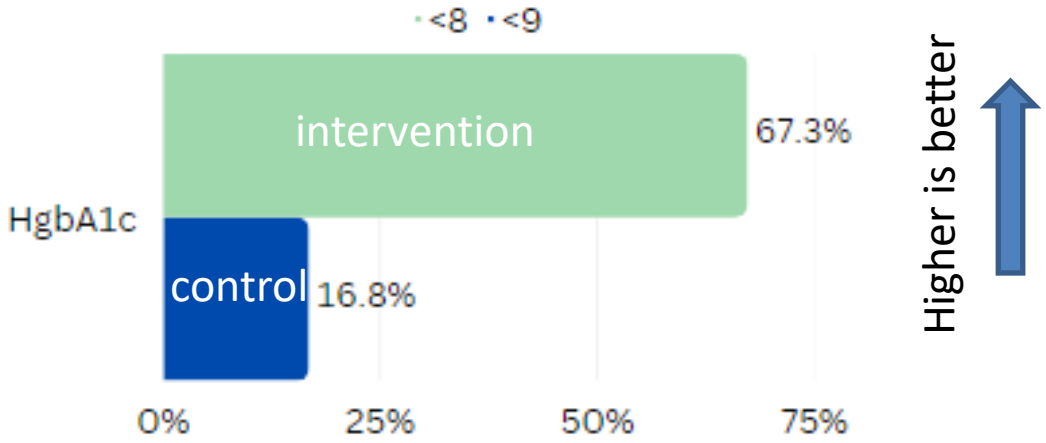
QEC non-intervention patients are **1.5x more likely to cancel or no show** their appointments compared to Kilolani patients.

No Show/Cancellation Rate of QEC Kilolani Patients Compared To Non-Intervention QEC Native Hawaiian Patients



84.1% of Kilolani intervention patients **decreased their HbA1c** by at least 1.0 point to <8 or <9

Percentage of QEC Kilolani Patients who decreased HbA1c by ≥1.0 to <8 or <9

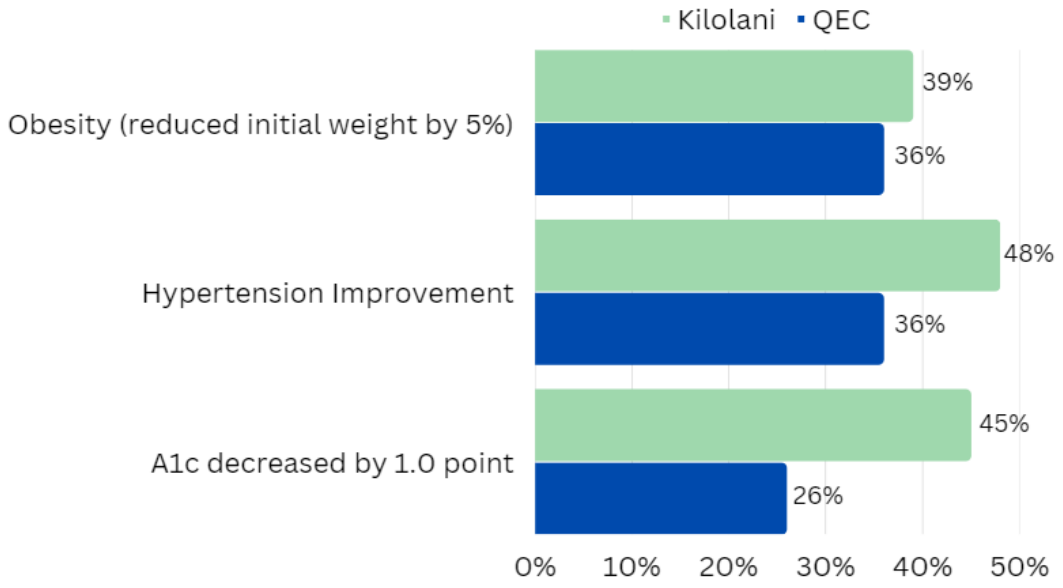


Source: Clarity Report Ka Ike Pono Patients - Encounters FY22 FY23 202307061530, Ambulatory Dashboard, & Clarity Report Ka Ike Pono - HbA1c - FY22 to FY23 202307031343

QEC Kilolani Patient Improvement in Clinical Outcomes

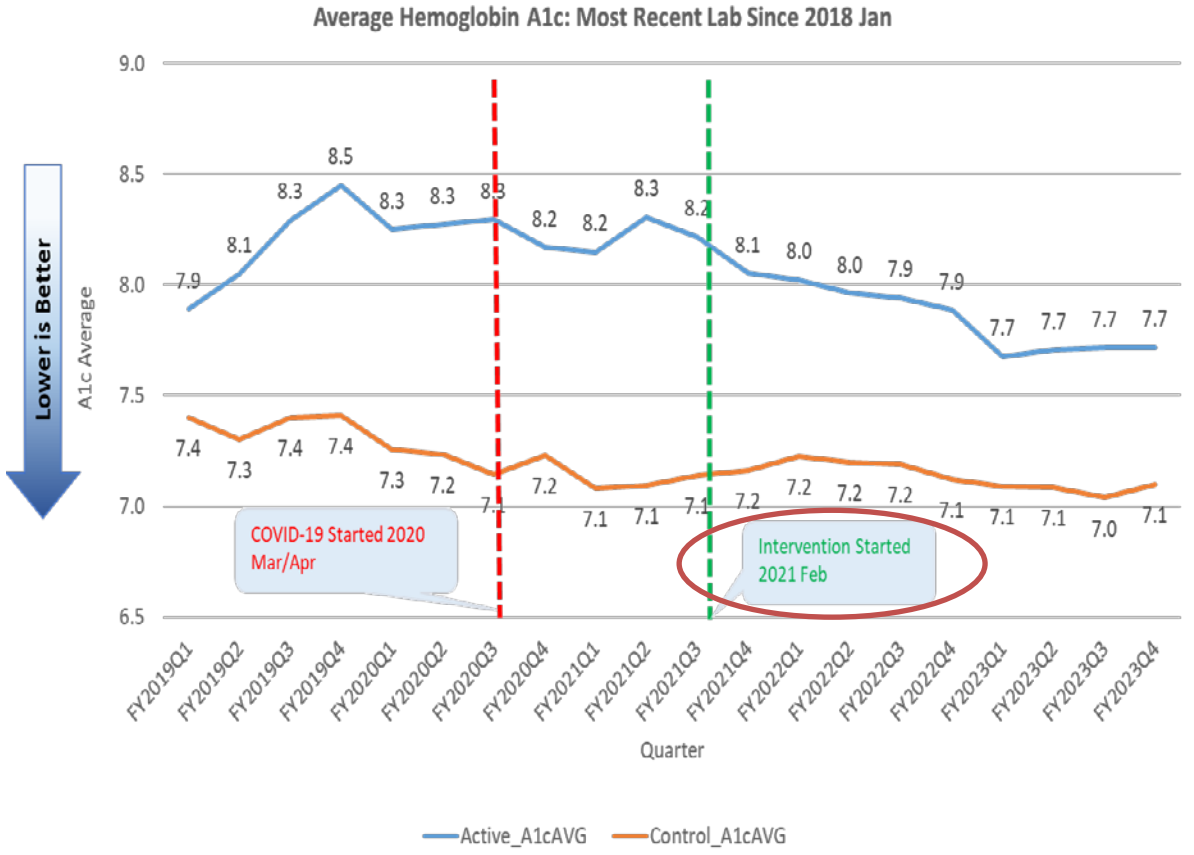
QEC Kilolani patients saw significant improvement in clinical outcomes

Improved weight, blood pressure, and HbA1c compared to QEC non-intervention control group



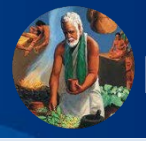
NOTE: QEC non-intervention control group is stratified to mirror similar demographics to Kilolani patients

QEC Kilolani patients **average Hemoglobin A1c saw improvement post-intervention** compared to control group



Source: Kilolani Monthly Report & Kilolani Quarterly Report

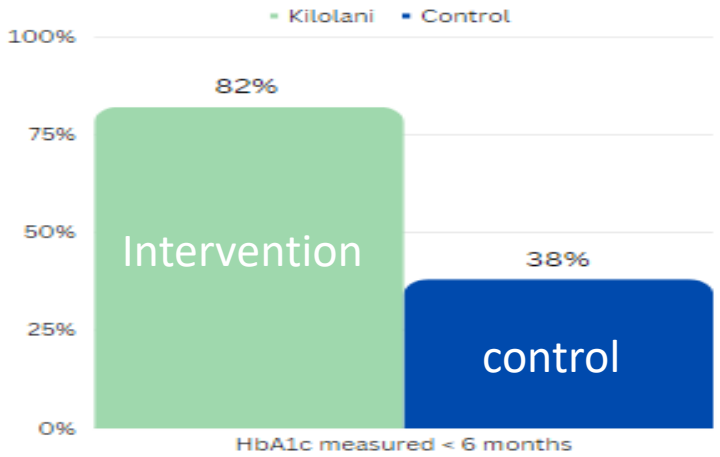
QEC Kilolani Results Indicate Patients Are Engaged Despite High-Risk



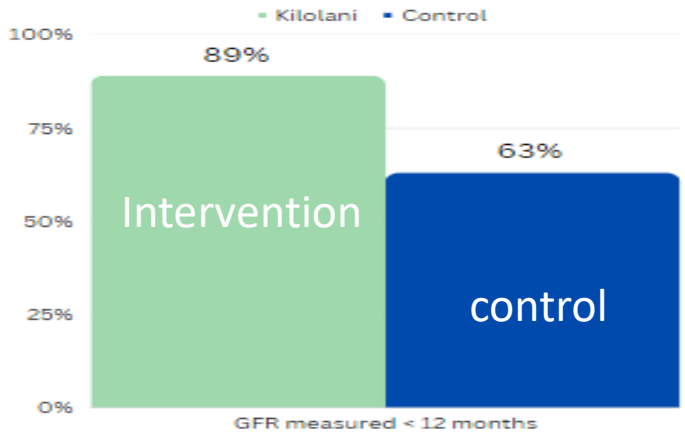

P1 P2

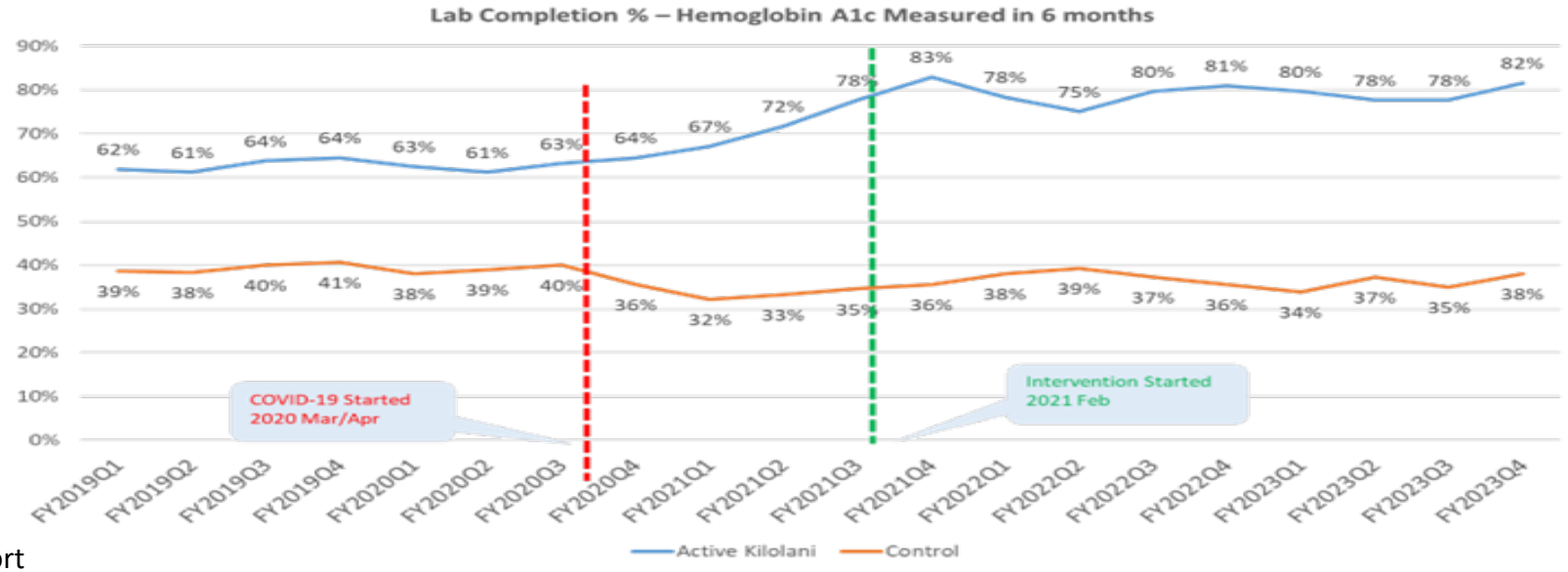
Compared to the control group, over 80% of Kilolani patients completed A1c and GFR labs

HbA1c lab completion



GFR lab completion



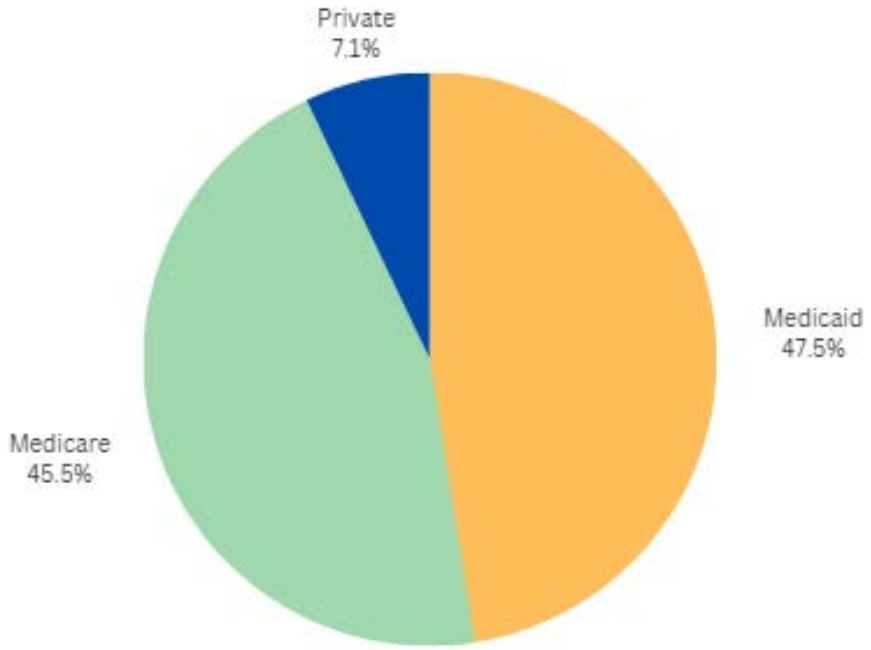


Source: Kilolani Quarterly Report

QMC QEC Kilolani Patient Demographics

Approximately **93%** of QEC Kilolani patients are **Living Below Poverty** or are **Aged, Blind, or Disabled**

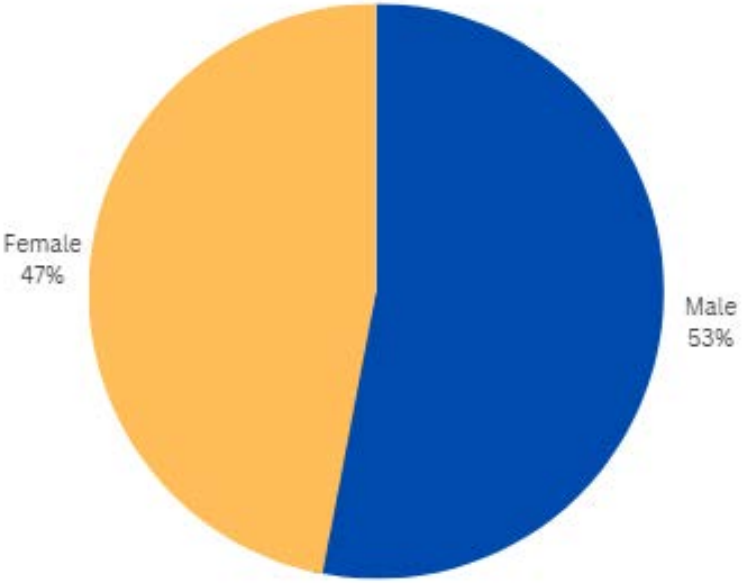
QEC Kilolani Insurance Coverage



Limited info on percentage of **Patients who Identify with a Non-Binary Gender**

Median Age
N= 61
(Age Range 25 to 88)

QEC Kilolani Gender



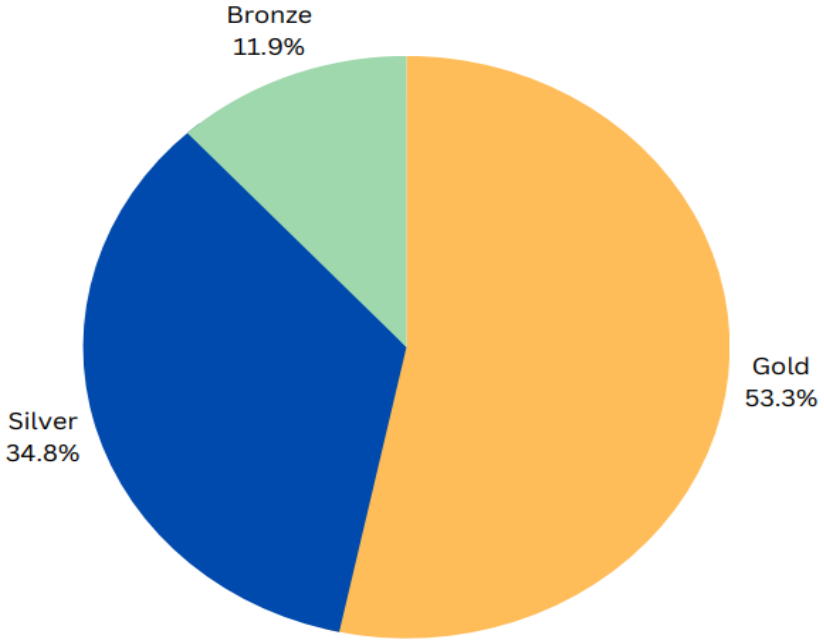
Source: Kilolani Quarterly Report

QMC QEC Kilolani Risk Stratification & Acuity

50% of the population **have substance or meth use**

	CURRENT Smoker	FORMER Smoker	SUBSTANCE Use	METH Use
HISTORY OF	**29 (21%)**	**60 (43%)**	**35 (25%)**	**35 (25%)**

Acuity Levels Based on Risk Assessment



Over 50 % of the population **are highest acuity (Gold) with:**

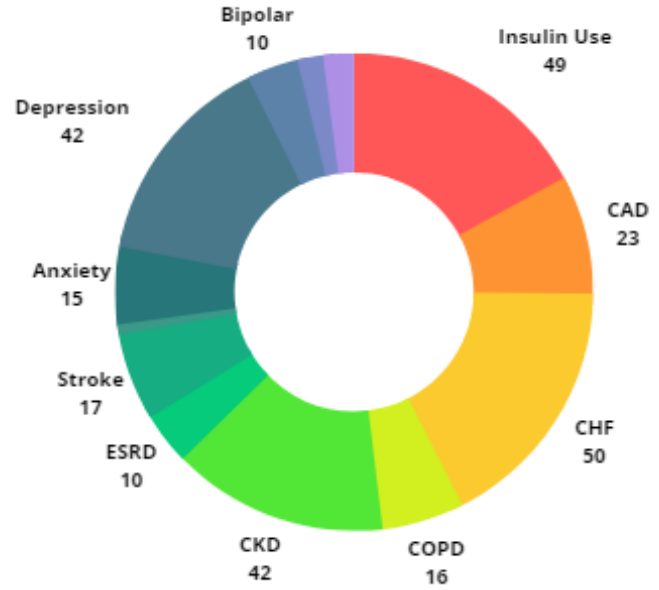
- multple risk factors
- Social Determinants of Health (SDOH)
- high or uncontrolled HbA1c
- and multiple comorbidities

Gold=Highest Risk **Silver**=Medium Risk **Bronze**=Lowest Risk

Source: Clarity Report-Kilolani 969 Report

Risk Assessment Factors By Unique Patient

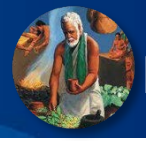
(Insulin usage, Comorbid Conditions, & Psychiatric Conditions)



Top 5

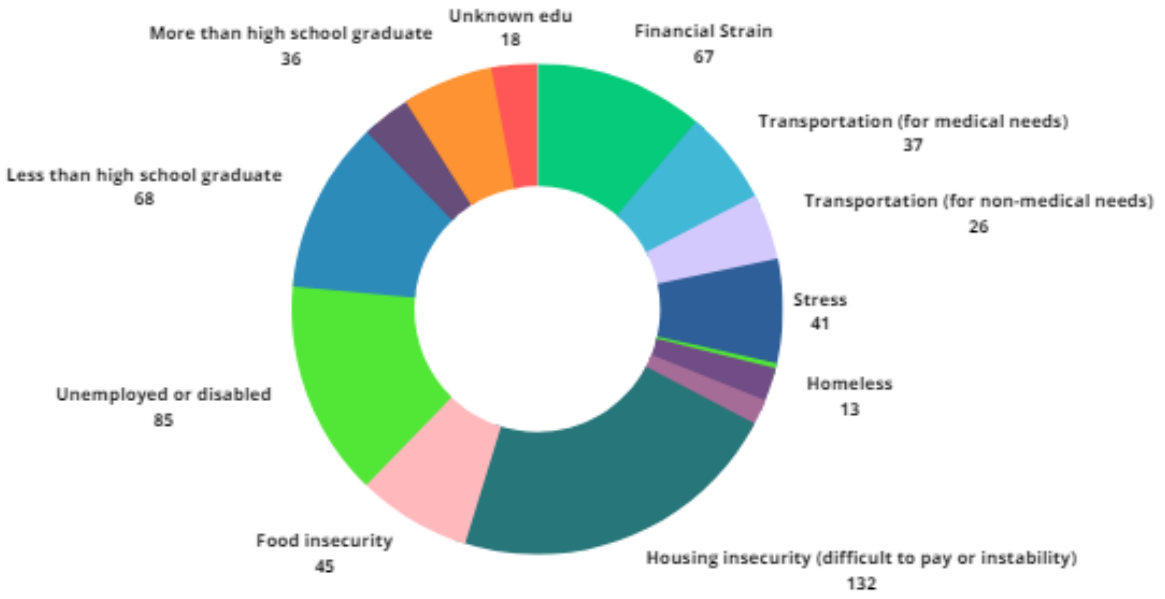
35%	35%	30%	30%	16%
Insulin Use	CHF	Depression	CKD	CAD

QEC Kilolani Program Population Needs Assessment



Majority of patients report significant SDOH

Social Determinants of Health



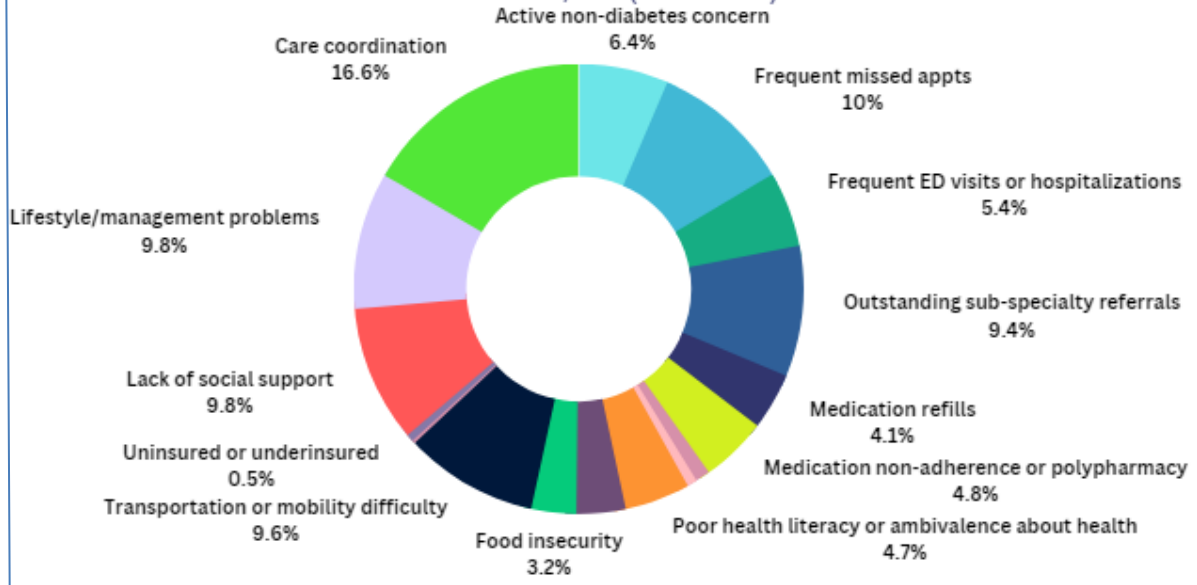
Top 5

94%	60%	48%	48%	32%
Housing insecurity	Unemployed or disabled	Less than high school graduate	Financial Strain	Food Insecurity

Over 5,000 interventions were facilitated by Kilolani team to address SDOH

SDOH Interventions/Barriers to Care

n=5,272 (total ever)



Top 5

17%	10%	10%	10%	10%
Care Coordination	Frequent Missed Appts	Lifestyle/ management problems	Lack of social support	Transportation or mobility difficulty

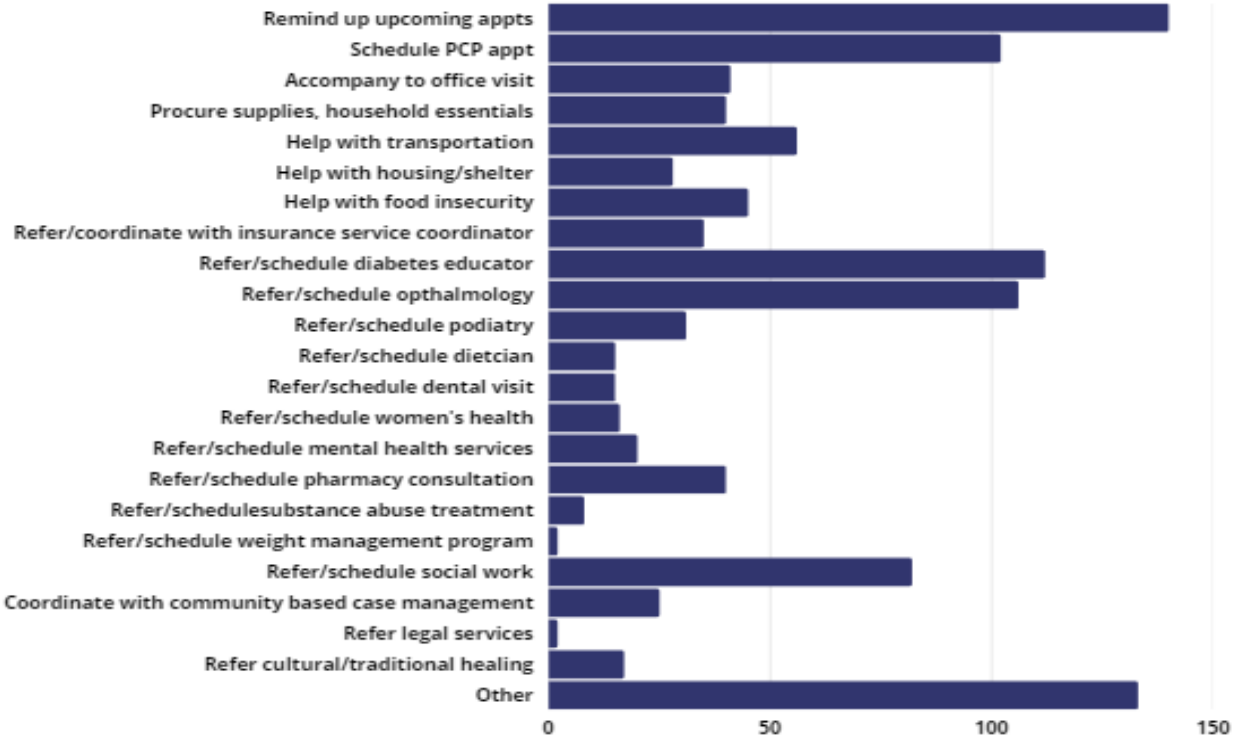
Patient-Centered Culturally Responsive Interventions


P1

P2

Completed Interventions by Patient Ever for Patient Gaps/Barriers to Care

n=1,121



Top 5

140 (12%) Remind of upcoming appts

133 (12%) Other

112 (10%) Refer/schedule diabetes educator

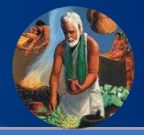
102 (9%) Schedule PCP appt

106 (9%) Refer/schedule opthamology

More Work is Needed to Improve Data Completeness – Efforts Underway

Comprehensive Patient Assessments and Follow-up Enable Culturally Responsive Patient Centered Care

QNHCH Kahu a Ola Ka ʻIke Pono Performance Report

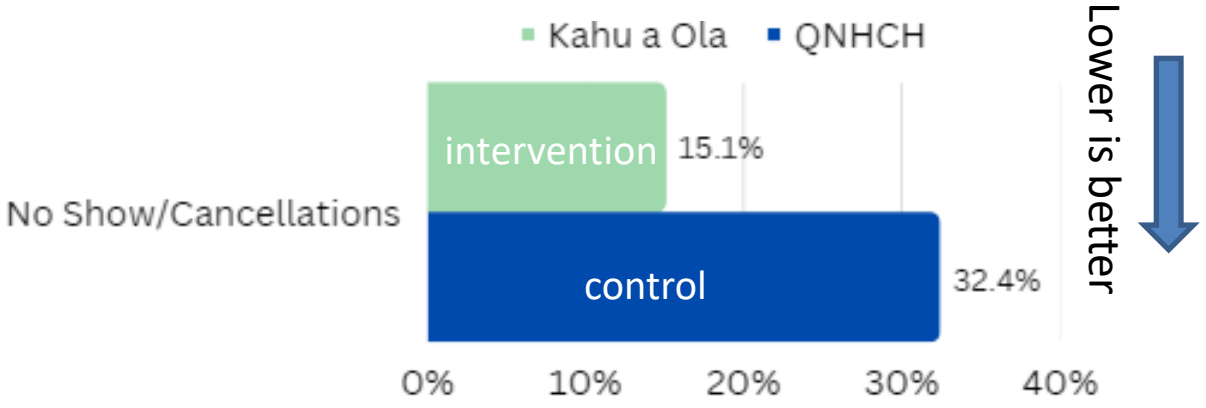

P1

P2

PROJECT UPDATE	Status	(✓ Completed ❖ In Process ☐ Not Started)
Scale-Up Progress	❖	• Navigator hired in Q4. Social worker position approved in Q4. RN Oprations Manager position pending approval • Program assessment complete. Gaps identified in completeness of HbA1c data due to inability for EPIC to interface with Clinical Labs of Hawaiʻi and standardize data input workflow in clinic to improve HbA1c data completeness • Process improvement strategies being developed and deployed • Healthy planet epic optimization underway to improve care delivery, data collection, quality and completeness • Data registry and reports in development • Process improvement strategies in development and workflow education for staff underway

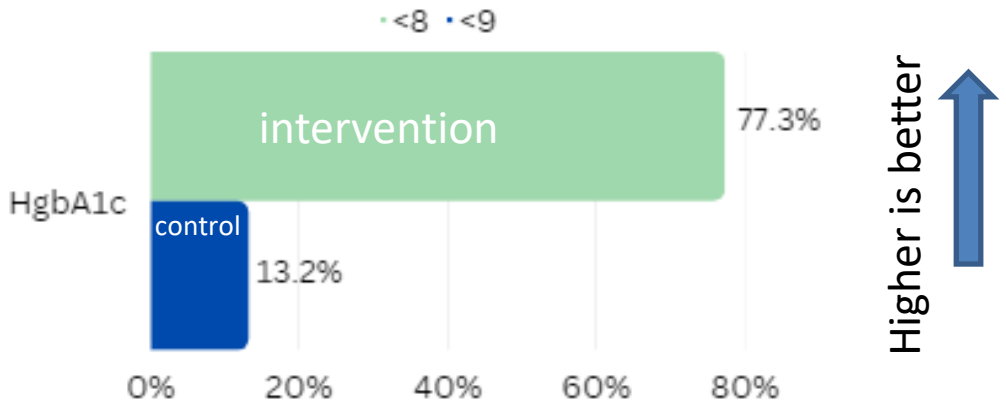
<u>QNHCH Kahu a Ola patients are half as likely to no show or cancel</u> compared to QNHCH Primary Care Patients.

No Show/Cancellation Rate of QNHCH Kahu a Ola Patients Compared To QNHCH Primary Care Patients



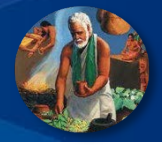
<u>90.5%</u> of Kahua a Ola patients **<u>decreased</u>** their **<u>A1c by 1.0 point to <8 or <9</u>**

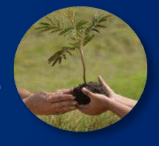
Percentage of QNHCH Kahu a Ola Patients who decreased HbA1c by ≥1.0 to <8 or <9



Source: Clarity Report Ka Ike Pono Patients - Encounters FY22 FY23 202307061530, Ambulatory Dashboard & Patient Navigator Records/Clinical Labs Hawaii

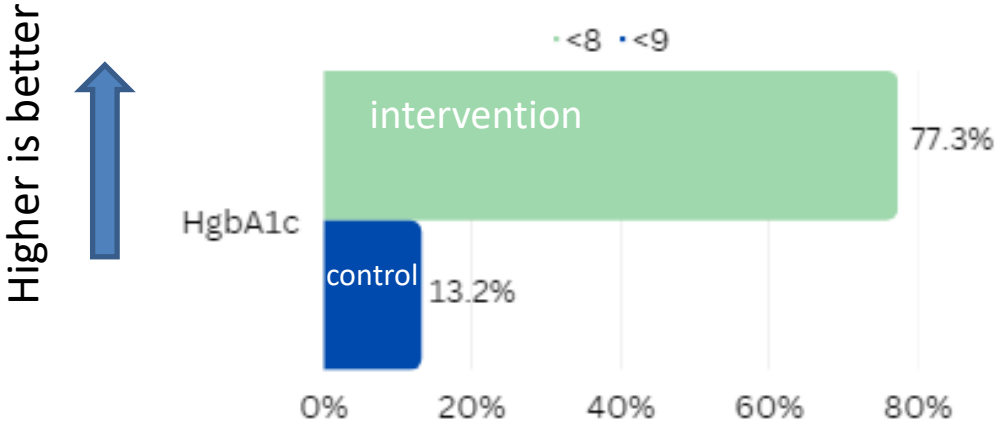
QNCHC Kahu a Ola Patient Improvement in Clinical Outcomes





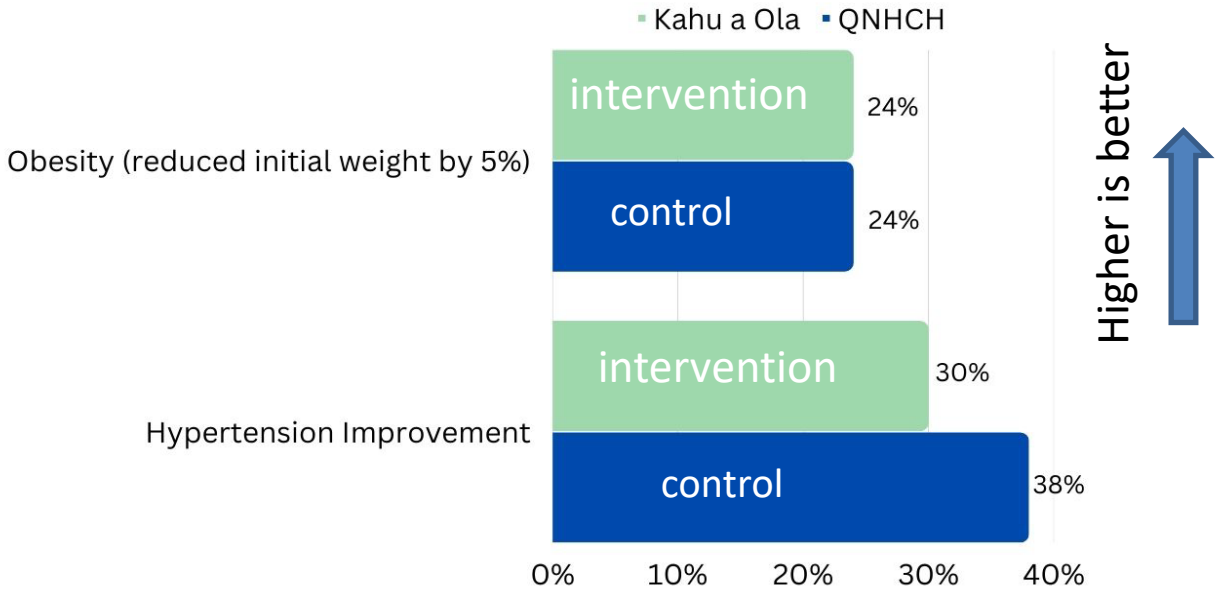
<u>90.5%</u> of Kahua a Ola patients **<u>decreased</u>** their **<u>A1c by 1.0 point to <8 or <9</u>**

% of QNHCH Kahu a Ola Patients who decreased HbA1c by ≥1.0 to <8 or <9



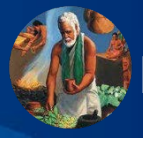
Despite no signficant improvement in blood pressure and weight, **<u>patients saw</u>** **<u>significant</u>** improvement in HbA1c

% of Patients with Improved BP and Wt



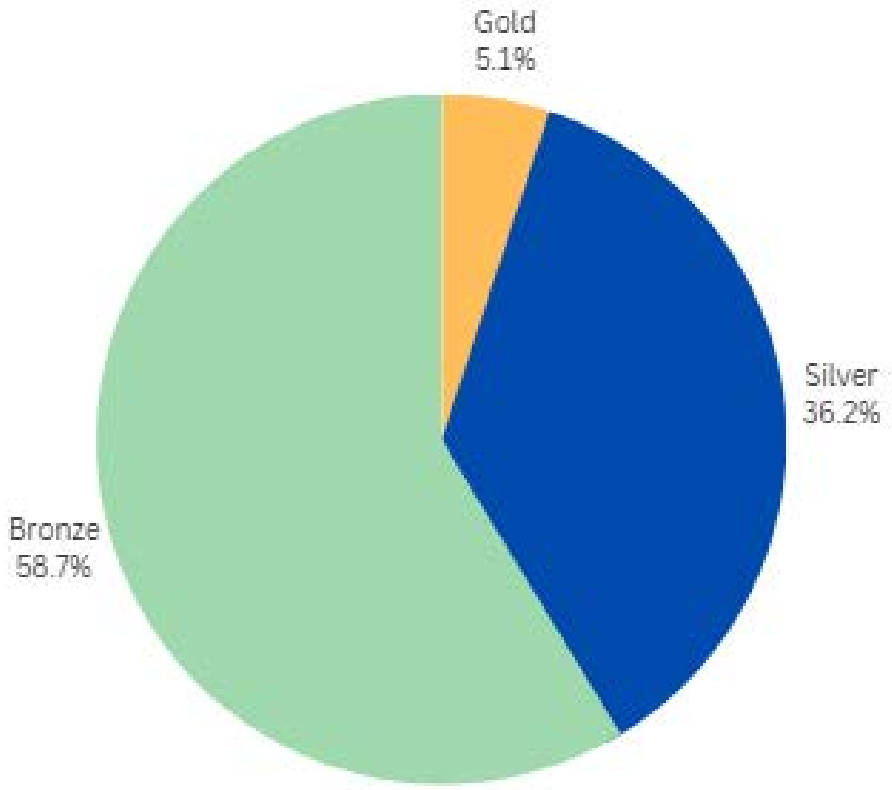
Source: Kahu a Ola Monthly Report

QNHCH Kahu a Ola Risk Stratification & Acuity



Approximately **59%** of QNCHC Kahu a Ola patients are low risk

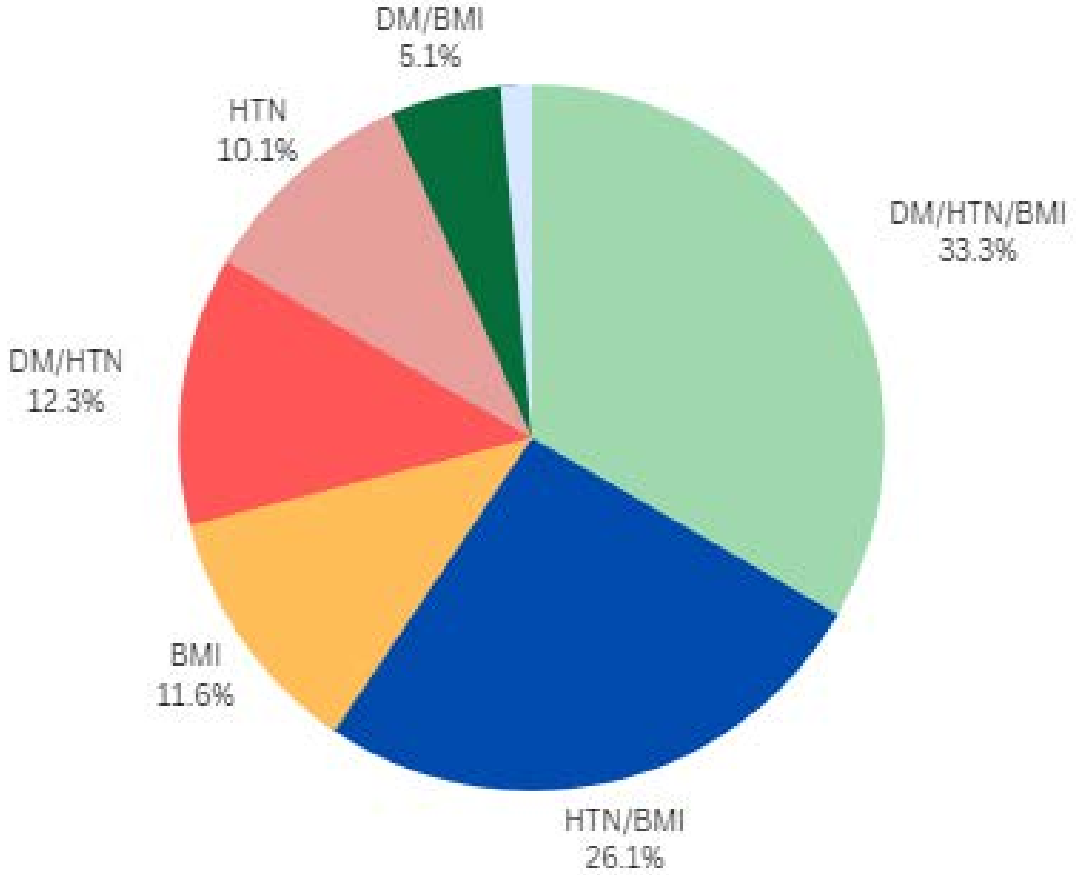
Acuity Levels based on Risk Assessment



Gold=Highest Risk **Silver**=Medium Risk **Bronze**=Lowest Risk

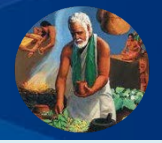
71% of Kahu a Ola patients **have 2 or more qualifying comorbidities**

Patient Chronic Diseases



Source: Patient Navigator Records

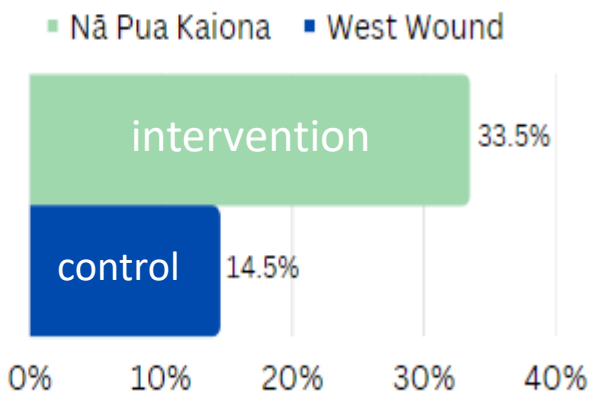
West Wound Nā Pua Kaiona Performance Report



Key Takeaway: Patients are high-risk with pervasive SDOH. Expanded support for health and health related social needs is necessary. Transportation support from one navigator during wound treatment period may be insufficient to address patient or health system factors contributing to poor outcomes or increased risk.

PROJECT UPDATE	Status (✓ Completed ❖ In Process ☐ Not Started)	
Scale-Up Progress **87** lives touched by 1 navigator in FY23	❖	• Program assessment complete. • Exploratory research and stakeholder meetings to inform expansion strategy to select specialty clinics with largest population of Native Hawaiians (i.e. QMCW Cardiology and QMCW Queen's Diabetes Education Center) in lieu of no primary care at QMCW. • RN Ops manager requested and awaiting approval to assist with scale-up & expansion. • Ongoing discussions with compliance and legal to support expansion. • Healthy planet epic optimization underway to improve care delivery, data collection, quality and completeness • Data registry and reports in development • Process improvement strategies in development and workflow education for staff underway

No Show/Cancellations FY 23

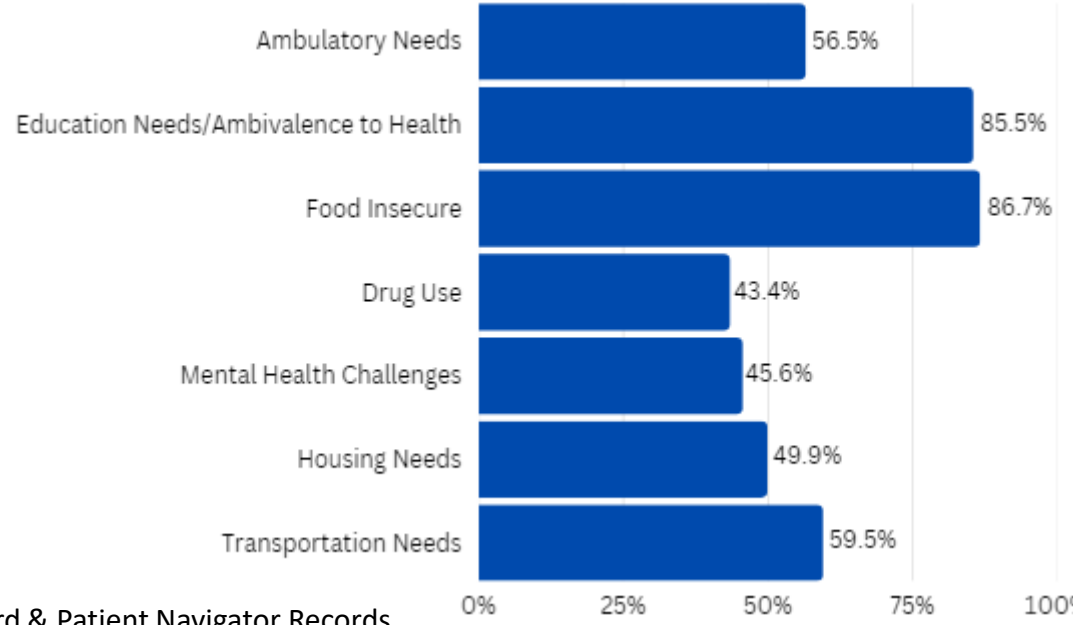


<u>Highest patient needs</u> include:

- **<u>food insecurity,</u>**
- **<u>education needs surrounding health</u>** and **<u>transportation</u>**

<u>Over half</u> of patient <u>have diffuculty ambulating</u> or <u>require bariatric support</u> limiting access to transportation

Social Determinants of Health



Source: Clarity Report Ka Ike Pono Patients - Encounters FY22 FY23 202307061530, Ambulatory Dashboard & Patient Navigator Records

Culturally Responsive Care Expansion into Specialty Care

Actionable data on Native Hawaiian disparities across QHS **is critical to understanding opportunities for improvement or practice change**

LOW REFERRAL CONVERSION RATES AMONG HAWAIIAN PATIENTS INDICATE OPPORTUNITY TO **IMPROVE ACCESS SPECIALTY CARE**

Referral conversion rate is defined by:

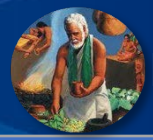
- % of referrals that result in a scheduled appointment.
- Referrals are given a 3 week-runtime.
- Higher is better.
- System wide goal >=80%

	QEC Cardiology	West Wound	West Cardiology	West Pulmonary	NHCH Cardiology
Referral Conversion Rate	32%	17.5%	42%	47%	25%

HIGH NO SHOW/CANCELLATION RATES AMONG HAWAIIANS REFERRED TO SPECIALTY CARE INDICATE OPPORTUNITIES TO **UNDERSTAND AND IMPROVE ENGAGEMENT**

	QEC Cardiology	West Wound	West Cardiology	West Pulmonary	NHCH Cardiology
No Show/Cancellation Rate	24.6%	14.5%	26.5%	22.6%	36%

QCIPN Hawai‘i Island CMC Project Performance

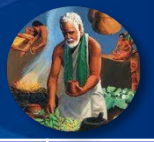

P1

P2

PROJECT UPDATE	Status (✓ Completed ❖ In Process ☐ Not Started)	
Infrastructure	❖	• Completed FY 21 Q2 Oct, 2020 – official patient care launch date • Kailua-Kona Patient Community Navigator (PCN) hired in FY 22 Q1 • FY 23 Q3: QCIPN Clinical Care Coordination has a full time clinical team to service the entire island. Team includes 2 navigators, 2 social workers and a nurse.
Patient Population	❖	• Criteria - NH and Non-NH patients who don‘t have PCP; MSSP ACO Provider & QCIPN CCC care team referred NH and Non-NH patients; QNHCH ED referred NH and Non-NH ED super users
Impact/Interventions	❖	• 344 patients touched from 10/1/20 to 06/30/23; 95 patients are Native Hawaiian (27.6%) • 188 patients referred for SDoH • 39 patients referred to mental health service/therapist • 36 patients established with new PCP • Continues to maintain physical presence at QNCHC ED every Wednesday

Short-Term Outcomes	FY 22	Target	FY 23
Increase NH patients who are established with a PCP in the Waimea, North Kohala and Kona service regions	25	TBD	36
Increase referrals for preventative services by increasing NH/Hawai‘i Island referrals to Queen's Preventative Health Services by 5%	125	131	216
Increase completed referrals for preventative health services for NH by 5%	104	109	168
Increased preventative care gap closure from baseline in NH population served in Akoakoa Primary Care practices by 5%	(CY 22) HbA1c=30.3% HTN =59.9%	HbA1c=75.6% HTN =65.76%	TBD CY 23 in progress

QCIPN Hawai‘i Island Project Performance cont...


P1

P2

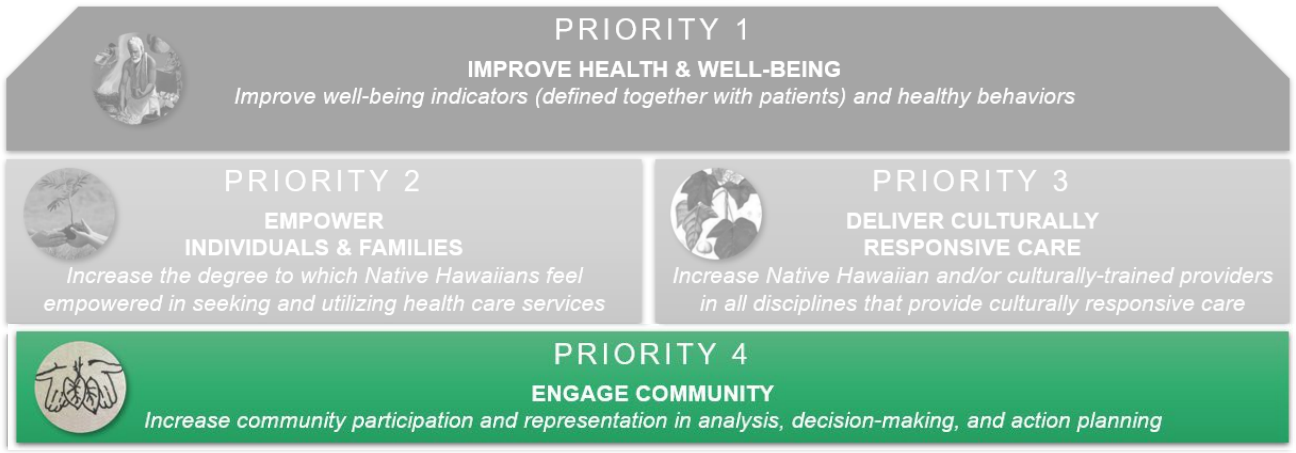
Short-Term Outcomes	FY 22	Target	FY 23 Q3
Increase NHs attributed to a primary care provider in the Akoakoa/QCIPN ACO by 5%	6,405	6,725	6,616
Decrease no-show rate for PCP visits from baseline	344	327	323
Reduce 30-day hospital readmissions within one year by 5% among patients served	9	8.6	10
Reduce ED utilization within one year by 5% among patients served	575	546	765
Increase referrals, utilization & patient engagement in community support services and healthy lifestyle programs.	109	114	188

NATIVE HAWAIIAN HEALTH

THE QUEEN'S HEALTH SYSTEMS

TRANSFORMATION IN COMMUNITY PARTNERSHIPS

Goal 2: Engage Community



Community Engagement Strategy

He maka au, he ʻupena kākou

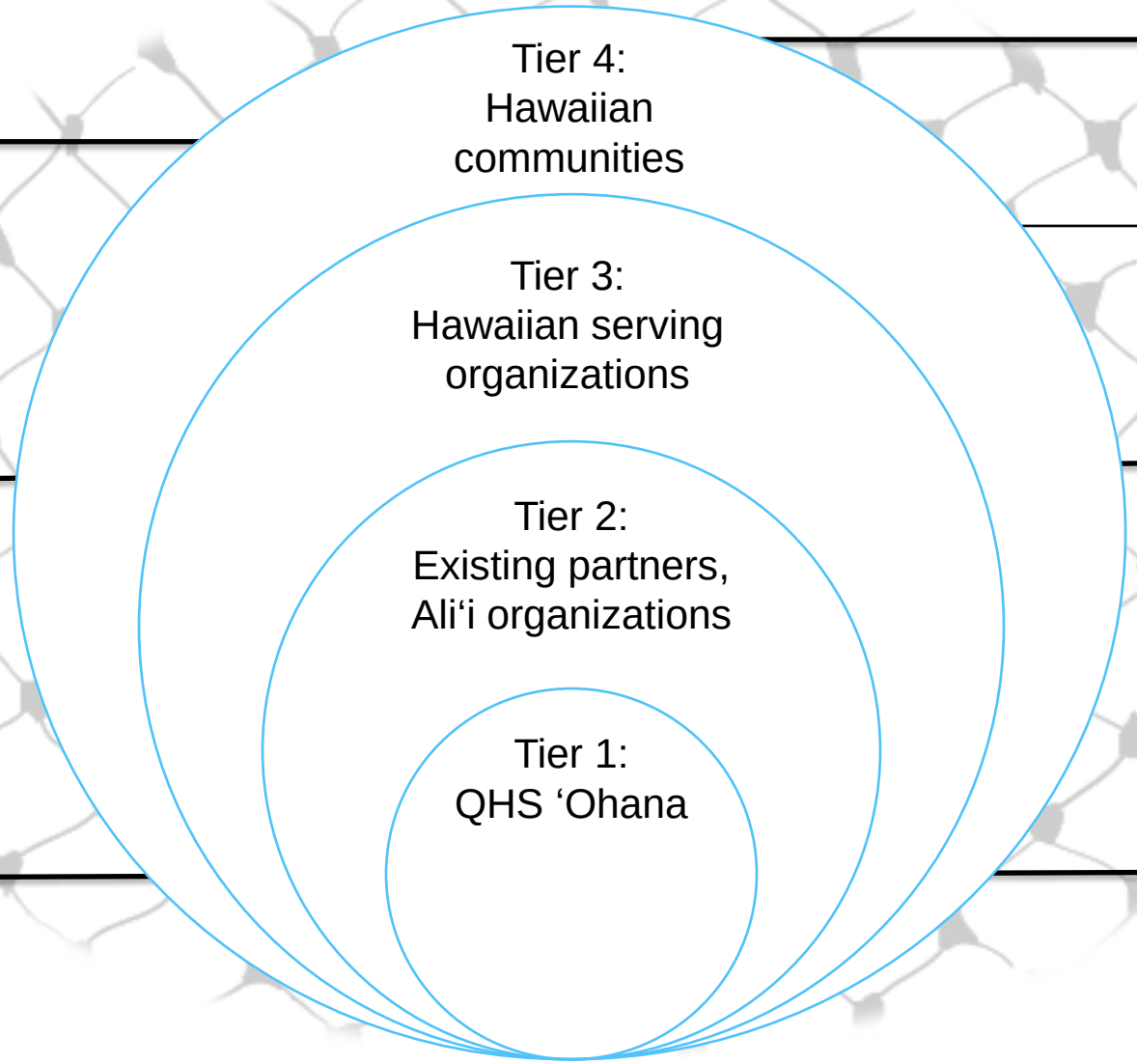
(I am an eye, we [collectively] are a net)

Topics for <u>engagement:</u>

Expectations that inform care needs and care delivery models

Individual and family challenges and barriers to accessing care and feeling empowered

Strengthening organizational capacity in Hawaiian communities



<u>Response:</u>

Share data

Redesign and/or improve care delivery models and care teams

Assess and eliminate health system barriers

Fund, collaborate, and support capacity building & strategic partnership in the community

Developing an Organizational Culture Grounded Queen's Founders and Their Values

Four System-Wide **Heritage Events** Successfully Completed

First System-Wide Commemoration of the Birthday of Prince Albert

Expansion of Events Included:

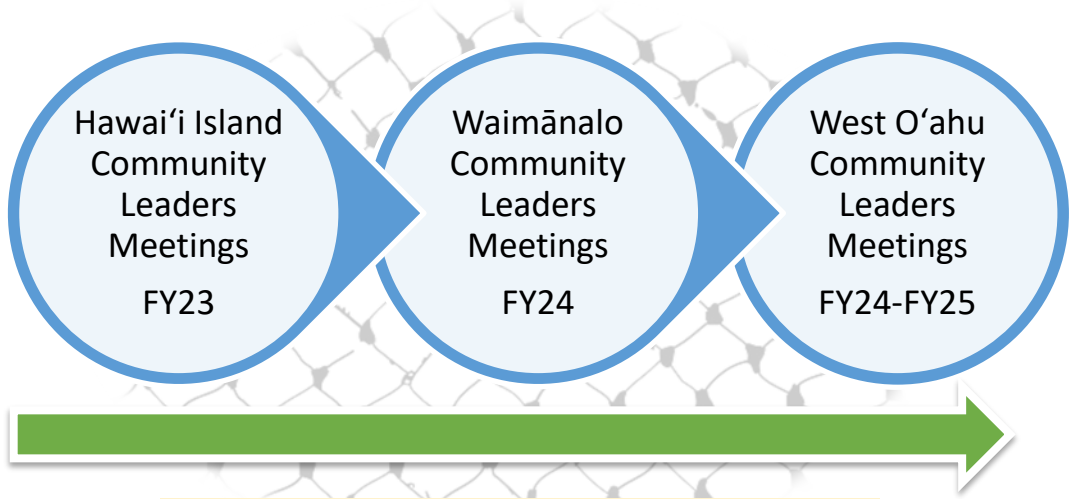
- CMEs in partnership with Schwartz Rounds and Clinical Grand Rounds
- Wahi Pana Tours for Caregivers
- Special employee recognition across the system

Convening Native Hawaiian Community Leaders

	Native Hawaiians*	Total Population	% of Total
C&C Honolulu	**182,121**	**953,207**	**19%**
Waiʻanae	28,404	48,519	59%
Windward Oʻahu	33,761	115,164	29%
West Oʻahu (excl. Waiʻanae)	46,590	270,964	17%
North Shore	9,085	34,452	26%
Central Oʻahu	16,269	94,019	17%
Urban Honolulu	48,012	390,089	12%
Hawaiʻi County	**54,919**	**185,079**	**30%**
East Hawaiʻi	33,453	104,704	32%
North Hawaiʻi	9,621	32,503	30%
West Hawaiʻi	11,845	47,872	25%
Maui County	**36,758**	**154,834**	**24%**
Maui	31,666	144,444	22%
Lānaʻi	611	3,135	19%
Molokai	4,481	7,255	62%
Kauaʻi County	**15,978**	**66,921**	**24%**
Total	**289,776**	**1,360,041**	**21%**

*May include Other Pacific Islanders

- Hawaiʻi County has the highest percentage (30%) of Native Hawaiians among its total population
- Communities with the *largest proportion* of Native Hawaiians
  - Molokai (62%)
  - Waiʻanae (59%)
- Communities with the *largest number* of Native Hawaiians
  - West Oʻahu, including Waiʻanae (74,994)
  - Urban Honolulu (48,012)
  - Windward Oʻahu (33,671)



Developing Pilina to Collectively Address Health Needs in Partnership

Source: State of Hawaiʻi Primary Care Needs Assessment 2016, Hawaiʻi Department of Health (data as of 2010)

Waimea, Hawai‘i Community Leaders Meetings As A Template

Native Hawaiian Community Leaders Gather to Address Health Needs

- Hawai‘i Island Community Health Center (FQHC)
- Hui Mālama Ola nā ‘Ōiwi (Native Hawaiian Health)
- The Kohala Center
- Hui Mālama i ke Ala ‘Ūlili
- Kū-A-Kanaka
- University of Hawai‘i System
- Native Hawaiian healers/practitioners
- Nā Kālai Wa‘a/Makali‘i
- Education
- Hawaiian Homestead
- Kūpuna
- Ka Pā o Lonopuha

- **Meeting 1** – September 7, 2022
  - Introductions
  - Kahua Ola Expanded Strategic Plan
- **Meeting 2** – February 7, 2023
  - Community Leaders Presentations
  - Q & A
- **Meeting 3** – April 27, 2023
  - Themes/Breakout sessions

PRIORITY 4

ENGAGE COMMUNITY

Increase community participation and representation in analysis, decision-making, and action planning

Waimea, Hawai‘i Nā Momi *(Pearls of Wisdom)*

- **‘Āina**: What are we doing about ‘āina? The health of the ‘āina = the health of the people.

- **Education**: Kū-A-Kanaka -- innovation for on-line, asynchronous cultural learning.

- **Access**: Remember the manapua man who brought food into communities.

FY23 Legislative Strategy Implementation

Overview of Legislative Affairs Strategy for NHH/DEIJ+CW:

1. Raise visibility and highlight the work the NHH/DEIJ+CW is doing to promote health equity for Native Hawaiians and marginalized populations.
2. Establish impactful collaborative partnerships (both external and internal to QHS).
3. Create and/or advocate for policy and funding that contributes to our QHS aspirational goals of reducing the gap in life expectancy for Native Hawaiians and being lifetime partners in care.

FY23 Q1

Explore Potential Collaborative Partners

Began discussions with Papa Ola Lōkahi (POL) to examine how we could partner on a federal level –

- Potential Change Idea – QHS to partner with POL to provide clinical support component to NH Healthcare Centers

FY23 Q2

Develop Strategic Narrative & Prepare for 2023 Legislative Session

Tell our unique story though our history, and data

- Look for extramural funding on the Local, State and Federal Level
- Create and maintain long-term partnerships w/ NH orgs and community

FY23 Q3

State of Hawai'i Legislative Season

- Work with QHS Government Relations team to identify important NHH/DEIJ+CW issues in the State legislative session
- Provide advocacy through letters of support and testimony
- Participation in the Legislative Hui (consoritium of NH orgs)
- Work on Medicaid Federal Medical Assistance Percentage (FMAP) Application for NH Health Center Designation

FY23 Q4

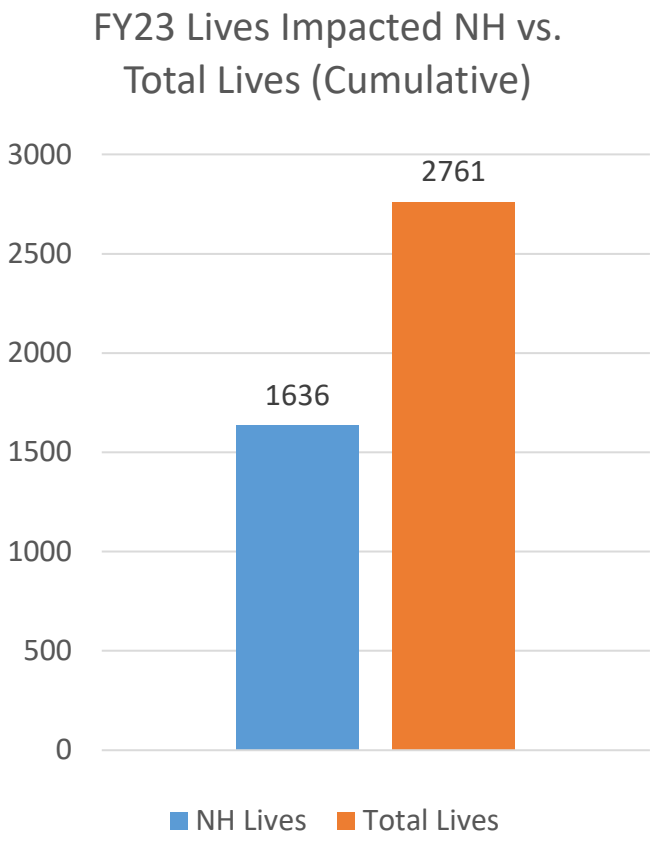
Washington, D.C. + NHH Center Designation for QHS

- Attended Hawai'i on the Hill presented by the Chamber of Commerce Hawai'i with over 1,800 other participants of local small businesses and NH organizations
- QHS Received NH Health Center Designation for Medicaid FMAP
- Visit with Dept of Interior Secretary Deb Haaland

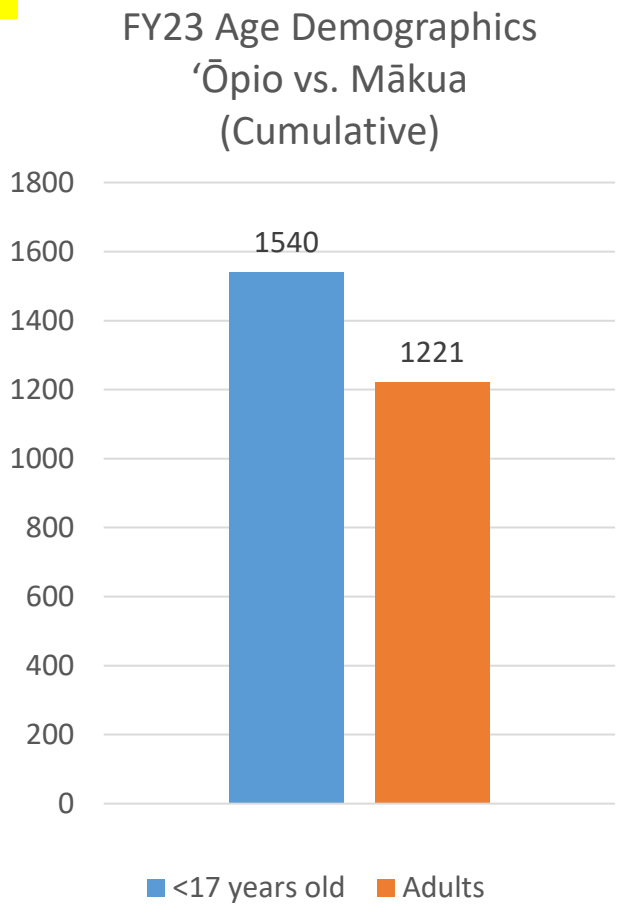
Mauliola Ke‘ehi Community Program Evaluation Grant

Improved Emotional, Physical, Mental, and Spiritual Wellbeing Among Most Participants

Majority (59.3%) of Participants are Native Hawaiian



Majority of Participants (79.3%) are School-Aged



Mauliola Ke‘ehi FY23 Deliverables

P2 P4

Key Deliverables	Measure	Target	FY 23 Q4	FY23 Cumulative
Pre-visit presentations with participants with school groups (excluding community groups)	# of participants in 12 months	250	n=67	n=675 270% completed
Deliver site visit programming with participants (non-treatment groups)	# of participants in 12 months	500	n=356	n=1242 248.4% completed
Deliver site visit programming with treatment groups	# of participants in 12 months	100	n=26	n=146 146% completed
Assessment of participant experiences	# of participants who have taken assessment	40%	n=298 (out of 390 surveys or 76.4%)	50.2% (784 out of 1563 completed)
Annual meeting with Continuous Quality Improvement (CQI) team to review data indicators, measures and findings to develop lessons learnd	Task completion	100%	100% Meeting held in March 2023	100% Completed in Q3
Quarterly program evaluation report submission to Executive Director & QHS	Quartlely and Annual reports	4 reports for FY23	Q4 report completed	100% completed
Complete 3-year program evaluation	Program Evaluation Completed	Complete at Year 3 (end of FY24)	In-progress	In-progress

GOAL 2: SUMMARY
Pilina - Community Services Support Network

#	Approved	Grant/Donation Recipient	Total Funding Amount	Term	Summary
1	FY21 Q3	Mauliola Keʻehi Program Evaluation	$200,000	3 yrs = FY21-FY23	Program evaluation using an ʻāina-based tool to understand program impact on quality of life & wellbeing
2	FY23 Q1	Hawaiʻi Academy of Recording Artists (HARA)	$10,000	One-time donation	Support for Nā Hōkū Hanohano Awards
3	FY23 Q1	Council for Native Hawaiian Advancement	$10,000	One-time donation	Support for the 21st Annual Native Hawaiian Convention
4	FY23 Q1	Office of Hawaiian Affairs	In-Kind	One-time donation	Provided community grant reviewer support for the health and ʻiwi repatriation grants
5	FY23 Q1	Moanalua Gardens Foundation: Prince Lot Hula Festival	In-Kind	One-time donation	Provided on-site safety protocol on the day of the event for participants, staff and volunteers
6	FY23 Q1	ʻAha Hīpuʻu Royal Societies	$5,000	One-time donation	Support for the 15th Annual Kalani Aliʻi Awards
7	FY23 Q1	Project Vision	$10,000	One-time donation	Support for the annual Eye Ball

GOAL 2: SUMMARY
Pilina - Community Services Support Network

#	Approved	Grant/Donation Recipient	Total Funding Amount	Term	Summary
8	FY23 Q2	Native Hawaiian Hospitality Association	$1,000	One-time donation	Support for their annual fundraiser
9	FY23 Q2	ʻIolani Palace	$10,000	One-time donation	Support for customized tours for QHS staff
10	FY23 Q2	Maunalua Fishpond	$5,000	One-time donation	
11	FY23 Q3	Papa Ola Lōkahi	$20,000	One-time donation	Support for the ʻAha Hoolōkahi Native Hawaiian Health and Wellbeing Summit in June 2023
12	FY23 Q3	Hawaii Academy of Recording Artists	$20,000	One-time donation	Support for the Nā HōkūHanohano Awards
13	FY23 Q3	Kula No Nā Poʻe	$1,732.43	One-time donation	Medical Supplies for the Papakōlea Health Fair
14	FY23 Q4	Moanalua Gardens Foundation	$5,000	One-time donation	Support for the Prince Lot Hula Festival

GOAL 2: SUMMARY
Pilina - Community Services Support Network

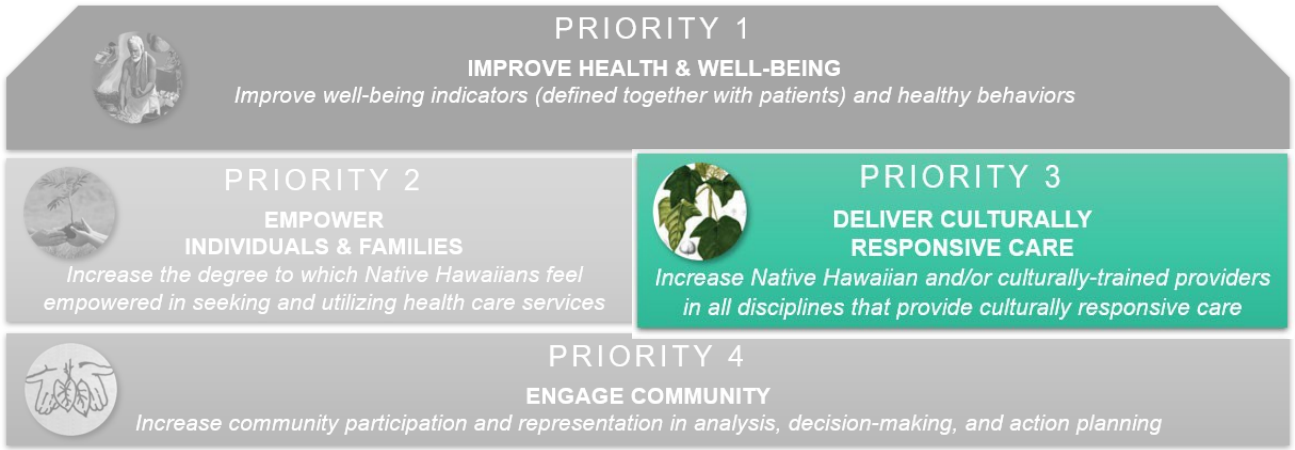
#	Approved	Grant/Donation Recipient	Total Funding Amount	Term	Summary
15	FY23 Q4	Pauahi Foundation	$1000	One-time donation	Support for their “Aha ‘Aina Pauahi Fundraiser for NH educational scholarships
16	FY23 Q4	Office of Hawaiian Affairs	In-Kind	One-time donation	Provided grant review support for OHA’s community grants
17	FY23 Q4	Chamber of Commerce Hawai’i	$7000	One-time donation	Support for 2023 Hawai’i on the Hill in Washington D.C.

NATIVE HAWAIIAN HEALTH

THE QUEEN'S HEALTH SYSTEMS

TRANSFORMATION IN EDUCATION AND TRAINING

Goal 3: ‘Ike Hawai‘i – Training and Education



Developing a Culturally Safe Environment to Deliver Culturally-Responsive Care

Redefining Access through an Indigenous Lens

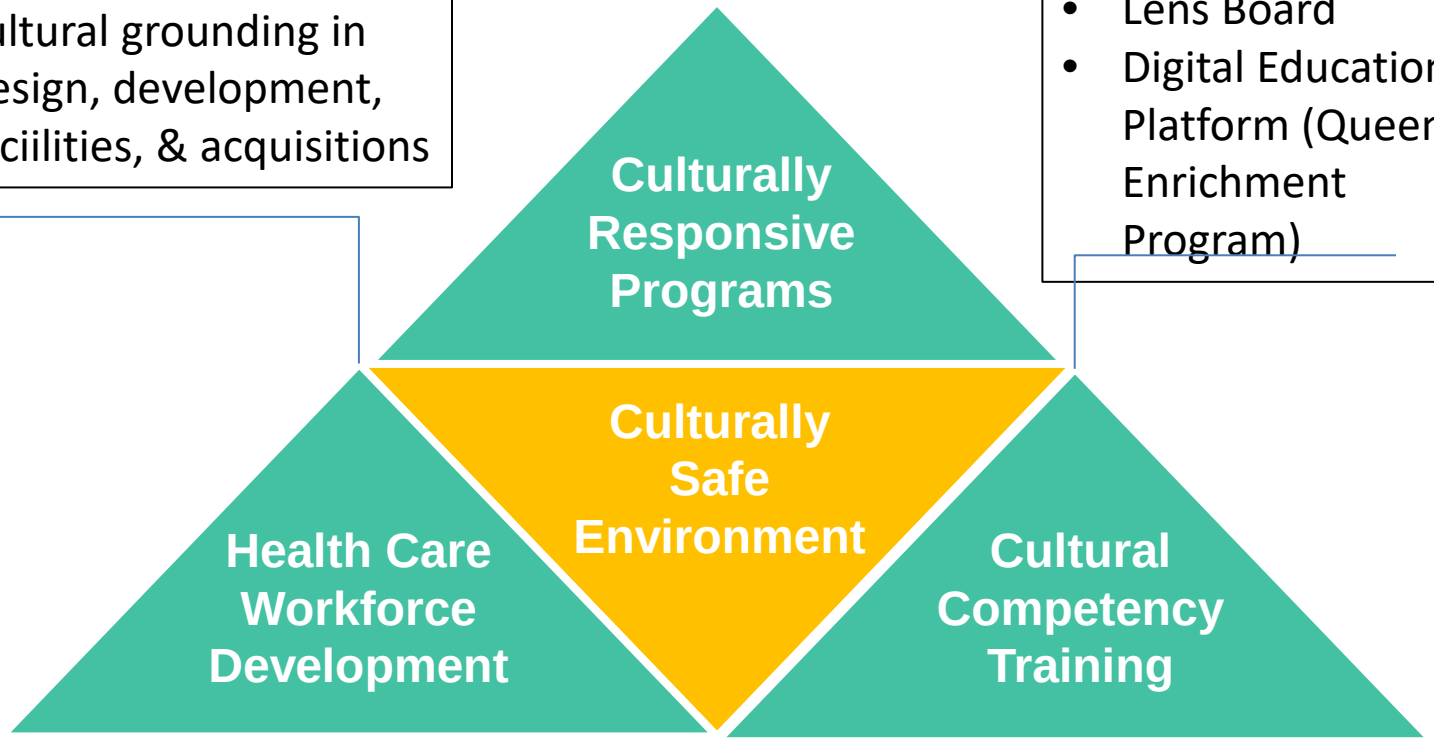
Defining Characteristics of an Indigenous Primary Care Program[1]

- ❑ ʻĀina & Cultural Stewardship
- ❑ Affordable
- ❑ Acceptable
- ❑ Approachable
- ❑ Accessible
- ❑ Available
- ❑ Adequately Address NH Needs
- ❑ Ability to Engage

Highlights in FY23

- Corporate Compliance Module Redesign
- Partner in Strategic Development for cultural grounding in design, development, faciilities, & acquisitions

- Cultural Training & Certification Program contract in progress
- Lens Board
- Digital Education Platform (Queen‘s Enrichment Program)



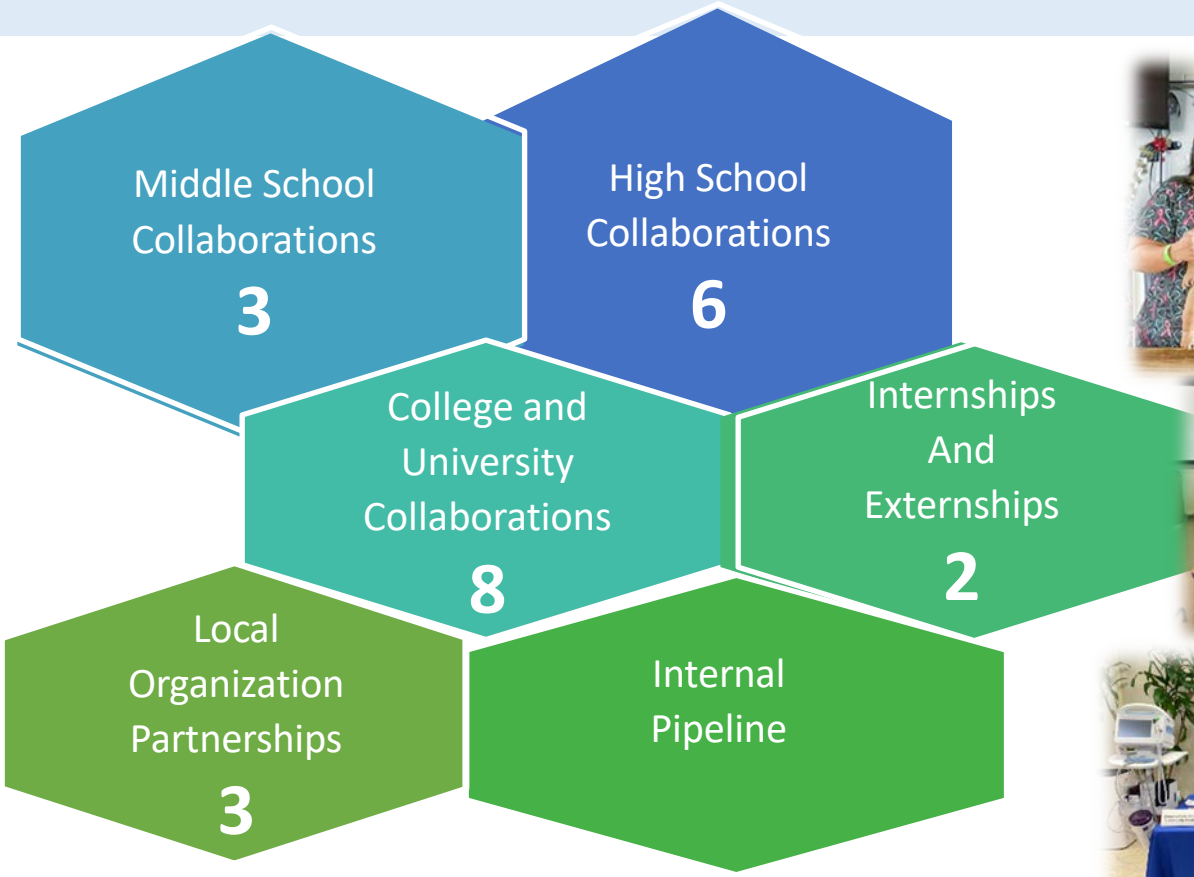
Source[1]: “Access to primary health care services for Indigenous peoples: A framework synthesis,” by Carol Davy, Stephen Harfield, Alexa McArthur, Zachary Munn and Alex Brown, 2016.

Source[2]: Assessment and Priorities for Health & Well-Being in Native Hawaiians & Other Pacific Peoples, Dept. of Native Hawaiian Health, Center for Native and Pacific Health Disparities Research, John A. Burns School of Medicine, 2020

Workforce Development Transformation on Hawai‘i Island

Strategic Partnership with Human Resources and DEIJ CW to Support Training, Education, and Workforce Development System-Wide and Specifically on Hawai‘i Island

Opportunities for local students, secondary through college, and QNHCH caregivers to enter or advance in the healthcare field, supported by QNHCH, NHH & HR



PRIORITY 3

DELIVER CULTURALLY RESPONSIVE CARE

Increase Native Hawaiian and/or culturally-trained providers in all disciplines that provide culturally responsive care

Ulu O Ka Hua Ola Year 2 Report

Community Engagement – Chronic Disease Management

- Funded 7 COVID-19 infection and chronic disease prevention programs
  - Over 90 Native Hawaiians reached

Community Engagement – Education and Training

- Diabetes 101 Community Health Worker Training
  - 37 trained (18 NHs)
- Heart Health 101 Community Health Worker Training
  - 22 trained (7 NHs)

Curriculum Development – Teaching Modules for Health Care Professionals

- Module 4: Belonging, Biases, and Building Relationship Development completed
- Plan created to solicit feedback for Module 4 from stakeholders: evaluation form, IRB application, and recruitment strategy

ʻImi Hoʻōla Post-Baccalareate Program

- 12 students enrolled AY 2022-2023
  - 6 men and 6 women
  - 3 NHs (25%), 1 Pohnpeian, 4 Filipino, 2 Chinese, 1 Vietnamese, 1 Japanese
  - 6 of 12 (2 NHs) completed program and matriculated into JABSOM in July 2023
  - All students had access to behavioral health specialist
  - Staffing challenge: Learning Specialist position unfilled since August 2022

ʻImi Hoʻōla: "Those Who Seek to Heal"

Background

- Educational opportunities in medicine for individuals from disadvantaged backgrounds (since 1996)
- Upon successful completion of the program, students enter JABSOM as first-year medical students
- **303 ʻImi alumni have now graduated from JABSOM** since its inception in 1973
- QHS NHH contract with JABSOM DNHH, Ulu o Ka Hua Ola has supported ʻImi Hoʻōla Program with stipends for their students up to **$233,280 per year**

Goal 1: Increase Recruitment

- Boost ʻImi Hoʻōla student outreach and recruitment efforts in Native Hawaiian communities - consider hiring a full time ʻImi Hoʻōla student recruitment/engagement specialist or part time health professions advisor
- Expand existing pathway programs such as the Native Hawaiian Center of Excellence into the ʻImi Hoʻōla program
- Provide high school and colleges counselors with resources and health professions advising to prepare NH students for successful admission into ʻImi Hoʻōla
- Metrics/Measures of success - tracking number of workshops/NH participants, total number/trends of NH applicants, program matriculants, and program completers

Goal 2: Improve Retention

- Ensured access to behavioral health support services via direct referrals to a JABSOM confidential counselor and community- based health care providers (Ka Malu a Waʻahila, ʻImi alumni in psychiatry)
- Revamped entire phase 1 learning strategies and skills development, enhanced team building through peer mixers, and provided increased support for student transitions (housing, financial aid guidance, food security, emotional/psychological support)
- Financial worries and family obligations are primary challenges (via enrollment survey and student conferences)

Cultural Education, Engagement, and Training Activities Summary

#	Audience	Cultural Training/Staff Engagement Activity	Total Completed
1	Community	Aha Hoʻolōkahi	1
2	QHS	Caregiver Wellness Retreat	2
3	QMC WO	Community Service Project – Waipahu Intermediate	1
4	QHS	Cultural Experience: Hoʻokupu and Mauna ʻAla Tour	4
5	NHH DEIJCW	Division In-Service (Program Proposal, Project Management)	2
6	Community	E Ola Mau 2023 Report	1
7	QMC M & QMC WO	Educational/Cultural Offerings	25
8	QNHCH	Hawaiʻi Island Community Leaders Meeting	3
9	Community	Hawaiʻi on the Hill	1
10	QHS	He Momi	45
11	QHS	Heritage Event	4
12	QMC WO & QNHCH	I Kua Naʻu	2
13	QMC M	Integrated Wellness – Hawaiian Meditation	1
14	QHS	Joint Board Retreat	4
15	QNHCH	Just Walk Waimea	100
16	QNHCH	Kahu a Ola In-Service: QNHCH ER	1
17	QNHCH	Kahu a Ola Webinar	5
18	Community	KKV -4MAT Workshop	1

Cultural Education, Engagement, and Training Activities Summary

#	Audience	Cultural Training/Staff Engagement Activity	Total Completed
19	Community	Birthing a Nation Moku o Keawe	9
20	MED/MEC (physicians)	Native Hawaiian Health/Legacy Presentations	2
21	QHS	Michael J Fox Foundation – Parkinson‘s Disease Webinar	1
22	QHS	Mid-Day Mana‘o Webinar	5
23	QMC & QNHCH	Mo‘o‘ōlelo o nā Ali‘i	18
24	Community	Native Hawaiian Research Hui	1
25	QMC M, QMC WO & QNHCH	New Hire Orientation	32
26	QHS	Ola Hou i Ka Hula	72
27	QHS	‘Ōlelo Hawai‘i Assistance	4
28	Community	Papakōlea Health Fair	1
29	Community	Prince Lot Hula Festival	1
30	Community	Pu‘uhonua o Wai‘anae/WCCHC	1
31	QMC WO	QMC WO Blessings	2
32	QNHCH	QNHCH Leadership – Hawai‘i Island Partnership Presentation	1
33	QHS	Queen‘s Enrichment website and digital archive	5
34	QMC M	Renovation Project	4
35	QMC M	Sodexo – Traditional Foods	1
36	QHS	Special Event: ‘Iolani Tour (DEIJ Workgroup Leaders)	1
37	Community	Workforce Development Career/Information Events	5

NATIVE HAWAIIAN HEALTH

THE QUEEN'S HEALTH SYSTEMS

SECTION

3

FY23 KAHUA OLA
Innovation & Sustainability

Remote Patient Monitoring Update: Our Sail Plan

What is Remote Patient Monitoring (RPM)?

- Uses technology to track biometric data such as vital signs from the comfort of a patient's home
- Examples: blood pressure, weight, glucose (diabetes), oxygen saturation, heart rhythm

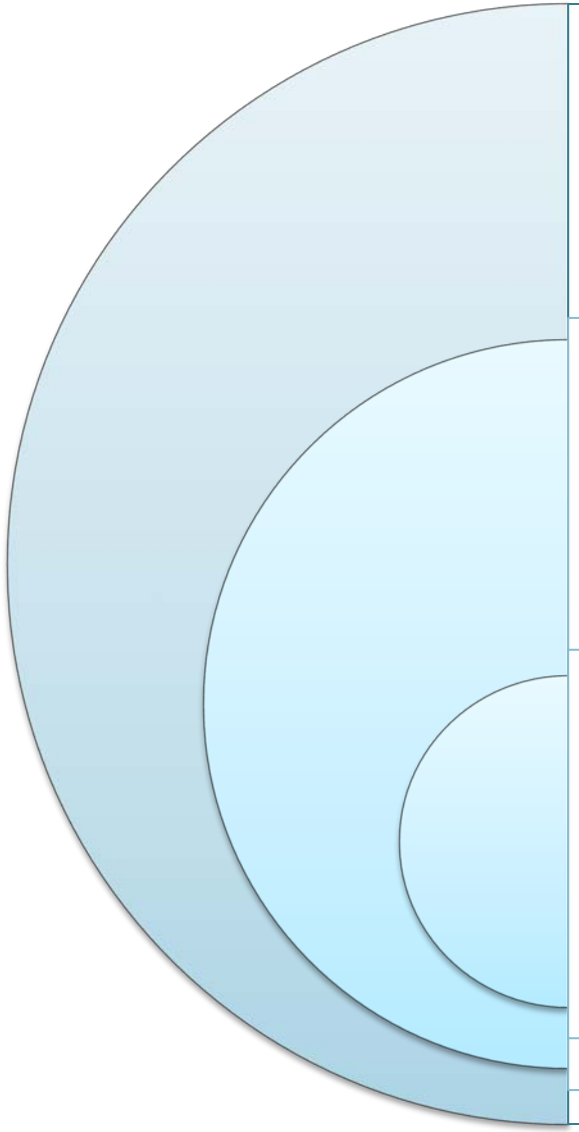
Why Remote Patient Monitoring?

- Improve access to clinical care
- Helps us to achieve our Aspirational Goal
  - To extend lifespan of NHs and reduce the gap (7-8 years) in half within 10 years
  - To be a lifetime partner

Where are we today?

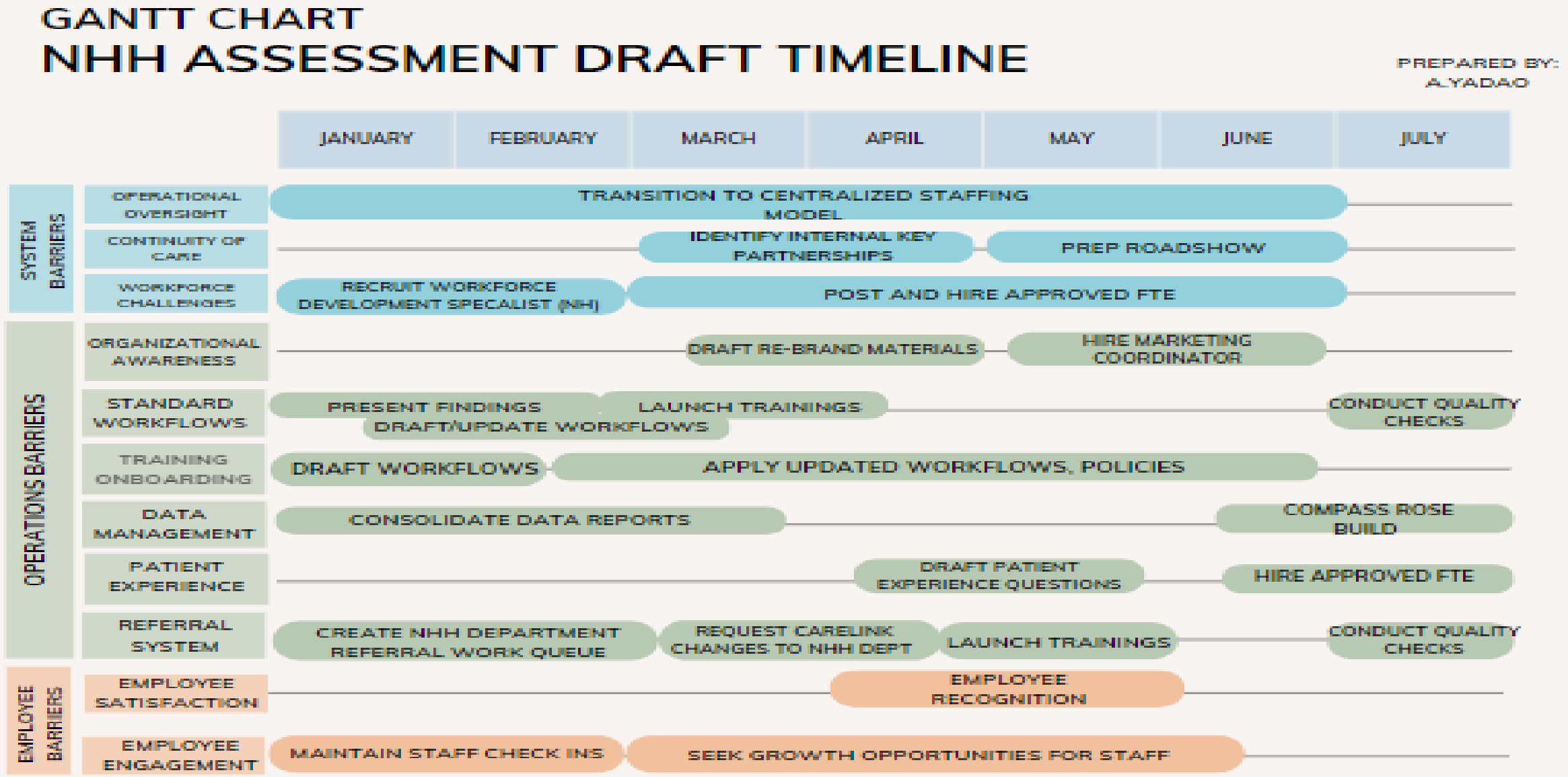
- NHH was designated as Phase 1 RPM business owner
- Evaluated 8 RPM vendors and narrowed to 2 finalists who will receive RFPs
- Anticipate funding from UH who will administer funds for DHHL grant from NTIA to utilize telehealth to improve health of NHs

FY23 Kahua Ola Program Assessment Themes

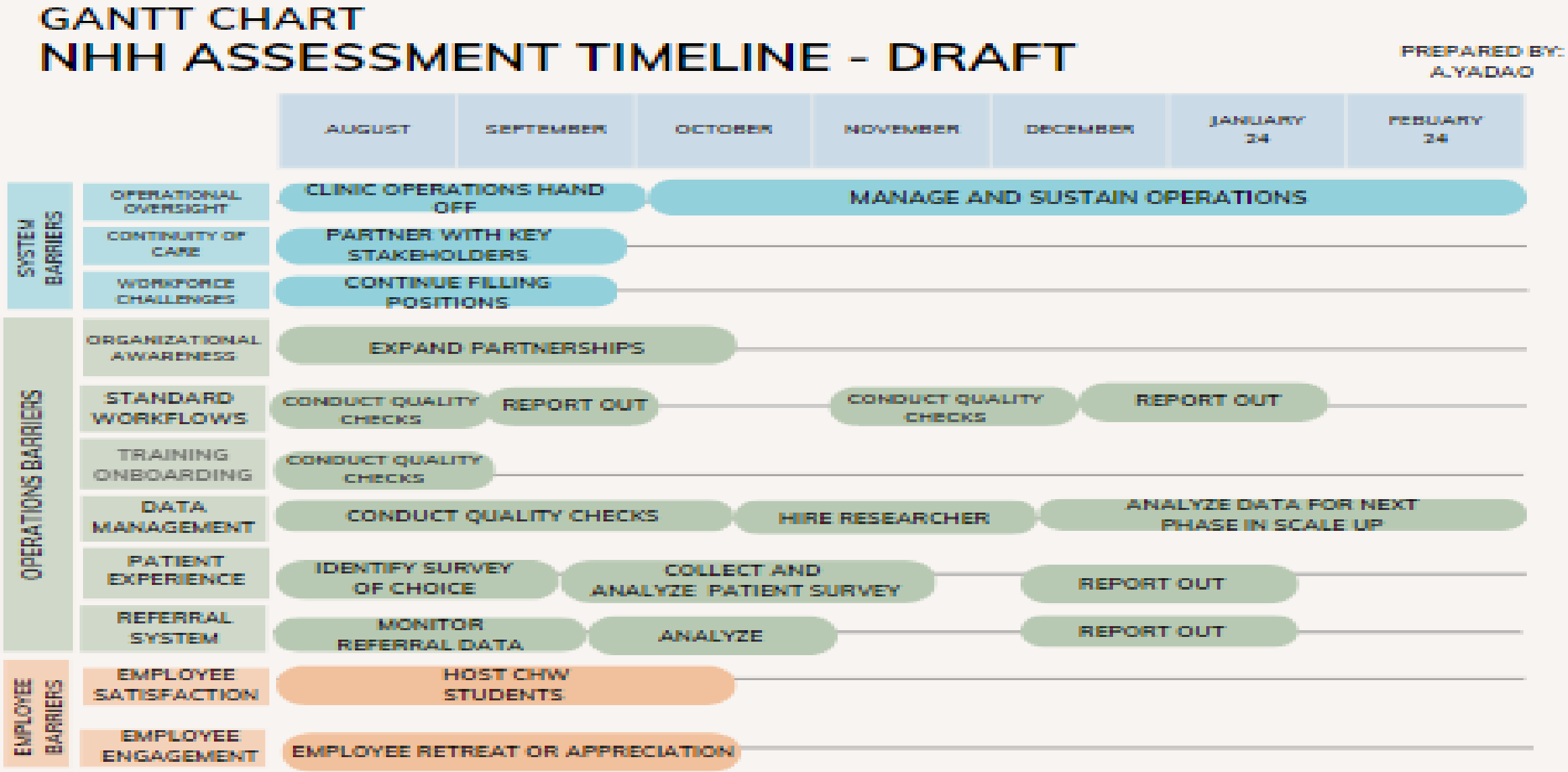


System Barriers	• Identify & address regional differences • Create umbrella inclusion policy to adequately address all populations • Have uniform policies throughout entire Queen's Health Systems
Operations Barriers	• Address provider burnout/employee retention • Address unconscious/conscious bias and micro-aggressions • Develop and implement trauma-informed care training • Require cultural competency/cultural safety training
Employee Engagement	• Stay informed and well versed on the most up to date themes and issues of diversity, inclusion, equity • Provide on-going professional development or trainings as needs are identified • Community networking and recognition • Compile and compare data regularly for quality metrics • Assist with completion of the community measurement applications and processes (i.e. HEI (Health Equality Index)) • Develop and implement an evidence based tool to assess patient satisfaction and outcomes

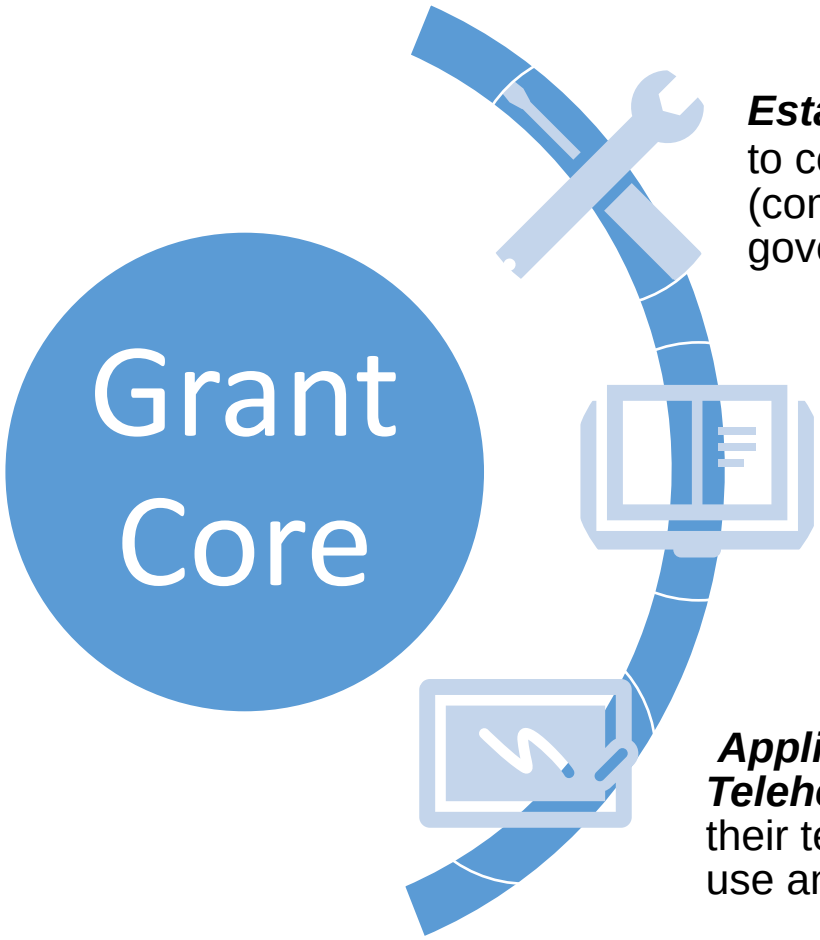
Process Improvement Proposed Timeline & Implementation
Jan 2023 to July 2023



Process Improvement Proposed Timeline & Implementation continued
Jan 2023 to July 2023



FY23 Donations Received & Grant Core Development Update



Established grant team to cover diverse grants (community, government, research)

Ongoing research in progress for grants to support goals

Application in progress for NTIA & DHHL Telehealth grant for $4 mil to increase their telehealth capacity through broadband use and adoption

THIS SECTION INTENTIONALLY LEFT BLANK

Kahua Ola Operating Expense & Donations

THIS PAGE INTENTIONALLY LEFT BLANK

NATIVE HAWAIIAN HEALTH

THE QUEEN'S HEALTH SYSTEMS

SECTION

4

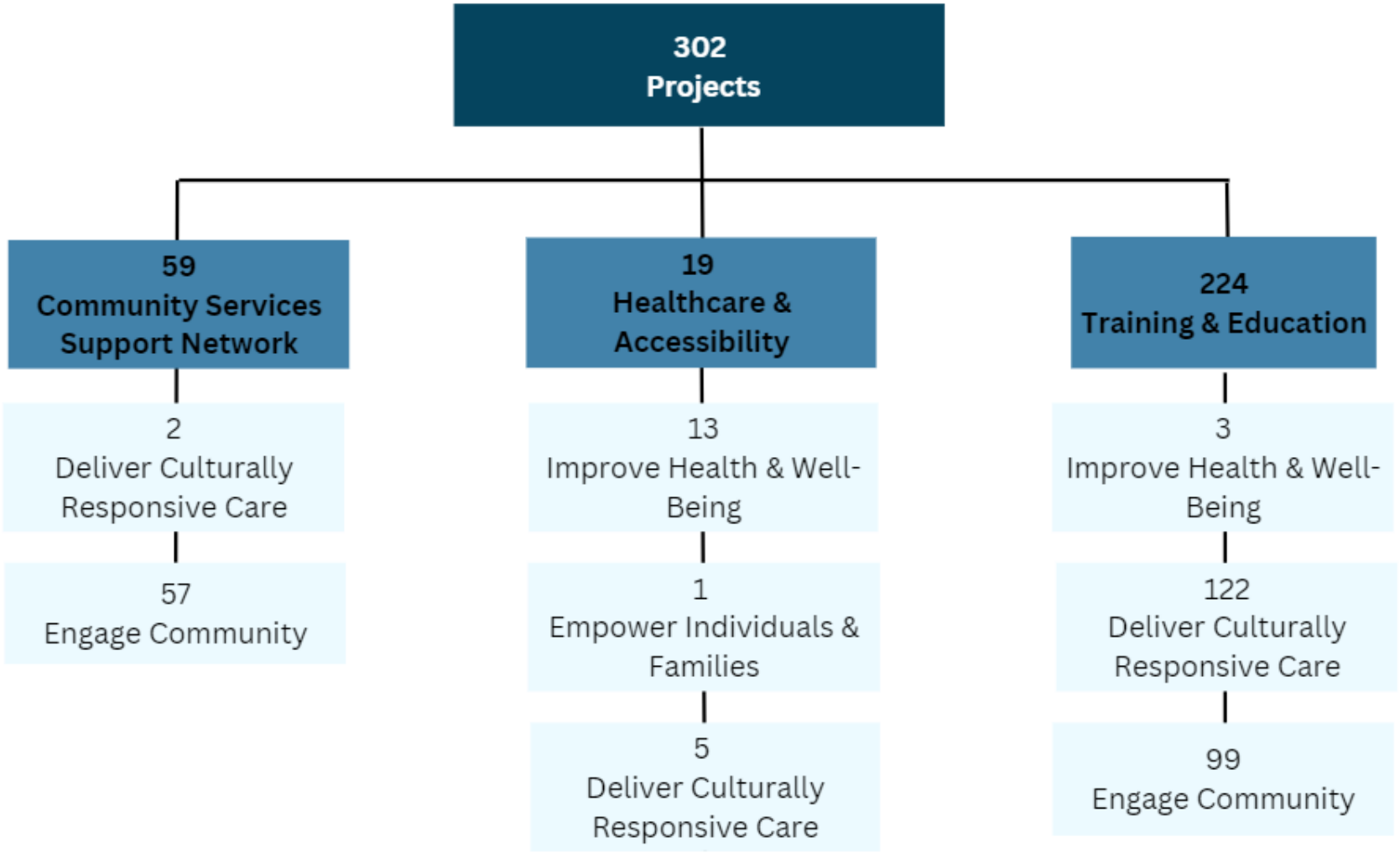
FY23 KO Project Management Report

FY23 KAHUA OLA PROJECT REPORT SUMMARY

Total Projects in FY 23= 302

Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Conception & Initiation	Definition & Planning	Launch or Execution	Performance & Control	Project Close
6	12	11	31	242

Project Breakdown by Kahua Ola Goal & Priority



Providing *training and education* regarding the *delivery of culturally responsive care* paves the way to ensuring Native Hawaiians are receiving care that reflects their values.

NATIVE HAWAIIAN HEALTH

THE QUEEN'S HEALTH SYSTEMS

END OF REPORT

NATIVE HAWAIIAN HEALTH

THE QUEEN'S HEALTH SYSTEMS

APPENDIX

Key Priorities to Achieve our Kahua Ola Goals

TEN-YEAR ASPIRATIONAL GOALS

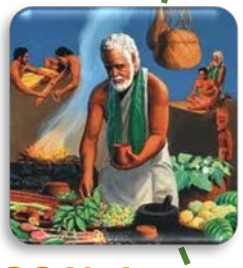
Lifetime partners in health

Increase the life expectancy of Native Hawaiians and **close the gap in half**

GOAL 2

COMMUNITY SERVICES SUPPORT NETWORK

Connect patients to resources in the community to address health-related social needs



GOAL 1

HEALTH CARE ACCESSIBILITY

Build trust and accessibility for Hawaiians in targeted communities

GOAL 3

TRAINING AND EDUCATION

Promote and support training and education of culturally responsive approaches to care delivery

PRIORITY 1

IMPROVE HEALTH & WELL-BEING

PRIORITY 2

EMPOWER INDIVIDUALS & FAMILIES

PRIORITY 3

DELIVER CULTURALLY RESPONSIVE CARE

PRIORITY 4

ENGAGE COMMUNITY

NATIVE HAWAIIAN HEALTH
THE QUEEN'S HEALTH SYSTEMS

Strategic Alignment with Community Health Needs Assessment (CHNA)

To Systematically Address Factors Contributing to Lower Life Expectancy

FINANCIAL SECURITY

FOOD SECURITY

MENTAL & BEHAVIORAL HEALTH

HOUSING

TRUST AND EQUITABLE ACCESS

Source[1]:Wu, Y., Uchima, O., Browne C. (2019) Healthy Life Expectancy in 2010 for Native Hawaiian, White, Filipino, Japanese and Chinese Americans Living in Hawaii, Asia Pacific Journals of Public Health

Source[1]:CHNA?

Transforming Care through Population Health

Primary Drivers

- Social Economic Disparities
- Negative Health Risk Behaviors
- Access to Health Care
- [Experience of Racial] Discrimination
- Biological & Psychological Determinants

Secondary Drivers

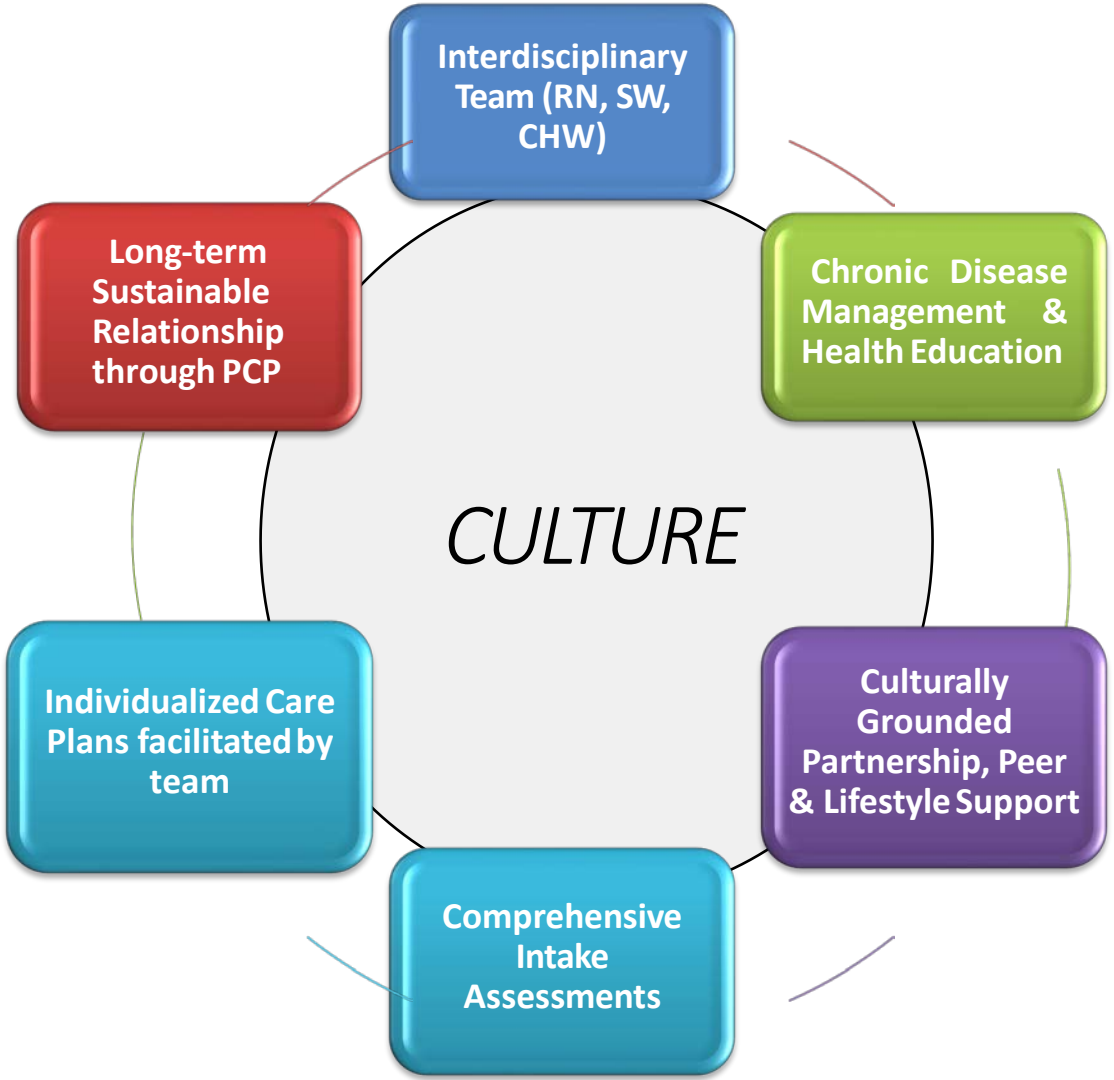
- Employment
- Poverty
- Incarceration
- Lower Education & Attainment
- Genes – biology & physical
- Trauma
- Social Supports
- Health Care Access (System Barriers)
- Health Care Access (Patient Factors)
- Power & Privilege
- Behavioral Health & Substance Abuse
- Safe & Healthy Lived Environment
- Historical Cultural, Generational Trauma
- Spiritual, Emotional, Physical Support

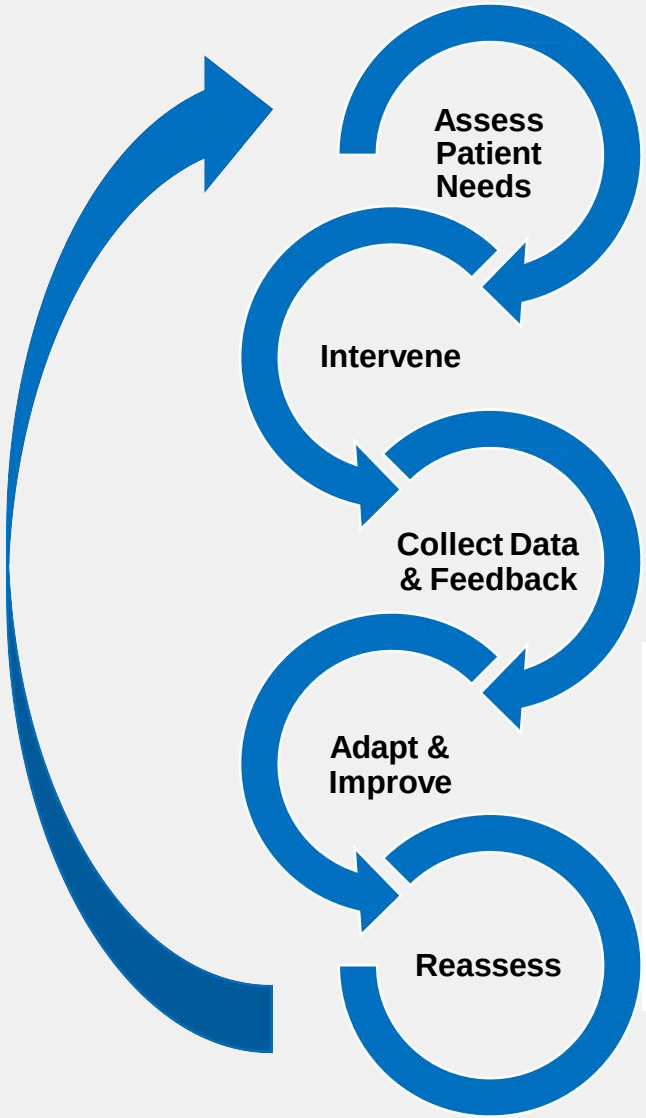
Developing An Infrastructure for Population Health to Reduce the Gap in Life Expectancy

Culturally Responsive Care Delivery (Population Health)

TO PROMOTE TRUST, EQUITABLE ACCESS, AND PATIENT ENGAGEMENT IN CARE

CARE DELIVERY COMPONENTS
ENABLING RESPONSIVENESS TO PATIENT & 'OHANA





Fluid Pathway

Population Health infrastructure supports fluid & care delivery that is responsive to patient needs

Native Hawaiian Health

POPULATION HEALTH

WHY THIS MEASURE IS IMPORTANT

- Our Aspirational Goals are (1) to increase the life expectancy of Native Hawaiians by closing the gap between Native Hawaiians and the statewide average, and (2) to become lifetime partners in health.
- Queen's aims to partner with Native Hawaiian communities to achieve ola (balance of physical, mental, and spiritual well-being).
- The key drivers of life expectancy for indigenous populations include: racial discrimination, access to health care, social & economic disparities, negative health risk behaviors, and adverse childhood events.
- Grounded in the Kahua Ola framework, the plan is focused on increasing access to culturally-safe care, strengthening relationships and engagement, and improving health outcomes through a population health approach.

CALCULATION

Native Hawaiian Data Registry On-line: identify NHs by NH flag and quantify unique NHs served within the Queen's Medical Center, Queen's North Hawaii Community Hospital, Molokai General Hospital, Queen's Health Care Centers, Queen's Island Urgent Care and EmPower Health (retrospectively within the last 3 years) by June 30, 2023

Threshold: Implement Kahua Ola 2.0 Milestones: by June 30, 2023

- QEC Kilolani, QWO Nā Pua Kaiona, and QNHCH Kahu a Ola programs: hired multi-disciplinary team and building workflows to increase # of NHs served
- Molokai Community Needs Assessment: stakeholders engaged & plan developed to conduct the community needs assessment

Target: For QEC Kilolani, QWO Nā Pua Kaiona, and QNHCH Kahu a Ola programs:

- Decrease No Show & Cancellation Rate: aggregated No Show & Cancellation Rate, calculated as # of NH patients who did not show up or who cancelled their appointment / total visits (no show appts + completed visits)
- Hgb A1c Levels: 60% of the NHs with Hgb A1c levels of = or ≥ 8 or ≥ 9 have reduced Hgb A1c levels below <8 or between 8.1 to <9, calculated as of June 30, 2023
  - Step 1. Identify NHs enrolled in a Kahua Ola program with Hgb A1c ≥ 8 and ≥9
  - Step 2. Calculate the % of NHs (with Hgb A1c > 8) who saw a decrease in Hgb A1c below 8 and NHs (with Hgb A1c >9) who saw a decrease in HgbA1c below 9

Superior: Increase NH Participants: 30% increase in NHs enrolled and engaged in the programs comparing 6/30/22 vs 6/30/23 (YTD)

FY22	FY23		
ACTUAL	THRESHOLD	TARGET	SUPERIOR
Completed Phase 1 of the NHH Data Registry	• Native Hawaiian Health Registry On-line (self-identified) • Implement Kahua Ola 2.0 milestones on Oʻahu, Hawaiʻi Island and Molokaʻi communities	• 5% decrease no show/cancellation rates for Native Hawaiian (NH) participants in QEC, QWO & QNHCH programs	• 15% decrease no show/cancellation rates for NH participants in QEC, QWO & QNHCH programs • Achieve Hgb A1c levels of <8 or <9 in 60% of NHs with Hgb A1c levels 8 or higher • 30% increase of NHs participating in NHH QEC, QWO, & QNHCH programs

Appendix - Acronyms

ACO	Accountable Care Organization
ARG-C	Applied Research Genomic Center
CCC	Clinical Care Coordination
CHNA	Community Health Needs Assessment
CIG-C	Clinical Individualized Genetics Center
CQI	Continuous Quality Improvement
CY	Calendar Year
DEIJ CW	Diversity Equity Inclusion Social Justice Caregiver Wellness
ED	Emergency Department
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GME	Graduate Medical Education
HR	Human Resources
JABSOM	John A Burns School of Medicine
KO	Kahua Ola
LGD-C	Laboratory Genomics Diagnostic Center
MSSP	Medicare Shared Savings Program
NH	Native Hawaiian
NHH	Native Hawaiian Health
PCP	Primary Care Provider
PCP	Primary Care Provider
Q	Quarter
QCIPN	Queen‘s Clinically Integrated Physician Network
QEC	Queen Emma Clinics
QEP	Queen’s Enrichment Program
QHS	Queen’s Health System
QMC	Queen’s Medical Center
QMC M	Queen’s Medical Center Mananama
QMC W	Queen’s Medical Center West O‘ahu
QNHCH	Queen’s North Hawai‘i Community Hospital
QUAAC	Queen‘s University Academic Affairs Committee
Queri	Queen‘s University Research Institutes
QWO	Queen‘s West O‘ahu
RPM	Remote Patient Monitoring
SDOH	Social Determinants of Health
TBD	To Be Determined
UME	Undergraduate Medical Education
YR	Year