COMPASSION
ALOHA
RESPECT
EXCELLENCE

NATIVE HAWAIIAN HEALTH

FISCAL YEAR 2026 QUARTER 2 IMPACT REPORT

OCTOBER 2025 - DECEMBER 2025

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Your paragraph text

QUEEN'S MISSION

To fulfill the intent of Queen Emma and King Kamehameha IV to provide in perpetuity quality health care services to improve the well-being of Native Hawaiians and all of the people of Hawaiʻi.

Renewed Health and Stability through Pilina & Collaborative Care

Remote Patient Monitoring Moʻolelo

ʻAnakē is a 69-year-old Native Hawaiian female **enrolled in RPM for hypertension and diabetes.** After experiencing major life changes following a car accident, she became highly motivated to stabilize her health.

She **demonstrated exceptional engagement**, missing only one day of vital sign reporting throughout the program. She worked closely with the pharmacist, dietitian, and her navigator **to improve medication adherence, diet, and overall self-management.**

A significant barrier arose when her medication costs increased to **$1,500 out of pocket** due to insurance changes. With navigator support, her **costs were reduced to $13, and she will transition to a Medicare Advantage** plan in 2026 **with $0 out-of-pocket expenses**.

Her commitment, with the support of the RPM team, led to **notable clinical improvement, including stabilized blood pressure and a reduction in A1c** from 9.2 at enrollment to 7.8 at graduation. Graduation was emotional but positive, and the patient expressed gratitude and pride in her progress.

Key Takeaways

- **Removing Barriers:** Addressing social determinants of health and optimizing her insurance eliminated financial strain, improved medication adherence, reduced stress, and allowed her to fully benefit from RPM, driving strong clinical gains.
- **High Motivation, Strong Outcomes:** Her high level of engagement and commitment was reflected in substantial clinical improvement, including A1c reduction from 9.2 to 7.8, and blood pressure maintained under 140/90.
- **Collaborative Care:** Shared effort between the patient and care team around medications, diet, and self-management supported her in meeting clinical goals and building confidence in her health journey.

Native Hawaiian Health Department‘s Kuleana at Queen’s

1 CULTURALLY SAFE CARE

Culturally safe care that Improves Clinical Access and Outcomes

Deepen Connection with our Founders

Cultivate connection & alignment with our Founders, heritage, mission, & culture for shared organizational identity

Address Health Disparities & Improve Well-being

Propagate data & research on Native Hawaiian health to inform decision-making, guide action, & measure progress toward well-being

Promote Equitable Care & Clinical Outcomes

Develop & optimize programs & services for Native Hawaiians that enable access, increase engagement, & improve clinical outcomes

2 COMMUNITY RELATIONSHIPS

Relationships & Pathways that Address Community Health Needs

Partner with Community

Understand community needs & foster relationships that connect communities with services, providers, & care

Strengthen Workforce Pathways

Create & expand workforce pathways for Native Hawaiians or others from disadvantaged backgrounds

Engage in Native Hawaiian Affairs

Engage in Native Hawaiian public affairs (government relations, well-being, rights, legacy, advocacy & cultural preservation)

Accomplishments

From July to December, Native Hawaiian Health engaged in the following activities:

102

(Activities include initiatives, Services, Partnerships, Programs, Projects, Research Studies)

The 102 unique activities align with the department's two functional roles: 1) *Culturally safe care* and 2) *Relationships and Pathways that Address Community Health Needs*. Notably, **76% of activities support multiple roles,** showing **intentional design and broad, cross-cutting impact**.

Culturally Safe Care that Improves Clinical Access and Outcomes

Deepen Connection with our Founders

Address Health Disparities & Improve Well-Being

145

Promote Equitable Care & Clinical Outcomes

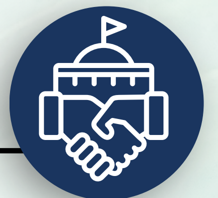
Relationships & Pathways that Address Community Health Needs

Partner with Community

Strengthen Workforce Pathways

78

Engage in Native Hawaiian Affairs



Performance Dashboard

NATIVE HAWAIIAN HEALTH DASHBOARD FY26 Q2

GOALS	FY25 (Baseline)	FY26 Q1 Actual	FY26 Target
CULTURALLY SAFE CARE			
Develop IT/Data Reporting Infrastructure to Capture NHs & Establish Baseline	In progress	In progress	Establish a baseline of the # (%) of NHs and all others with A1c gaps
COMMUNITY RELATIONSHIPS & PATHWAYS			
Community Engagement	31	2*	Baseline +3 NH Partnerships

*See a list of partnerships in Appendix 1 on page 19

Native Hawaiians Served

Entity	Unique NH Patients at Entity	% of Unique NH Patients at Entity	2020 Census % by Geographic Location
Kahi Mohala	19	33%	N/A
Molokai	2,760	66%	66%
North Hawai'i	4,558	26%	30%
Manamana	25,919	16%	14%
Wahiawā	1,750	21%	14%
West O'ahu	12,697	23%	25%

FY26 Year-to-Date

(July to December)

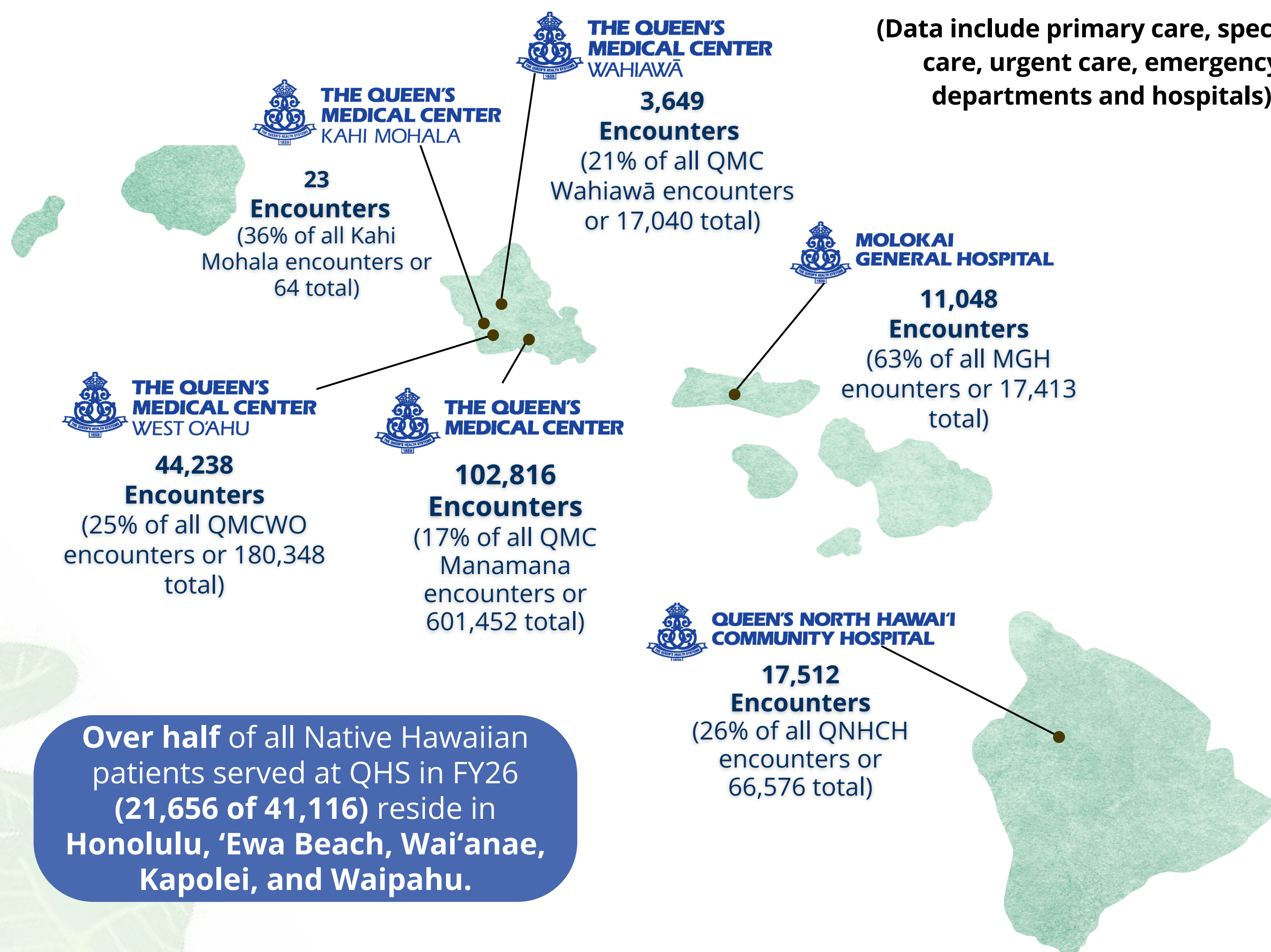
41,116

served at QHS

179,603

unique encounters at QHS

(Data include primary care, specialty care, urgent care, emergency departments and hospitals)



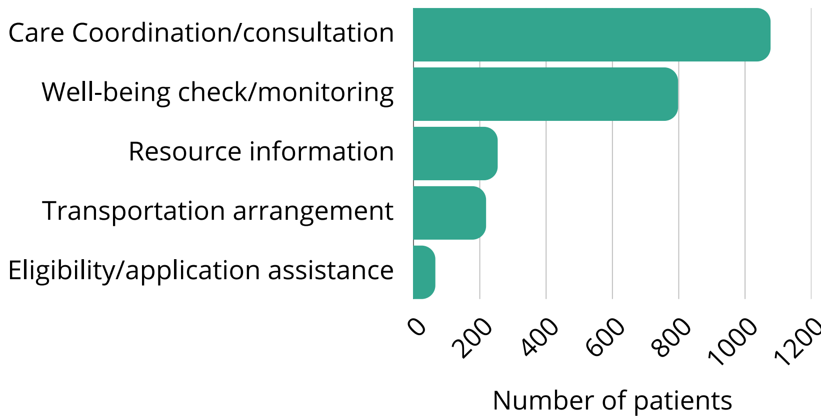
Over half of all Native Hawaiian patients served at QHS in FY26 **(21,656 of 41,116)** reside in **Honolulu, 'Ewa Beach, Wai'anae, Kapolei, and Waipahu.**

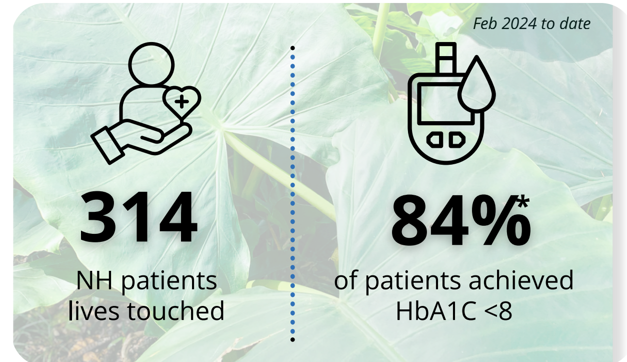
Culturally Safe Care: Kahua Ola Programs

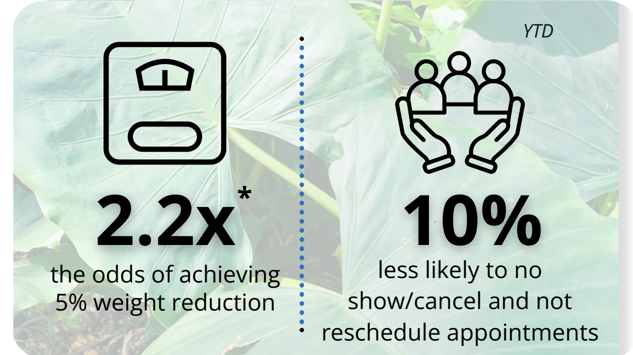
Our three Kahua Ola programs (Kilolani, Kahu a Ola, Nā Pua Kaiona) address health equity and promote access to care for Native Hawaiians through culturally responsive chronic disease management and healthcare navigation.

CUMULATIVE PROGRAM RESULTS

Top 5 navigator services across Kahua Ola programs







*Represents patients in the Kahu a Ola and Kilolani Primary Care programs, where HbA1C and weight are tracked. Nā Pua Kaiona is excluded.

PROGRAM HIGHLIGHTS

Kilolani (Queen Emma Clinics)

Patients enrolled in Kilolani had

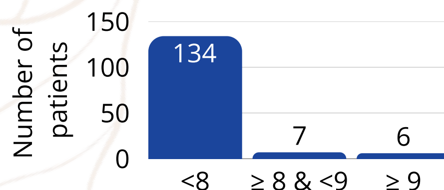
2.7x higher

odds of achieving a 5% reduction in body weight compared to clinically similar patients not enrolled.

Kahu a Ola (QNHCH Primary Care)

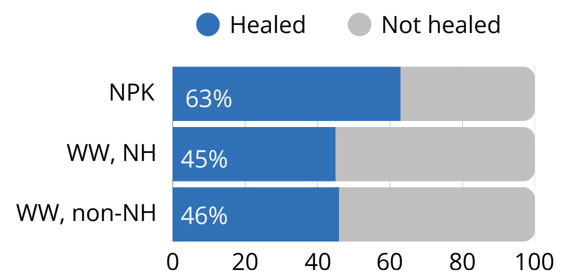
91%

of Kahu a Ola patients experienced at least a 1 point reduction in HbA1c to achieve an HbA1c <8.



Nā Pua Kaiona (QMCWO Wound Care)

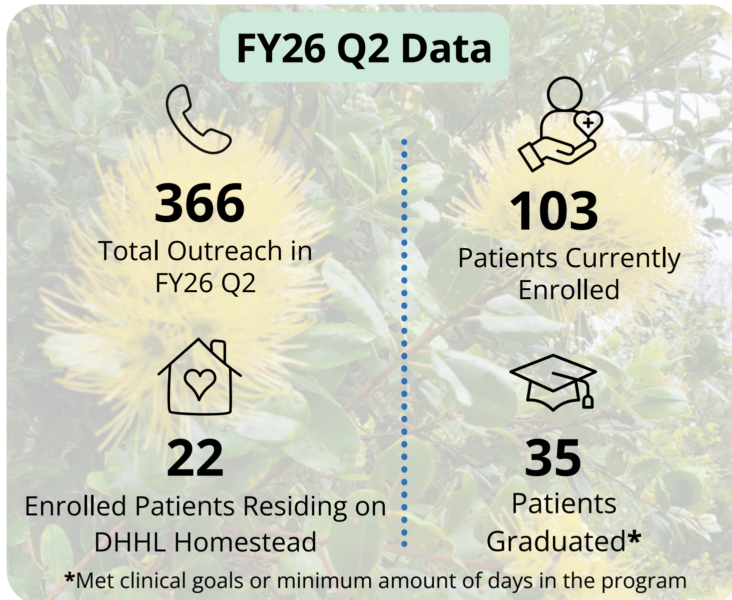
Patients with diabetes enrolled **in Nā Pua Kaiona showed greater wound healing ($p < 0.05$)** than Native Hawaiian and non-Native Hawaiian patients with diabetes receiving care at the West Wound Center.

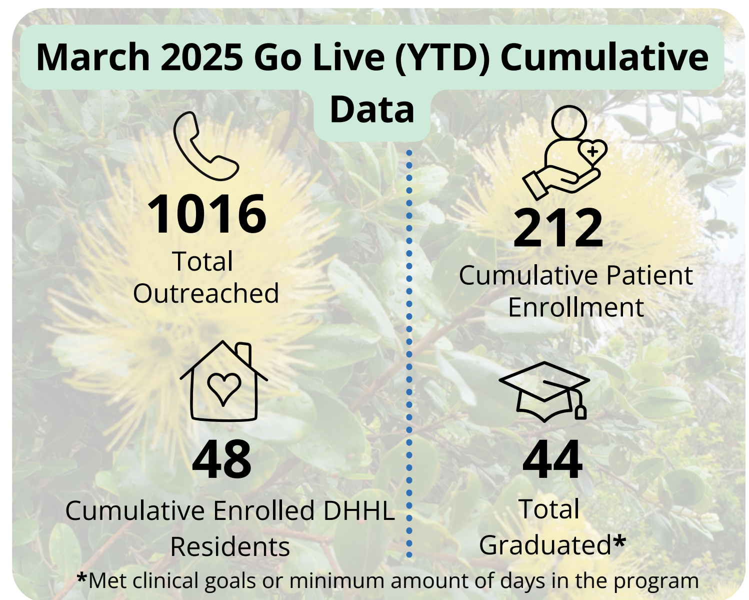


Note: NPK = Nā Pua Kaiona, WW, NH = West Wound, Native Hawaiian, WW, non-NH = West Wound, non-Native Hawaiian; Data from 2/23/2024 - 12/31/2025

Culturally Safe Care: Remote Patient Monitoring

RPM is expanding access to care by enabling patients to receive continuous home health monitoring. This model reduces barriers such as transportation challenges and limited appointment availability, ensuring timely interventions, particularly for underserved Native Hawaiian communities.





Adherence Rates

Regular self monitoring is a key element to **successful, long term chronic disease management.**

Adherence rates among RPM patients are:

43% higher than HRS's national average for **weight monitoring**

37% higher than HRS's national average for **blood glucose monitoring**

Mental Health

Patients' self-reported mental health scores **improved** by an average of

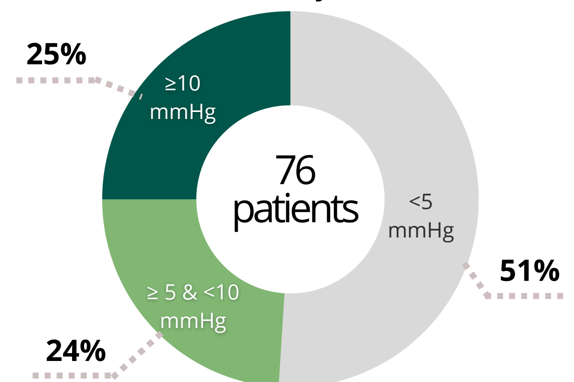
3.4 points

Note: Survey tool used is PROMIS (Patient-Reported Outcomes Measurement Information System). PROMIS is a patient-reported physical, mental, and social well-being.

A 2- to 6-point increase is considered the threshold at which **patients perceive themselves as meaningfully changed.**[1]

Blood Pressure

Change in systolic blood pressure among patients enrolled at least 90 days



- A **5 mmHg reduction** in systolic blood pressure **reduces risk of stroke by 10%.**[2,3]
- **Each 5 mmHg reduction** in systolic blood pressure results in **a 10% decreased risk of cardiovascular disease events.**[2,4]

1. Terwee, C. B. et al. Minimal important change (MIC): a conceptual clarification and systematic review of MIC estimates of PROMIS measures. Qual Life Res 30, 2729–2754 (2021).
2. Ettehad, D. et al. Blood pressure lowering for prevention of cardiovascular disease and death: a systematic review and meta-analysis. The Lancet 387, 957–967 (2016).
3. Kaindl, L., Hotz, J. F. & Ferrari, J. Cutting-edge stroke prevention strategies. eNeurologicalSci 39, 100561 (2025).
4. Canoy, D. et al. How Much Lowering of Blood Pressure Is Required to Prevent Cardiovascular Disease in Patients With and Without Previous Cardiovascular Disease? Curr Cardiol Rep 24, 851–860 (2022).

Performance Dashboard

KA ʻIKE PONO GOALS FY26-28

	FY25 ACTUAL (NHH)	FY25 ACTUAL (QHS)	FY26 YTD ACTUAL (NHH)	FY26 YTD ACTUAL (QHS)	FY26 GOAL (QHS)
L/T OBJECTIVE: TO REDUCE INCIDENCE, PREVALENCE & IMPACT OF DISEASE					
Chronic Disease Management (Diabetes): % Controlled A1c (Care Gap Closure) +3.0% (# lives impacted) by FY28	Baseline	Baseline			
TIMELY & EQUITABLE ACCESS					
Referral Management (specialty care) NHs compared to All	N/A	N/A	In Progress	In Progress	Referral Process Standardization & Baseline
PROUD TO BE QUEEN'S					
Culture and Engagement NHH/Kaleiopapa Trainings Offered	N/A	N/A	48	25% of leaders completed a self-development or wellness activity (Jul-Dec)	90% of leaders engaged in self-development & wellness activities
COMMUNITY PARTNERSHIPS					
Community Engagement - # of NH partnerships	31	N/A	2 new partnerships (Jul-Dec)	57 community engagements (Jul-Dec)	50 community engagements
HIGH QUALITY & SAFETY					
Mortality (Observed to Expected Ratio) among NHs	N/A	1.00 (Jan-Apr)	In Progress	0.86 (Jul-Oct)	≤1.00
Patient Experience (Inpatient/Outpatient) NH Inpatient/NH Outpatient	80.7%	78.5%	80.7% (Jul-Dec)	78.7% (Jul-Dec)	79.6% (+1.1% Improvement)
SUSTAINABILITY AND RESOURCEFULNESS					
Healthcare Operating Margin NHH Operating Budget Met		-3.0% ($65.5M loss) (Unaudited)	$775,248 actual $890,509 budget 87% ($115,261) Jul-Dec	0.1% (Jul-Dec)	FY26 Budget: -1.5% ($35M loss)

Ka ʻIke Pono Goal FY26-28
Long Term Objective: A1c Gap Closure

Purpose:
Queen's long-term objective is to reduce incidence, prevalence & impact of diabetes management through improved A1c control among high-risk and high-utilization populations from FY26 - FY28.

Goal:
This project aims to improve A1c by 3% among Native Hawaiians and other vulnerable populations.

Primary : Establish population baseline report. A1c intervention gap closure includes enhancing bulk ordering capabilities.

Clinical pathway: Implement Clinical pathways for PCP

Other Specialties: Develop care pathways for other specialties to capture multisystemic approach

HOW WILL NHH SUPPORT THIS KA ʻIKE PONO GOAL?

Meeting Our Mission Together:
NHH's role is to partner with multidisciplinary teams across the system to maintain a strong focus on the Native Hawaiian population and to guide culturally responsive practices for all. Through this collaboration, we strengthen the system's capacity to identify the Native Hawaiian population, design culturally responsive care pathways, and monitor the impact of culturally grounded interventions. This work will advance health outcomes for Native Hawaiians and other vulnerable groups whose needs are not fully met by traditional models of care.

FY26 Key Workstreams:

Work Group:
Data/Reporting

Surveillance Baseline
Define Patient Population
Data Validation

Work Group:
Clinical Practice
Change

Gap Analysis
Establish Baseline
Bulk Ordering
Define Success Metrics

Work Group:
Care Pathway

Systemwide DM
Interventions
Assessments

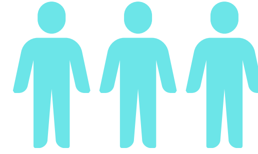
Ka ʻIke Pono Goal FY26-28
Long Term Objective: A1c Gap Closure

Patient Baseline Data

**Patients seen at Queen's in the last 18 months*
Data Source: Epic, pulled on 1/26/2026

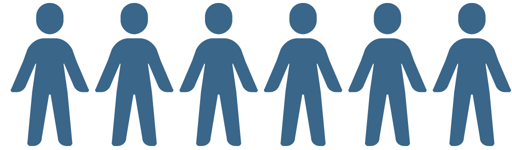
2,944
n=22,873

Native Hawaiian Patients with Prediabetes

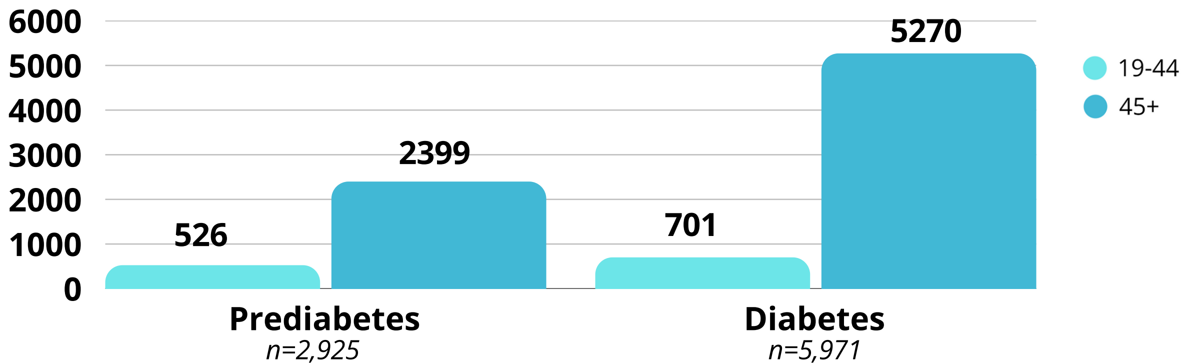


5,979
n=34,084

Native Hawaiian Patients with Diabetes



Number of Native Hawaiian patients with prediabetes or diabetes in each age group

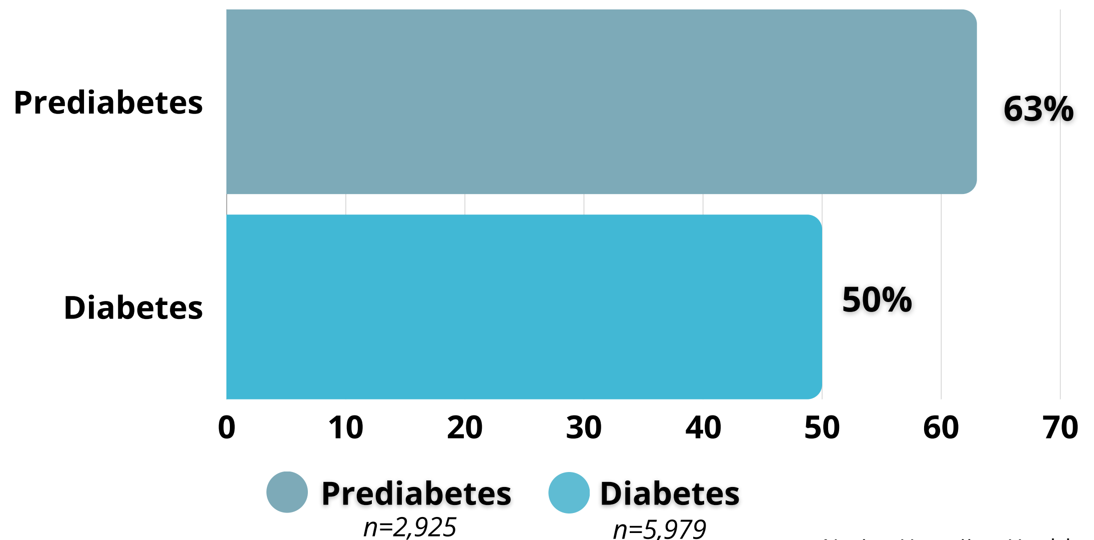


Highlight

50%

of Native Hawaiian patients with diabetes are connected to a QCIPN PCP

Native Hawaiian Patients with Diabetes or Prediabetes who have QCIPN Providers



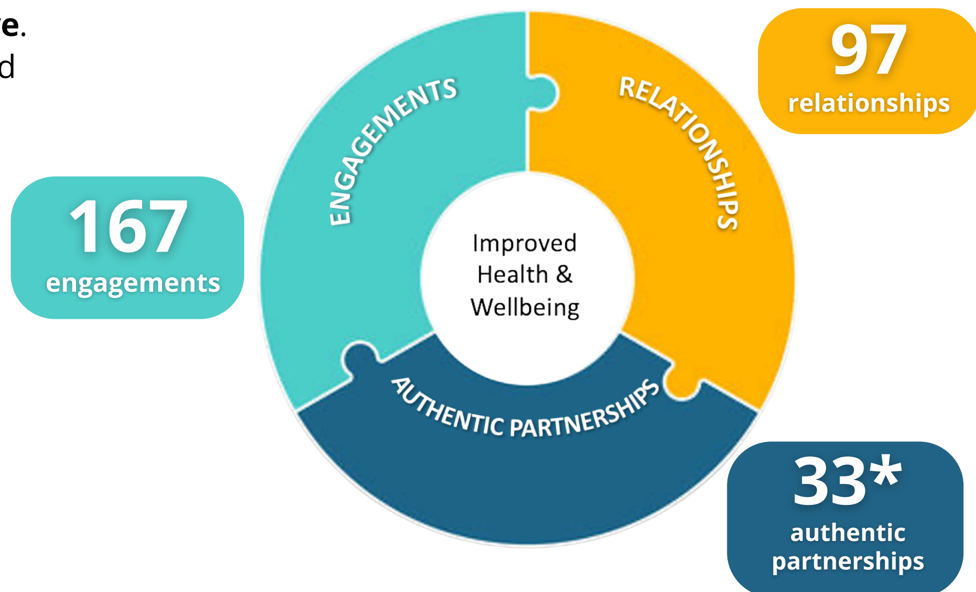
Ka ʻIke Pono (KIP) Goal FY26-28: Community Engagement for Native Hawaiian Health

Through the KIP community engagement plan, we have developed a framework grounded in the fundamental truth that health and well-being are strengthened through connection. Engagements, relationships, and authentic partnerships (Figure 1) are not just supportive elements of our work; they are essential to creating meaningful, lasting change.

Authentic partnerships ground our health system in the **shared values and priorities of the communities we serve**. By forming new relationships, we expand our reach and deepen our impact for Native Hawaiians and all the people of Hawaiʻi.

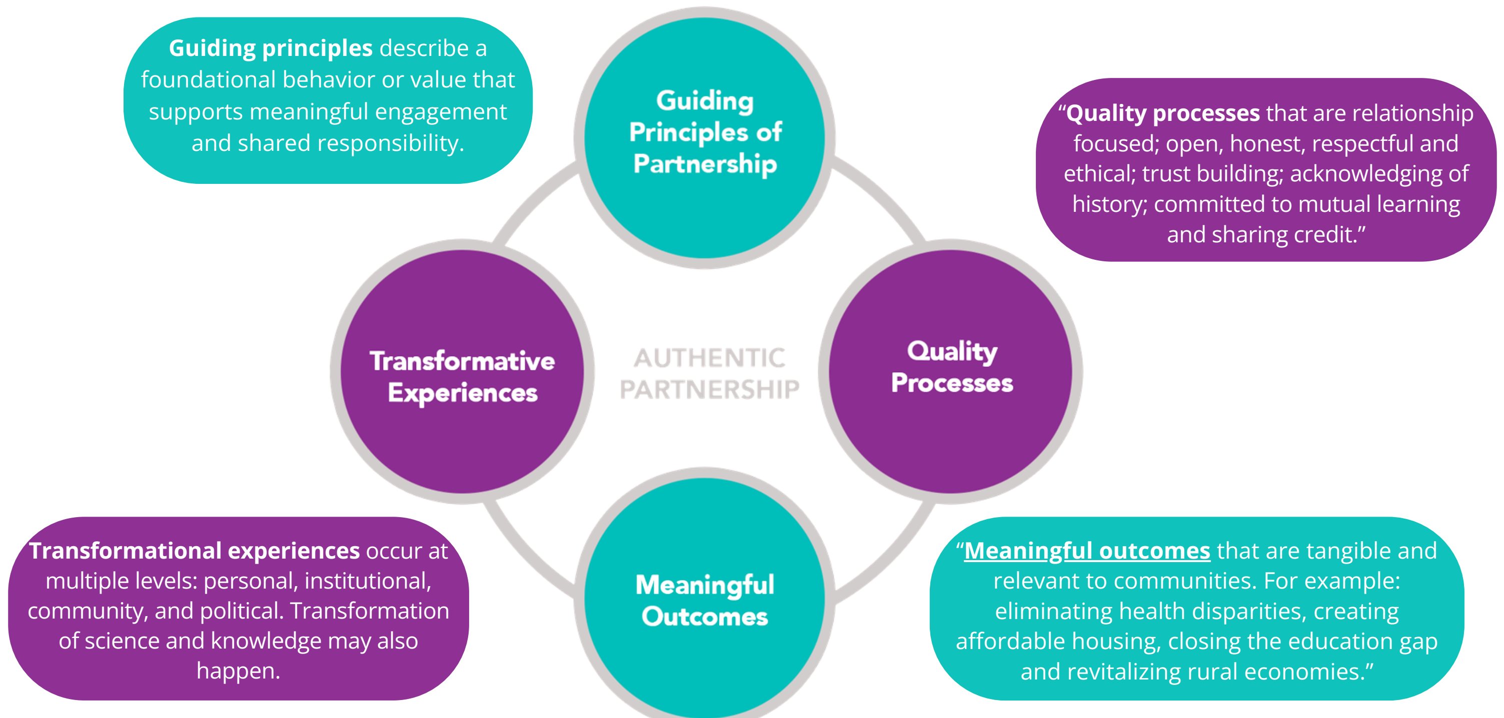
When we engage with intention and humility, trust grows. Guided by the four components (Figure 2), **authentic partnerships create pathways to improved health and well-being that no single effort or organization can achieve alone**. The following pages, 15-17, provide examples of this framework.

Figure 1. Proposed Community Engagement Framework with data from Native Hawaiian Health



(*See Appendix, page 19)

Figure 2. Authentic Partnership Framework



Citation: CCPH Board of Directors. Position Statement on Authentic Partnerships. Community-Campus Partnerships for Health, 2013.

Community Partnership Highlight: Kahi Mohala Aquaponics Project

Strengthening Mental Health in Hawaiʻi Youth through Ancestral Well-being Practices

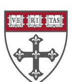
Fourteen leaders from five Native Hawaiian community organizations came together to help shape an ʻāina-based curriculum for youth at Kahi Mohala. Through this effort, an aquaponics system was developed. In addition, focus groups were conducted to learn, from a cultural perspective, how to promote health and well-being for youth. By integrating cultural practices such as aquaponics grounded in ancestral land stewardship, the project creates pathways for youth empowerment, land reciprocity, and family support, bridging hospital care with community-led healing to strengthen mental health.

Qualitative Findings & Outcomes

Youth Empowerment: Youth gained confidence and leadership through responsibility and ancestral values. Mentorship and teamwork inspired pride in continuing their kūpuna's (ancestors') legacy.

Land Reciprocity: Caring for the ʻāina was seen as vital to physical, mental and spiritual well-being. Youth viewed the land as a teacher that fosters balance and responsibility.

Family Support: Strong family ties provided guidance, healing, and belonging. Kūpuna modeled values that built resilience and affirmed each youth's place in the community.



HARVARD
T.H. CHAN
SCHOOL OF PUBLIC HEALTH

NATIVE HAWAIIAN HEALTH

THE QUEEN'S MEDICAL CENTER
KAHI MOHALA

Applying the Authentic Partnerships Framework to the Kahi Mohala Aquaponics Project

The guiding principles of the **Authentic Partnership Framework** (Figure 1, page 14) came alive when we applied them in the community. This project was a powerful example of how our authentic partnerships helped weave ancestral knowledge into clinical spaces for our youth. Adolescents in Hawai'i face significant mental health risks and challenges influenced by social, economic, and environmental factors. Anxiety and depression are increasing, and suicide is the leading cause of death among Native Hawaiian and Pacific Islander youth ages 15-24.

Through this initiative, cultural reverence and traditions were elevated to help Queen's address these factors. These organizations, with whom Native Hawaiian Health had previous relationships and engagements, represent a diverse network of Hawaiian kūpuna, traditional practitioners, youth at high risk, and community leaders. Bringing these five grassroots organizations together as key stakeholders serving youth is an example of the impact of community engagement, allowing us to collectively solve the challenges our community faces. Using the **Authentic Partnerships Framework**, we identified the following:

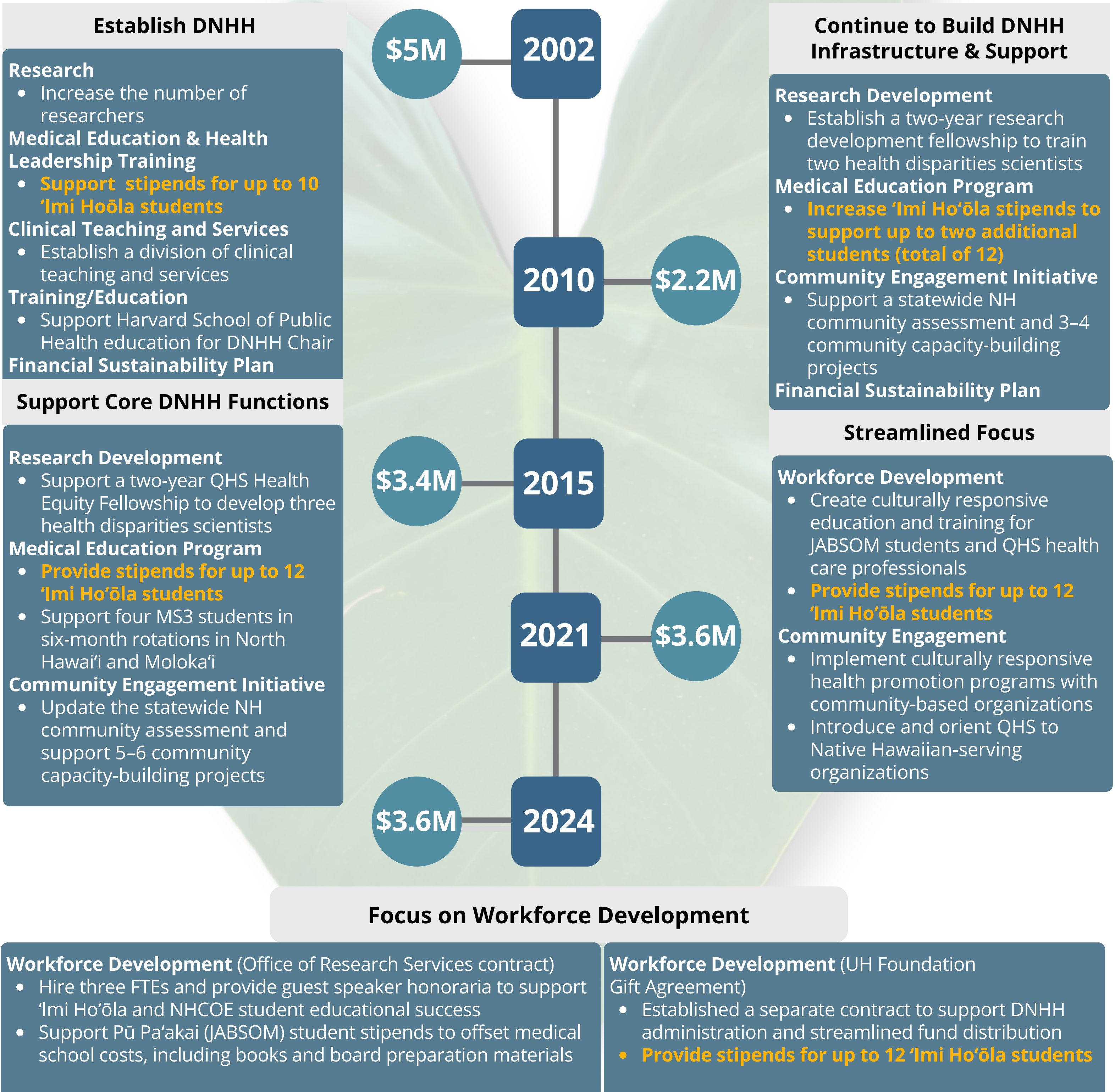
3
AUTHENTIC PARTNERSHIPS
Mauliola Ke'ehi
KE KULA NUI O WAIMĀNALO
WAIANAE COAST COMPREHENSIVE HEALTH CENTER

2
RELATIONSHIPS
MĀLA 'AI 'ŌPIO MA'O ORGANIC FARMS
Lualualei, Wai'anae, Hawai'i
PU'ULOA OUTRIGGER CANOE CLUB

13
COMMUNITY ENGAGEMENTS

Authentic Partnership Highlight: UH MĀNOA, JABSOM Department of Native Hawaiian Health

Another authentic partnership we would like to highlight is the **more than two-decade** collaboration between QHS and the UH JABSOM Department of Native Hawaiian Health. With over **$17 million** committed by QHS, both entities have worked together to enhance Native Hawaiian health and the communities we serve.



Focus on Workforce Development

Workforce Development (Office of Research Services contract)
- Hire three FTEs and provide guest speaker honoraria to support ʻImi Hoʻōla and NHCOE student educational success
- Support Pū Paʻakai (JABSOM) student stipends to offset medical school costs, including books and board preparation materials

Workforce Development (UH Foundation Gift Agreement)
- Established a separate contract to support DNHH administration and streamlined fund distribution
- **Provide stipends for up to 12 ʻImi Hoʻōla students**

Summary of Learnings

Ma ka hana ka ʻike. *Through the work we learn.*

Fragmented Health Data - NHH data continues to be fragmented and difficult to aggregate because it is drawn from multiple, unaligned sources and often lacks completeness. As a result, obtaining a comprehensive view of Native Hawaiian patient health, utilization, and outcomes remains challenging. More coordinated effort is needed to improve data accuracy, consistency, and integration across systems.

Unclear Cost Drivers - Understanding the true cost of care and patient attribution for Native Hawaiians remains difficult due to our heavy reliance on insurance carriers for data. These datasets often have delays, gaps, or limited transparency, making it challenging to track spending, utilization trends, and population level impact with precision. Improved access to timely, comprehensive cost data is needed to support accurate analysis and decision-making.

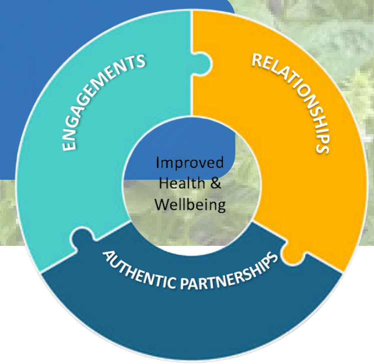
Relational Outcomes Overlooked - Emotional, relational, and cultural well-being are critical components of health for Native Hawaiian patients, yet these outcomes are often overlooked or not systematically measured. Current systems emphasize clinical and quantitative metrics, leaving limited space to capture patients' experiences, trust, connection, and sense of support. Greater attention to these relational outcomes is needed to reflect a fuller picture of health and healing for our community.

Scaling Cultural Training - Efforts to scale culturally responsive and safe training programs face significant challenges because these trainings rely heavily on pilina (relationship-building) and experiential learning, both of which require time, presence, and meaningful engagement. Staff and leadership often have limited availability due to operational demands, making it difficult to offer trainings at scale without compromising depth or cultural integrity. New strategies are needed to balance cultural fidelity with practical workforce constraints.

APPENDIX

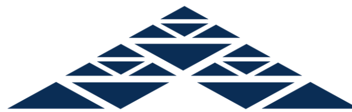
19 **List of Authentic Partnerships**

AUTHENTIC PARTNERSHIPS



1. aio Digital
2. ACP Decisions
3. Bobby Yamauchi Company
4. Consuelo Foundation
5. Daughters of Hawaiʻi
6. Department of Hawaiian Home Lands
7. Derigo Health Healthcare
8. Department of Land & Natural Resources
9. Hawaiʻi Food Bank*
10. Hawaiʻi Good Food Alliance*
11. Hawaiʻi Residency Program
12. Hawaiian Council
13. Hui Mālama i ke Ala ʻŪlili
14. ʻIolani Palace
15. ʻIolani School
16. John A. Burns School of Medicine, Department of Native Hawaiian Health
17. Kamehameha Schools
18. Kawānanakoa Foundation
19. Ke Kula Nui o Waimānalo
20. Kealiʻi Poʻoloa
21. Kōkua Kalihi Valley
22. Leila Ryusaki
23. Liliʻuokalani Trust
24. Lisa Watkins-Victorino, PhD
25. Mauliola Keʻehi
26. Office of Hawaiian Affairs
27. Papa Ola Lōkahi
28. Parker Ranch
29. Research Corporation of the University of Hawaiʻi
30. St. Andrew's Schools
31. University of Hawaiʻi Foundation
32. Waiʻanae Coast Comprehensive Health Center
33. Waimānalo Health Center

*Authentic Partners as of FY26



NATIVE HAWAIIAN HEALTH

THE QUEEN'S HEALTH SYSTEMS

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Email: nhh@queens.org
https://www.queens.org/about/native-hawaiian-health-qhs/