

Queen's North Hawai'i Community Hospital Primary Care Kahu a Ola Program





FY21 Q3 Population Health: QNHCH Kahu a Ola Initiative Report

PROJECT Q3 UPDATE	Status (✓ Completed ❖ In Process □ Not Started)
Outcome measures	 Increase number of Native Hawaiian encounters within Primary Care by 5% Improvement in HbA1C, BMI, blood pressure by end of FY 2021
Patient Cohort Demographics	 N=45 Members; Enrolled from June – March 2020 22 Female, 23 Male Ages 10 – 84, average age of 53 40% (18 patients) Dx of Diabetes Type 2 or HbA1c > 7.0 80% (36 patients) Dx of Obesity or BMI >30 80% (36 patients) Dx of Hypertension or BP > 140/90 29% of patients have 1 diagnosis (13 patients) 42% of patients with 2 diagnosis (19 patients) 29% patients with all 3 diagnosis (13 patients)
Process Measures	 Enrolling in Kahu a Ola Compliance with PCP care plan Identify and address barriers to care Transportation, access to prescriptions, etc. Reach out / reminders to return to care Kahu a Ola programming & support Clinical Therapy – 19 identified, 16 engaged Social Work/Case Management – recruitment in progress Patient Navigation (engagement stats) Just Walk Waimea (participation stats) Ola Hou I Ka Hula (participation stats) Home blood pressure monitoring (cuffs) Home weight monitoring (scales)

Just Walk







Hula and Hypertension:

Ola Hou i ka Hula, restore health through hula, is a 6-month program for people with high blood pressure. It was developed by University of Hawai'i medical school doctors and scientists in collaboration with kumu hula from across Hawai'i. Endorsed by medical experts at the American Heart Association, the program includes heart health education and twice-a-week hula classes led by a hula instructor. Open to men and women, 18 years or older, and no hula experience required.

This program is for you! Learn hula & improve your health Better control your high blood pressure



at Queen's North Hawai'i Community Hospital Starting



Kumu Hula Mapuana de Silva Hālau Mōhala 'Ilima Ka'ōhao, O'ahu





For more information or registration:
Call QNHCH Primary Care
Clinic at
(808) 881-4606

byee@queens.org





Ola Hou i ka Hula



Start Date: January 11, 2021

- 8 enrolled
- Classes held 2x per week for 3 months
- Then once a week for 3 months
- BP cuffs and a BP log book distributed to Kahu a Ola patients.





BLOOD PRESSURE LOG

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Home blood pressure cuff distribution & monitoring

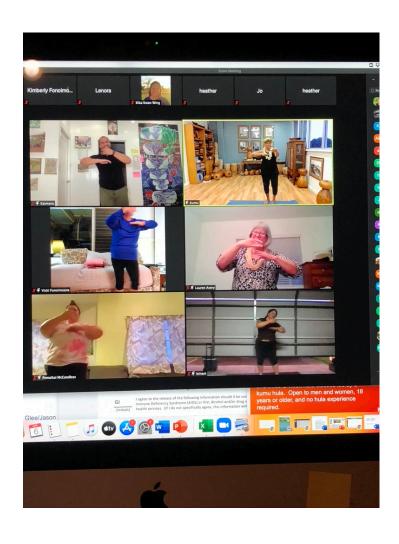


Start Date: February 2021

- Patients are asked to log their BP twice a day & turn in weekly or bi-monthly logs to our Community Patient Navigator
- 27 patients have received their BP cuffs thus far



Positive Patient Experience

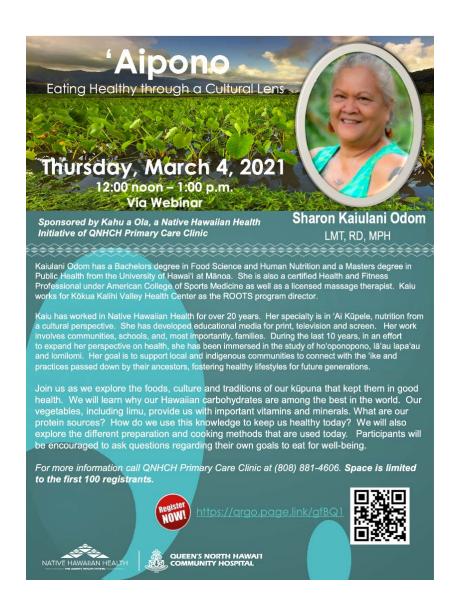


Patient Comments:

- "It was fun. Nobody got left behind. Hula does it, it works out everything. It was nice to start a community with each other."
- "I have such a deep appreciation of the cultural grounding of hula and the ability to use Hawaiian cultural practices to achieve healing."



Culturally-Relevant Health Education



Evaluation Results:

- 100% of respondents rated their satisfaction of webinar as a 5.
- ~91% self identified as Hawaiian.

Comments:

- Very refreshing to see a Hawaiian RD!
- I liked the use of a cultural food pyramid because it was very relatable.
- I should think how my ancestors ate and respect what I put in my body.





QNHCH North Hawai'i Kahu a Ola CMC Project Performance

✓ Completed ❖ In Process □ Not Started)			
In progress = Recruitment of RN Case Manager In progress = Health indicators report to track impact to HbA1c, BP, BMI, demographics, process measures, and other outcomes In progress = 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 Completed = CARE*Link/EPIC enhancements: Kahua Ola side bar report; episodes of care, documentation flowsheets, smartlinks and phrases, referral button, data tracking sheets, data reports Completed = Strategic plan, marketing plan, and operational workflows developed and initiated			
H with DM Type 2 or Obesity or Hypertension = 4,083 in FY 20 QNHCH primary care			
o c			

Short-Term Outcomes	Baseline	Target	Q3
Expand behavioral health department by 3 FTE	0 FTE	3 FTE	2 FTE
Increase number (#) of Native Hawaiian encounters within primary care by 5% within one year	FY 20 4,083	4,287	3,367
Improvement in Hemoglobin A1c (HbA1c) among participants within one year	FY 19 7.72	2% decrease	7.53
Improvement in Body Mass Index (BMI) among participants within one year	FY 19 37.7	2% decrease	35
Improvement in Blood Pressure (BP) among participants within one year	FY 19 140/83	2% decrease	139/83

FY21 ORGANIZATIONAL STRATEGIC GOALS Population Health





Population Health QNHCH Kahu a Ola

		FY 20	FY 21		
Focus	Measure	Baseline	Target	Superior	Q3 Actual
Native Hawaiians with Access to Primary Care	% of total # of patients improved in a sub-cohort (BMI, A1c, BP)	0	5% improvement in 1 health indicator (BMI, A1C, or Blood Pressure)	5% improvement in 2 or more health indicators	All 3 health indicator had improvement of 5%
Health Indicator Target Status (✓ Completed ❖ In Process □ Not Started)					
BMI 5% of BMI (Obesity) cohort lose 5% of weight Target met- 8% achieved goal (3 of 36 patents) N=36 (2 patients)				f 36 patents)	
	5% of A1c (Diabetic) cohort reduce A1c by ≥1			of 18 patients)	
	% of BP (Hypertension) cohor 1 stages (2 patient	rt reduce BP by	v ❖ Target met	- 19% achieved goal (7	of 36 patents)

I ka wā ma mua ka wā ma hope (the future is found in the past)

Lessons Learned

- Provider turnover and shortage
- Limited access to community based & culturally responsive resources
- Limited data infrastructure
- The need for an in-program clinical resource
- Importance of ongoing evaluation of our workflow and patient needs.
- Patients value the importance of building relationships with peers and caregivers.

Future Plans

- New Ola Hou I Ka Hula cohort July 2021
- Continued patient, family, and community engagement opportunities
- Increase contacts and contracts for culturally grounded classes and webinar series
- FTE converted from LSW to RN CM for additional clinical support and case management services

