Native Hawaiian Health 10-Year Strategies & Projects

July 8, 2022
## 10-Year Strategies & Projects

### PRIORITIES

1. Complete Kahua Ola II Strategic Plan by Sep 2022 and continue execution
2. Complete scale up of clinical programs (Population Health, interdisciplinary team model of care)
3. Complete the development, buildup and testing of the Native Hawaiian Health Registry to go live by February 2023
4. Cultural Integrity of our corporate identity and character to operate guided by our Ali‘i legacy within the Kahua Ola framework. Complete the assessment and curriculum.
5. Establish a Grant Writing core and strategy to generate 30% of the NHH/DEIJ overall budget by FY 2025.
6. Develop and implement a Legislative Strategy to provide support to our NHH and DEIJ Strategic Plans and projects.
7. Complete due diligence and community soft-sounding to assess the community interest and will to complete be a QHS Moloka‘i Population Health project by Feb 2023
8. Develop the Business Case and proforma of the Oncology Education & Engagement program by Oct 2022
9. Complete the clinical and research development plan and business case for the Genomics Institute within 12 months of hiring 1 and retaining the other key principals and advisors
10. Develop and implement a Native Hawaiian cultural behavioral and psychiatric assessment and treatment program for children, adolescents, adults, and elders
KAHUA OLA 2.0 PLAN COMPLETION
Kahua Ola: Native Hawaiian Health Strategic Plan Expansion (Draft 2)

**TEN-YEAR ASPIRATIONAL GOALS**
Lifetime partners in health
Increase the life expectancy of Native Hawaiians and close the gap in half

**KANAKA ‘ŌIWI OUTCOMES**

**IMPROVE HEALTH & WELL-BEING THROUGH CLINICAL PROGRAMS**
NH Data Registry, Ka Hua Ola Program Scale-Up

**EMPOWER INDIVIDUALS & FAMILIES IN WELLNESS PROMOTION**
Patient engagement in care management.

**INTERACTIVE ENGAGEMENT WITH COMMUNITY**
Healthcare workforce development, education & training. Leadership & workforce pathways

**DELIVER CULTURALLY RESPONSIVE CARE**
Partnership with cultural practitioners for culturally responsive education and cultural practice.

**QHS OUTCOMES**

**PATIENT EXPERIENCE**
Patient satisfaction, engagement, trust

**ACCESS TO PREVENTIVE, PRIMARY, SECONDARY & TERTIARY CARE**
Equitable and timely

**HEALTH OUTCOMES**
Self-reported overall health status CARE*Link measures of morbidity and mortality

**QUALITY**
Sustained improvements in clinical indicators
CLINICAL PROGRAM SCALE UP:
Population Health & Interdisciplinary Team Model of Care
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

Approach to Reducing the Gap in Life Expectancy

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
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- Trauma
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LEGISLATIVE ADVOCACY TEAM

- Addressing Key Population Drivers
- (Cultural Practitioners, Programs, Stories of our Founders)

CLINICAL & BASIC SCIENCE RESEARCH TEAMS

- (Primary Care, Behavioral Health, Chronic Care, Prevention, Specialty Care)

INTER-DISCIPLINARY TEAM-BASED CARE

- NĀ ‘ŌWI HAWAI’I COMMUNITY CULTURAL & WELLNESS TEAMS
- (Cultural Practitioners, Programs, Stories of our Founders)

QHS Nā ‘Ōwi Quality Performance Teams

- Nā ‘Ōwi IT/Data Management Teams

NĀ ‘ŌWI HAWAI’I COMMUNITY CULTURAL & WELLNESS TEAMS

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NĀ ‘ŌWI HAWAI’I COMMUNITY CULTURAL & WELLNESS TEAMS

- (Cultural Practitioners, Programs, Stories of our Founders)
Addressing Needs of Native Hawaiians

PRELIMINARY AREAS OF FOCUS

HOUSING  FOOD INSECURITY  TRANSPORTATION  BEHAVIORAL HEALTH

Kahu a Ola Program
Outcomes

**Improved BP, Weight, A1c**

**QNHCH Kahu a Ola Cohort**

- Blood Pressure: 24% improved, 5% target
- Weight: 21% improved, 5% target
- HbA1c: 6% improved, 6% target

**Improved Systolic Blood Pressure**

**QNHCH – Ola Hou I Ka Hula**

- Avg Systolic BP: Baseline N=11, 3-Month Follow Up N=4, 6-Month Follow Up N=3
- Avg Diastolic BP: Baseline N=11, 3-Month Follow Up N=4, 6-Month Follow Up N=3

*Graphs showing percentage of patients improved and target improvement.*
# QNHCH Kahua Ola: Key Priorities

## TEN-YEAR ASPIRATIONAL GOAL

Increase the life expectancy of Native Hawaiians and close the gap in half  
Become lifetime partners in health with the community we serve

### QNHCH LEARNINGS

**IMPROVE HEALTH CARE ACCESS & DATA INFRASTRUCTURE**

**INCREASE PATIENT RECRUITMENT & ENGAGEMENT**

**ADDRESS CRITICAL WORKFORCE SHORTAGE & STAFF RECRUITMENT**

**COMMUNITY OUTREACH, PARTNERSHIP, EDUCATION & AWARENESS**

### QNHCH PRIORITIES

**EXPAND KAHU A OLA**  
Expand access to (virtual care, outreach), healing, prevention, and disease management services

**HEALTH EDUCATION & OUTREACH**  
Promote awareness of services, engage new or lost-to-care patients, new referral partners

**WORKFORCE DEVELOPMENT**  
Dedicated local recruitment support, specialized training, pipeline development for future workforce

**EXPAND COMMUNITY PARTNERS**  
Dedicated community liaison to develop new partnerships, coordinate community events, and engage cultural practitioners

### QHS KEY PRIORITIES

**IMPROVE HEALTH & WELL-BEING THROUGH CLINICAL PROGRAMS**

**EMPOWER INDIVIDUALS AND FAMILIES IN WELLNESS PROMOTION**

**DELIVER CULTURALLY RESPONSIVE CARE**

**INTERACTIVE ENGAGEMENT WITH COMMUNITY**
**QNHCH Scale-Up**

**TEN-YEAR ASPIRATIONAL GOALS**

Lifetime partners in health
Increase the life expectancy of Native Hawaiians and close the gap in half

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**QHS OUTCOMES**

**PATIENT EXPERIENCE**
Patient satisfaction, engagement, trust

**ACCESS TO PREVENTIVE, PRIMARY, SECONDARY & TERTIARY CARE**
Equitable and timely

**HEALTH OUTCOMES**
Self-reported overall health status
CARE*Link measures of morbidity and mortality

**QUALITY**
Sustained improvements in clinical indicators

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**KANAKA ‘ŌIWI OUTCOMES**

**IMPROVE HEALTH & WELL-BEING THROUGH CLINICAL PROGRAMS**
NH Data Registry, Kahua Ola Program Scale-Up

**EMPOWER INDIVIDUALS & FAMILIES IN WELLNESS PROMOTION**
Patient engagement in care management. Mauliola Keʻehi Program. Evaluation on ʻāina-based education and wellbeing

**INTERACTIVE ENGAGEMENT WITH COMMUNITY**
Partnership with cultural practitioners for culturally responsive education and cultural practice.

**DELIVER CULTURALLY RESPONSIVE CARE**

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**QNHCH OUTCOMES**

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**EXPAND COMMUNITY PARTNERS**
Dedicated community liaison to develop new partnerships, coordinate community events, and engage cultural practitioners
<table>
<thead>
<tr>
<th>Expand Clinical Program</th>
</tr>
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<tbody>
<tr>
<td>Remote Patient Monitoring (RPM)</td>
</tr>
<tr>
<td>Care Coordination</td>
</tr>
<tr>
<td>Transitional Care</td>
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<tr>
<td>○ ED Discharges</td>
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<tr>
<td>○ Inpatient Discharges</td>
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<tr>
<td>Telehealth (Primary Care Scheduled Visit + Home Visits/Outreach for High Risk Patients)</td>
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<tr>
<td>Expand eligibility criteria to all NHs</td>
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<table>
<thead>
<tr>
<th>Outreach</th>
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<tbody>
<tr>
<td>Community Fairs &amp; Events</td>
</tr>
<tr>
<td>Outreach/Education on Specialized Services for Referrals</td>
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<table>
<thead>
<tr>
<th>Community Partnerships</th>
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</thead>
<tbody>
<tr>
<td>Hui Mālama Ola Nā ‘Ōiwi (Papa Ola Lōkahi)</td>
</tr>
<tr>
<td>FQHCs</td>
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<tr>
<td>Kohala Center</td>
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<tr>
<th>Workforce Development</th>
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<tbody>
<tr>
<td>Develop Comprehensive Healthcare Workforce Development Program (1 FTE)</td>
</tr>
<tr>
<td>Strategic Pipeline Partnerships (middle/high school/College Program)</td>
</tr>
<tr>
<td>QNHCH Internships</td>
</tr>
<tr>
<td>On Island CHW/Social Work Workforce Development</td>
</tr>
<tr>
<td>Standardized Specialized Training</td>
</tr>
</tbody>
</table>
QNHCH North Hawai‘i Kahu a Ola CMC Project Performance

PROJECT UPDATE Status (☑ Completed ☠ In Process ☐ Not Started)

Infrastructure ✓ • RN Patient Care Coordinator hired in September 2021 (Mailani Lim)
• Implemented culturally-based clinical intervention (i.e. Ola Hou i ka Hula), diabetes support, dietician support, health education support, and chronic care management supplies) developed & initiated

Patient Population ❖ • NH with DM2, Obesity or Hypertension at Primary Care Clinic
• Total Kahu a Ola Enrollees (as of March 2022) = 122
  • 66 patients have DM (54% of enrollees); 103 patients have HTN (84% of enrollees); 89 patients are Obese (73% of enrollees)
  • 28 patients (23% of enrollees) have 1 of 3 qualifying diagnosis; 52 patients (43% of enrollees) have 2 of the 3 qualifying diagnosis; 42 patients (34% of enrollees) have all 3 diagnoses
• 35 patients had behavioral health services with the Kahu a Ola Clinical Therapist

<table>
<thead>
<tr>
<th>Short-Term Outcomes</th>
<th>FY 21</th>
<th>Target</th>
<th>FY 22 Quarter 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand behavioral health department by 3 FTE</td>
<td>0 FTE</td>
<td>3 FTE</td>
<td>3 FTE</td>
</tr>
<tr>
<td>Increase number (#) of NH encounters within primary care by 5% within one year</td>
<td>4,539</td>
<td>4,766</td>
<td>3,005</td>
</tr>
<tr>
<td>Improvement in Hemoglobin A1c (HbA1c) among participants within one year (2% decrease)</td>
<td>7.45</td>
<td>7.3</td>
<td>7.2</td>
</tr>
<tr>
<td>Improvement in Body Mass Index (BMI) among participants within one year (2% decrease)</td>
<td>36.5</td>
<td>35.8</td>
<td>33.8</td>
</tr>
<tr>
<td>Improvement in Blood Pressure (BP) among participants within one year (2% decrease)</td>
<td>138/82</td>
<td>137/81</td>
<td>140/82</td>
</tr>
</tbody>
</table>
QEC KILOLANI PROGRAM
1. Updated Data
2. Scale-Up Focus Areas/Plan
3. Health Care Workforce (Need)
Queen Emma Clinics - Increased Patient Engagement

Lab Completion % – Hemoglobin A1c: Most Recent Lab Since 2018 Jan

Higher is Better

Active Kikolani  Control
NĀ PUA KAIONA PROGRAM
QMC QEC Kilolani CMC Project Performance

PROJECT Q3 UPDATE Status (✓ Completed ✗ In Process ☐ Not Started)

Infrastructure ✗  • In Progress – Expansion of team (navigator started November 2021; social work position submitted)

Patient Population ✓  • Current Kilolani Patients as of March = 122

Lives Touched ✓  • Navigator visits = 186
  • Navigator meaningful encounters = 135
  • Social worker visits = 154
  • Social worker meaningful encounters = 201
  • RN visits = 482
  • Meaningful encounters with RN = 289
  • Registered visits with MA = 155
  • Meaningful encounters with MA = 263

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<tr>
<td>Increase NH DM encounters by 5% in primary care within one year</td>
<td>2,407</td>
<td>2,527</td>
<td>2,174</td>
</tr>
<tr>
<td>Increase NH DM new unique patients by 3% in QEC within one year</td>
<td>17</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Decrease no show rate of NH DMs within one year by 2% in QEC within one year</td>
<td>198</td>
<td>194</td>
<td>176</td>
</tr>
<tr>
<td>Decrease 30-day hospital readmissions for NH DMs within one year</td>
<td>11</td>
<td>TBD</td>
<td>12</td>
</tr>
</tbody>
</table>
Kahua Ola Alignment:

Goal #1: Health care accessibility – Building trust and accessibility for Hawaiians in targeted communities

- Improve health care accessibility for Native Hawaiians residing in the West O‘ahu region seeking wound care and treatment by providing transportation to patients who would not otherwise have access.
- Improve trust with Native Hawaiian patients by engaging patients through community navigation.
# QMC West-O‘ahu Nā Pua Kaiona Project Performance

## PROJECT UPDATE

<table>
<thead>
<tr>
<th>Status</th>
<th>Completed</th>
<th>In Process</th>
<th>Not Started</th>
</tr>
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<tbody>
<tr>
<td><strong>Infrastructure</strong></td>
<td>✔</td>
<td></td>
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<tr>
<td>• Completed Dec 2020 - Official patient care launch</td>
<td>✔</td>
<td></td>
<td></td>
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<tr>
<td>• Completed Aug 2020 - PCN recruitment &amp; training</td>
<td>✔</td>
<td></td>
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<tr>
<td><strong>Patient Population</strong></td>
<td>✔</td>
<td></td>
<td></td>
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<tr>
<td>• All NHs scheduled at wound clinic with transportation or navigation needs</td>
<td>✔</td>
<td></td>
<td></td>
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<tr>
<td>• N= 24 active caseload (as of April 29, 2022)</td>
<td>✔</td>
<td></td>
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<tr>
<td>• N= 17 on wait list (as of April 29, 2022)</td>
<td>✔</td>
<td></td>
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<tr>
<td>• SDoH needs of the current active caseload (as of April 29, 2022)</td>
<td>✔</td>
<td></td>
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<tr>
<td>• Food Insufficiency</td>
<td>✔</td>
<td></td>
<td></td>
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<tr>
<td>• Mobility – 73%</td>
<td>✔</td>
<td></td>
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<tr>
<td>• Educational – 92%</td>
<td>✔</td>
<td></td>
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<tr>
<td>• Cost – 85%</td>
<td>✔</td>
<td></td>
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<tr>
<td>• Housing - 55%</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mental Health – 55%</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Substance abuse – 30%</td>
<td>✔</td>
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## Short-Term Outcomes

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<td>Decrease no show/cancellation by 10% by the end of FY21</td>
<td>1,786</td>
<td>1,604</td>
<td>727</td>
</tr>
<tr>
<td>Increase NH visits by 10%.</td>
<td>1,954</td>
<td>2,149</td>
<td>2,016</td>
</tr>
<tr>
<td>Increase unique NHs served by ride share program, Year over Year (YOY)</td>
<td>20</td>
<td>≥100</td>
<td>37</td>
</tr>
<tr>
<td>Increase NHs served by navigator, YOY</td>
<td>157</td>
<td>&gt;157</td>
<td>54</td>
</tr>
<tr>
<td>Decrease wound-specific readmissions for QMCWO wound patients</td>
<td>57</td>
<td>&lt;57</td>
<td>15</td>
</tr>
<tr>
<td>Decrease ER visits for wound care for QMCWO wound patients</td>
<td>85</td>
<td>&lt;85</td>
<td>34</td>
</tr>
<tr>
<td>Improve wound healing rate through appointment compliance</td>
<td>3.24%</td>
<td>&gt;3.24%</td>
<td>5%</td>
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NATIVE HAWAIIAN DATA REGISTRY
Development, Build-up, Testing
Go-Live By February 2023
CORPORATE IDENTITY & CHARACTER GROUNDED IN CULTURAL INTEGRITY

Assessment & Curriculum Development
ESTABLISH GRANT WRITING CORE & STRATEGY
The royal majesties exceeded their goal in just over a month raising $13,530.

Hale Ma‘i O Ka Wahine Ali‘i
Founded on May 24, 1859 by Queen Emma and King Kamehameha IV

A Royal Legacy

to “stay the wasting hand that is destroying the Hawaiian people”
**THE GRANT LIFE CYCLE**

**START PLANNING EARLY**

FROM “PLAN” TO “APPLY” COULD TAKE 8+ MONTHS

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1 Source: The concept of the ola triangle resembles the Hawaiian Worldview for individuals as described in “ʻIke Hawai‘i – A Training Program for working with Native Hawaiians,” Journal of Indigenous Voices in Social Work, Duponte, Martin, Mokuau, Paglinawan, Vol 1, Issue 1, February 2010.
NIH Grants are hard to get

Diversifying the CTR Workforce and Thinkforce

- Between 1992 and 2018, only 0.17% of the total NIH budget went to support research that involved Asian American, Native Hawaiian, and Pacific Islander participants.

Native Hawaiians and Pacific Islanders are nearly absent as NIH-funded investigators and as participants of NIH-funded research.

Filipinos are aggregated with other Asian subgroups, which renders them invisible.

Kahua Ola guided our activities for FY21, while a planning team was convened to expand the existing plan toward achieving QHS’ aspirational goal to “reduce the gap in life expectancy for Native Hawaiians”

**Vision: E ola ka ‘ōiwi**
(Healthy and well are the Hawaiians)

**Ultimate Outcome:**
Improvements in negative health behaviors or risk factors

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DEVELOP & IMPLEMENT A LEGISLATIVE STRATEGY
### Federal Legislative Strategy Projected Timeline

#### Guiding Questions to Inform Our Strategy:

1. **What do we want?**
   - Identify 3-4 priorities for NHH/DEIJ + Wellness

2. **How do we highlight what QHS is already doing, raise our visibility and take favorable action?**
   - Investment in NHH/DEIJ + Wellness from Leadership

3. **Who are our potential internal/external partners?**
   - Ensuring alignment and coordinated efforts

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<th>Event</th>
<th>Details</th>
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<td>July 2022</td>
<td><strong>Exploratory meeting with Papa Ola Lōkahi</strong></td>
<td>Revisit to Native Hawaiian Health Care Improvement Act</td>
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<tr>
<td>July/August 2022</td>
<td><strong>Develop white paper/narrative</strong></td>
<td>Tell our unique history, provide data and 3-4 identified priorities for NHH/DEIJ + Wellness</td>
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<tr>
<td>August 2022</td>
<td><strong>Vetting our Strategy (ongoing)</strong></td>
<td>Work with internal and potential aligned external partners</td>
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<tr>
<td>September 2022</td>
<td><strong>Washington, D.C. Site Visit</strong></td>
<td>Coordinate an initial site visit to Washington D.C. to open up discussion and lay the groundwork</td>
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</table>
Researching grants re NHH, DEIJ and Employee Wellness to support goals

QHS NHH was written into a Department of Native Hawaiian Health (DHHL) grant from National Telecommunications and Information Administration (NTIA) for $4 mil to increase their telehealth capacity through broadband use and adoption
QHS MOLOKAʻI POPULATION HEALTH
Assessment of Community Interest & Will
ONCOLOGY EDUCATION & EDUCATION PROGRAM
Develop Business Case & Proforma
GENOMICS INSTITUTE
Complete Clinical & Research Development Plan & Business Case
NH CULTURAL BEHAVIORAL, PSYCHIATRIC ASSESSMENT & TREATMENT PROGRAM
Development & Implementation
E Ola Ka Ōiwi
“Healthy and Well Are the Hawaiians”

1 Strengthen the resilience, identify and social connectedness of Native Hawaiians to enhance our physical, mental, and spiritual health.