

**Chronic Disease Management and Control Branch**  
**Asthma ~ Bilingual Health ~ Cancer ~ Diabetes ~**  
**Healthy Communities ~ Heart Disease & Stroke ~ Tobacco**

**Chronic Disease Summit 2011, Part II: Community Planning & Action**  
**Community-Based Promising Practices**

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**The All Mike Women's Volleyball Tournament**

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Pacific Center of Excellence in the Elimination of Disparities (Pacific CEED)

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**(1) Program/Project: Briefly describe your program/project in one paragraph.**

The goal of this project was to rally Micronesian women and their families together in a healthy activity and provide health education to them through the venue of a women's volleyball tournament. A wide array of health messages focusing on prevention and early screening touched on topics of Cancer in particular, Breast and Cervical cancer, tobacco, nutrition and hypertension as well as communicable disease. It was also a way to empower them to know that they can take charge of their health, and participate in active sports and other prevention activities to lower their risk for developing cancer and other chronic diseases, and to promote increased physical activity and encourage healthier outcomes for themselves, their families and their community.

Objectives addressed were:

- Increase awareness of breast and cervical cancer, and the risk factors and other cancer-causing practices such as tobacco smoking and unhealthy diets. Awareness that infections such as Hepatitis B are also potential cancer causing exposures.
- Create opportunities to provide prevention through a healthy activity for their community
- Increase partnerships within the Micronesian and health care provider communities

Micronesians are our newest and fastest growing migrant population to Hawaii. As the new arrivals there have been many barriers for them to obtain health care and access to health care on a timely basis. Data shows this population with a high incidence of cancer, chronic and communicable diseases, diabetes and hypertension. Challenges such as poverty, language barriers, and difficulty in schools may contribute to the limited access to health care. In addition to these challenges, last year the State sought to place all Micronesian adults onto a Basic Health Hawaii plan which limited their coverage for health care under the State's Quest program. Ultimately this plan was deemed unconstitutional by the Hawaii District Court however this decision is being appealed to the 9th Circuit Court. This incident increased the awareness of the urgent need to provide prevention and awareness not only to the adults but also to a younger group of Micronesians attending school, living and working in Hawai'i, and living with elders struggling with their own care. In addition, it was noticed that many of these youth and young adults do not participate in the local sports leagues in Hawaii, possibly due to associated costs and cultural barriers.

For these reasons, under the auspices and financial support of Center of Excellence in the Elimination of Disparities (Pacific CEED), the Micronesian Community Network group in partnership with Micronesian Health Advisory Coalition designed a volleyball league for Micronesian women and young girls to participate in that would provide them with exercise, health messages and health screenings, and to provide a social network for Micronesian

women, build community cohesiveness, and empower Micronesian women to take care of their health through education, activity and knowledge of available services here in Hawaii.

**(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

This project targeted the Micronesian community living in Hawai'i, a minority community with an excess burden from disease. This project was designed to address Micronesian women, in particular because women are the foundation of the Micronesian family and their health issues are usually the last to be addressed due to their focus on caring for the family.

Volleyball was chosen as an appropriate cultural and community access point as it is a sport that many Micronesian women enjoy.

Service Providers/ health professionals, from KKV, nurses from DOH and Hepatitis Network also participate in the project and provided health screenings and lectures on health issues each week of training leading up to the Tournament.

**(3) Evidence-Base: *How did you develop this program? Was it community specific or did your follow examples from other places?***

This was a community-specific program based loosely on the extremely successful framework used in developing the first All Mike Basketball Tournament earlier in 2011 for Micronesian men. The participation levels shown during the men's tournament indicated that sports tournaments are an effective venue. The numerical response created an opportunity to couple physical activity with health messages that would be appropriate and relevant to the women that would be gathering.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

The response to participate in a Micronesian Volleyball Tournament was overwhelming. Approximately 144 young girls and women participated on 12 teams ranging in ages from 12-40 years old. Family members, children, youth, men, and elders from their communities all supported the teams and were present. It was estimated that the total audience reached was over 200.

Many Micronesian women from a number of Micronesian communities across Honolulu County came out to participate, including Marshallese, Chuukese, Kosraen, Ponapean, and Palauan. One team even included Samoan women.

The overwhelming response and level of participation in the project is an initial indication of its success. Women volleyball participants brought friends and family to the health presentations and participant attendance did not wane throughout the six-week program leading up to the final tournament held at Blaisdell Center. All participants completed a registration form and a non-identifier questionnaire regarding their health status was completed. Participants were provided with information from blood pressure screening and referred for follow-up if high, and waist measurements were taken and information shared with each participant. (The tournament ended on July 30. Final evaluation data was not available for the deadline of this submission. Data will be available on pre and post physical activity levels, project evaluation, final number of participants, and number of referrals issued)

Through collaboration and coordination with Kokua Kalihi Valley (KKV) Community Health Center staff and the Hawaii Department of Health and Hepatitis Network, speakers were scheduled on a vast range of health topics including cancer awareness, prevention, and early detection of breast and cervical cancer, tobacco use, nutrition and exercise, Tuberculosis, Hansen's disease, STD/HIV, nutrition, hypertension, and hepatitis. Health related brochures and educational material were provided to the Tournament participants. A final evaluation was completed by the participants to evaluate the six-week program and final tournament, including soliciting suggestions for next year's event.

Key outcomes:

- Capacity building within their communities to work cohesively together to address cancer and chronic disease prevention, awareness and screening and to learn about other health risks
- Increase partnerships between Micronesian community living in Hawaii and Community agencies and organizations
- Innovative education to community through development of sports events

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

Strengths:

- Most of the Micronesian island groups were represented in the tournament
- New partnerships were developed within their communities
- Each group learned to work with each other during the tournaments
- It empowered the women to see that they can take charge of their health through active living.
- Many families and children attended the event.
- MCN and MHAC grew as a visible organization for the communities
- Resource agencies were open to working with the planners
- Information and resources provided were appreciated by the women

Weaknesses:

- Due to the extremely high level of interest and participation among the community, more planning prior to the events is needed to maximize the impact of the program
- Better audio/visual systems needed to convey health messages at volleyball gyms.
- Need to educate speakers on culture and language of the audience to ensure that their messages are conveyed effectively to the whole audience.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

As with the All Mike Basketball Tournament, the All Mike Volleyball Tournament was created by Micronesians for Micronesians. The high level of response and participation of Micronesian women in the Volleyball Program indicates the overwhelming need for healthy community-based activities that support the development of community cohesion and individual and community empowerment to engage in improving the health status for hard to reach populations experiencing health disparities. Poverty, low education level, low income and other societal, economic and environmental factors such as housing and access to health care are among the many conditions that affect the health status of the Micronesian community, otherwise referred to as the Compact of Free Association (COFA) Migrant community living in Hawaii. COFA migrants are often isolated and have few opportunities to interact with others within as well as outside the Micronesian community. Further, prejudice and open hostility toward COFA migrants continue to emerge in Hawaii's schools, the workplace, and even the Hawaii's media. This six-week Volleyball Program has tapped into a vital need where the disparate social, economic, and environmental factors influencing the excessive health disparities experienced by Micronesians had no impact on participation and where women, no matter how difficult their lives found ways to help each other participate in the Tournament events, even to the point of sharing their athletic shoes with each other so that all could play volleyball. This project illustrated that despite many barriers, the Micronesian community has the strength, tenacity, determination and ingenuity to participate in improving their health status and address their health issues. This project is low-cost investment in building community capacity and empowering community members to engage in addressing their health needs and participate in solving their community health issues.

The use of sports tournaments proved to be an effect access point that is culturally appropriate and community based.

As a result of the very positive response received from participants to health screenings and education series associated with the Volleyball Tournament, a similar health education and screening module is being designed for men participating in the 2012 All Mike Men's Basketball Tournament.

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## **Breathing, Stretching, and T'ai Chi Chih DVD and Program for People with Chronic Conditions**

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### **(1) Program/Project: *Briefly describe your program/project in one paragraph.***

Aloha Self-Care/Peer Support, Warriors Against Diabetes, and Bay Clinic coordinated development of a self-care/peer support program for people with diabetes and other chronic conditions. Modules were developed and field-tested, followed by technical consultation. The preliminary DVD and 9 pages of written instructions are being field-tested with various groups in Hawaii and on the mainland. The program emphasizes nurturing and nourishing your "self" in all that you do, as well as sharing whatever you learn that works for you. All movements emphasize being grounded, keeping the spine aligned, and using a soft, even, long, full breath. Whether standing, seated, or lying down, participants move their spine in all directions. Neck stretches and massage and a 7-part "peer backrub" are each described on a single sheet of paper to encourage sharing. Because exposure to tobacco smoke negatively impacts people with chronic health conditions, the program is promoted as a tool to assist in smoking cessation. The DVD covers several aspects of the Self-Care/Peer Support program, which includes breathing, hydration, nutrition, rest, physical activity, service, intimacy, and spirituality.

### **(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

The program was initially developed for people with cancer, (1980's), followed by a focus on people with HIV/AIDS (mid 1980's to mid 1990's), and then COPD (mid 1990's to 2005). Each shift in populations resulted from a lack of self-care/peer support programs in any treatment options. After moving to Hawaii and becoming aware of the high incidence of diabetes and the high rate of concurrency between diabetes and cancer, HIV/AIDS, COPD, and other chronic conditions, I became involved with Warriors Against Diabetes and Bay Clinic. We developed a "Hawaii Demonstration Project," which is being field tested.

### **(3) Evidence-Base: *How did you develop this program? Was it community specific or did your follow examples from other places?***

As a disabilities advocate in the 1980's, I developed a self-care/peer support approach, after recognizing that most people with disabilities and chronic conditions would not be able to access and benefit from the body/mind/spirit modalities I had learned to alleviate chronic back pain (39 years) and arthritis (two artificial hips). I reduced the several modalities in which I eventually became certified (yoga, t'ai chi chih, seijaku, traditional massage of Thailand, polarity therapy) to their universal principles and put together a breathing and stretching routine that could be done in a few minutes or over two hours. The program is unique, as far as I know, both in its movement sequencing, in several specific techniques, and in its emphasis on "learn one/share one" as a peer support component of a quality of life program. Although the program varies with each community it is designed to serve, the essential components are the same.

### **(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

Each of the modalities I use has been tested on various populations, with an increasing number of specific research results being published in recent years. Yoga and massage have been

demonstrated as beneficial for many physical and mental conditions. T'ai chi in general has been extensively studied, even in Western medicine, and t'ai chi chih in particular has achieved symptom relief for many specific conditions, including shingles. I make no claim to "reducing chronic disease." I focus solely on improved quality of life through very basic and "doable" practices. My whole program has never been "studied," but the fact that I have been doing it in some locales for nearly 30 years is enough "evidence" for me that it works! Various groups are producing their own materials, featuring members of their group as leaders.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

My consistent challenge is identifying potential leaders to help each group develop its own program. Several of my "students" have become accredited in various modalities (yoga, t'ai chi chih), but because most of them have a serious chronic condition or even life-threatening illness, continuity is an issue. It is always a challenge to get people to assume responsibility for their own health and quality of life and then to move from "knowing" to "doing." I am hoping that the "adaptive" program I am developing with Marty Mimmack, focusing on people with disabilities, will provide some answers. Born without arms, Marty is a role model for empowerment.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

Company is better than will power when someone is trying to stop an unhealthy behavior or move toward more healthy behaviors. It is clear that self-care/wellness works; it is clear that self-help or support groups, which provide peer support, work. I invite participants to become involved in a program that includes both components and evaluate in the laboratory of their own bodies and own communities whether or not the combination works. As the author of the 365-page Cultural Competence Compendium (American Medical Association, 2000), as a member of the State University of New York Faculty Senate Committee on Diversity and Cultural Competence, as a member of Hawaii tobacco-free and asthma coalitions, I am known for my efforts to promote health equity in personal and public health practices.

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## **Hawaii Prostate Cancer Coalition**

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**(1) Program/Project: *Briefly describe your program/project in one paragraph.***

The HPCC mission is to promote awareness of prostate cancer with special emphasis on early detection, treatment options, long term wellness, and support through family and fellow survivors. We recognize that the community and individuals have often been hampered in obtaining the most timely and proper selection of treatments. They have been influenced by lack of knowledge, reluctance to seek medical advice, and psychological barriers concerning the male sexual functions. The HPCC goals include sponsorship of open support forums, educational seminars, legislation and funding for further awareness programs.

**(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

(The HPCC targets the community because we are acutely aware that cancer not only affects the individual but impacts on the entire family. Men who may be susceptible to prostate cancer or who already have symptoms of the disease would benefit most from the information. However, we are also aware that concerned family members, including spouses and children also need to be knowledgeable of prostate cancer for their support that they can provide and the impacts to the health and welfare of their loved one.

**(3) Evidence-Base: How did you develop this program? Was it community specific or did your follow examples from other places?**

HPCC was organized in 2004 by Phil Olsen to benefit from an affiliation of the National Alliance of State Prostate Cancer Coalitions and their program and experience of similar organizations in the U.S. He established the organization to enhance the advocacy of prostate cancer programs. HPCC continues its program in the community because its members strongly believe that its program of education and awareness of prostate cancer is a recurring and constant need.

**(4) Outcomes: How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?**

HPCC knows its program works simply by the statements of members and their families in various forums. They are encouraged by the forthright statements of the experience from prostate cancer survivors. The prostate cancer patients usually confirm their proposed treatment but sometimes alter their treatment or timing to assure themselves that they have secured all the information needed for a proper decision.

**(5) Challenges/Lessons Learned: What are the challenges/lessons learned and how did you overcome them?**

The challenge is continuing to keep up the enthusiasm and commitment from members to spread the awareness of prostate cancer. As indicated above, the reluctance of some men in openly discussing their own personal health conditions also limits the spread of knowledge and reduction of this chronic disease. HPCC must continue to promote forums and involve other family members, such as spouses and in addition, involve younger individuals to carry out the program in the future.

**(6) Takeaway: What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?**

The key takeaway message is not to reduce or give up the messages. We must continue to promote awareness in the public sector, particularly challenging the misguided perceptions that prostate cancer is a disease for the aged or is so slow growing that nothing can be done about it. There are early detection techniques and the earlier that is performed, the quicker the diagnosis can be made which will positively affect survival and the quality of life for the affected individuals.

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**Hawaii Healthy Aging Partnership**

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**(1) Program/Project: Briefly describe your program/project in one paragraph.**

The Healthy Aging Partnership is a statewide partnership with public health, aging, academia, and community programs implementing the Stanford Chronic Disease Self Management Program (CDSMP) <Better Choices, Better Health Ke Ola Pono (and?) EnhanceFitness Program, both are evidence-based programs targeted for persons with chronic conditions. These programs are designed to complement and enhance medical treatment, healthy behaviors, and disease management.

**(2) Audience: What population(s) or audience does the program/project focus on? Why focus on this population?**

Because the CDSMP research and testing was conducted for those who are older (55 and older), the programs are implemented for this age group and their caregivers. The EnhanceFitness is a group exercise program to increase the strength, flexibility, and balance of older adults. The program focused on older adults because they are more likely to fall and the study has shown minimize the risk of falling.

**(3) Evidence-Base: *How did you develop this program? Was it community specific or did you follow examples from other places?***

CD/DSMP was tested and developed by the Stanford University; EnhanceFitness was tested and developed by the University of Washington, both are deemed as evidence based programs.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

We found these programs developed in mainland are applicable to our community (75% Asian Pacific Islanders). The presentation will provide data and findings on the statewide effort that shows the impact of the programs and can relate it to high risk population/ communities where the programs were implemented.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

These are major challenges and successes our partners have encountered.

- Developing an infrastructure to support implementation of both programs
- Developing and maintaining a pool of master trainers and lay leaders in the community
- Coordinating referrals
- Marketing the program – sustainability of the programs
- Ensuring Fidelity

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

- Review resources that are already created, tested, and are evidence –based program; test for compatibility and appropriateness with various cultures, ethnic groups, etc.
- Assess the data and implement programs where such programs are limited; help create ease of access to good programs by community members
- Don't assume that everyone will like your program but add to the variety to allow communities and individuals a choice from a menu of services and programs.

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## **Healthy Heart Healthy Family**

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**(1) Program/Project: *Briefly describe your program/project in one paragraph.***

Kokua Kalihi Valley Comprehensive Family Services, a federally qualified community health center in Honolulu, Hawaii, collaborated with NHLBI to test the impact of the *Healthy Heart Healthy Family* curriculum facilitated by community health workers on Filipinos with cardiovascular disease risk factors.

From 1 July 2008 to 2009, 11 Filipino community health workers were trained to deliver the 11-session curriculum. We enrolled 99 Filipino adults with cardiovascular disease risk factors in 6 groups, each with 2 facilitators. We provided monthly activities following the sessions. Knowledge and clinical measures were assessed at baseline, 6 months, and 12 months. At 12 months, we found the total cholesterol decreased from 177 mg/dl at baseline to 166.69 mg/dl at 12 months ( $p=.004$ ); mean systolic blood pressure decreased 129 to 125, mean diastolic blood

pressure decreased from 72 to 69 ( $p=.03$ ), and mean fasting blood glucose decreased from 111 to 104, ( $p=.006$ ). Post-test knowledge and satisfaction among participants was high. Community health workers have cultural and bilingual tools for building trust and serving as health care navigators. We demonstrated that they can be trained to deliver evidence-based curricula and facilitate improvements to cardiovascular health in Filipino Americans.

**(2) Audience: What population(s) or audience does the program/project focus on? Why focus on this population?**

Filipino American

Cardiovascular disease (CVD) is the leading cause of death among Filipino Americans, and CVD mortality rates are higher among Filipino Americans than in other ethnic groups. In addition to high prevalence of CVD, Filipino Americans also are more likely to have hypertension than other Asian American groups. For Filipino Americans who are also facing poverty, limited English language, and cultural barriers, preventative care and treatment for CVD can be especially challenging.

**(3) Evidence-Base: How did you develop this program? Was it community specific or did your follow examples from other places?**

Kokua Kalihi Valley Comprehensive Family Services collaborated with NHLBI to test the impact of the *Healthy Heart Healthy Family* curriculum facilitated by community health workers on Filipinos with cardiovascular disease risk factors.

*Healthy Heart, Healthy Family* is a curriculum to prevent and control CVD specifically created for Filipino Americans by the National Heart, Lung, and Blood Institute (NHLBI) at the National Institutes of Health.<sup>5</sup> *Healthy Heart, Healthy Family* curriculum was adapted from existing NHLBI community group education curricula, including *With Every Heartbeat is Life* (for African American populations), *Honoring the Gift of Heart Health* (for American Indian populations), and *Healthy Hearts, Healthy Homes* (for Latino populations).

**(4) Outcomes: How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?**

At 12 months we observed slight decreases in systolic blood pressure from 129 to 125, diastolic blood pressure from 72 to 69 ( $p = .03$ ), and fasting blood glucose from 111 to 104, ( $p = .006$ ). Self efficacy, knowledge, and confidence in management of chronic diseases increased. Although these changes were statistically significant, they are small and not clinically meaningful in reduction of CVD risk. Also, the mean value for hemoglobin A1C (%) did not change. Mean values for BMI and waist circumference increased, but increases were not statistically significant. Unfortunately, we did not realize the meaningful clinical outcomes we were hoping for. We wonder if these mixed findings were related to the advanced age of the participants and the relatively short follow-up (12 months).

**(5) Challenges/Lessons Learned: What are the challenges/lessons learned and how did you overcome them?**

Limitations of this study were its small sample size and the fact that data on health habits were collected from participants and may be subject to recall bias. However, the study's strengths include its unique setting and population whose CVD needs have not been studied previously.

**(6) Takeaway: What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?**

CHWs have cultural and bilingual tools for building trust and serving as health care navigators. We demonstrated that they can be trained to deliver an evidence-based, CVD risk-reducing curriculum to Filipino Americans. CHWs hold tremendous promise as connectors to health care. Government agencies and researchers should tailor this CHW-delivered, group education

curriculum to other chronic diseases, such as asthma and diabetes, and to other vulnerable groups in the US.

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## **Hep Free Hawaii**

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(1) PROGRAM/PROJECT: Briefly describe your program/project in one paragraph.

### **(1) Program/Project: *Briefly describe your program/project in one paragraph.***

Hep Free Hawai'i (HFH) is a community-driven awareness campaign to raise awareness about hepatitis B and C in Hawai'i. By raising awareness, HFH encourages the people in our communities to:

- Learn their hepatitis status through screening
- Protect themselves and their families through appropriate vaccinations
- Connect those with hepatitis B/C or other liver diseases to medical care and other support

### **(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

Hep Free Hawai'i (HFH) is a grassroots awareness campaign to educate the people and communities of Hawai'i about viral hepatitis and liver disease. These communities include:

- Communities at-risk for hepatitis — especially Asians, Native Hawaiians, and Pacific Islanders for hepatitis B, and people with exposure to blood for hepatitis C
- Healthcare providers
- The general public

Hawai'i has the highest rate of liver cancer in the U.S., and the leading causes of liver cancer are chronic hepatitis B and C. In fact, 1 out of 10 Asian Americans, Native Hawaiians, and other Pacific Islanders (AANHOP) in the US are living with chronic hepatitis B, compared to 1 out of 100 people in the general population. According to the last census, more than half of the people living in Hawai'i identify as AANHOP which accounts for the high rates of this disease in our communities. However, most people who have hepatitis B and/or C don't know it because there are little to no symptoms until it becomes liver cancer. There is currently effective treatment for these diseases, so raising awareness about viral hepatitis in Hawai'i will actually save lives.

### **(3) Evidence-Base: *How did you develop this program? Was it community specific or did your follow examples from other places?***

HFH is modeled after the successful Hep B Free campaign in San Francisco ([www.sfhepbfree.org](http://www.sfhepbfree.org)), which has seen increased testing and treatment since it began its awareness campaign. Because Hawai'i has its own unique culture and community, Hep Free Hawai'i is really driven by community stakeholders including medical specialists, doctors, community advocates, and others from agencies ranging from support groups and the Hepatitis Support Network to the Liver Center and the Department of Health. Since its inception in March 2011, Hep Free Hawai'i has created a website ([www.hepfreehawaii.org](http://www.hepfreehawaii.org)) and collaborated with 211 Aloha United Way to solidify its infrastructure for disseminating information and awareness.

### **(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

On World Hepatitis Day (July 28, 2011), HFH collaborated with the Department of Health Adult Hepatitis Prevention Program to offer free testing and linkage to care statewide for the public. Through an extensive media campaign that includes newspaper, television, internet, and radio, HFH was able to raise awareness about the impact of viral hepatitis on Hawai'i and encourage people to get tested. Over 140 people who otherwise would not have been tested participated

in the free screenings that day. All of those who tested positive for hepatitis B and/or C (about 10) were linked to care either through their own primary care providers or community clinics. By getting these individuals into care, HFH and the Department of Health were able to ensure that they were able to manage their disease before it progressed to liver cancer.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

One of the major challenges for HFH was raising awareness and education among the general public and at-risk populations. Viral hepatitis is not a well-known disease in general, and there is also stigma attached to having hepatitis B and C since it can also be spread sexually. The most important component of HFH's campaign to overcome these barriers has been its strong collaborative practices with agencies in and around the state. The successful World Hepatitis Day media campaign only came about because HFH had built strong relationships with community health centers, the Department of Health, and other community agencies.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

Hep Free Hawai'i provides an excellent model for increasing and education and awareness for a chronic disease through extensive collaboration. By garnering support from hepatitis stakeholders from all levels of the community (from advocates to providers, from non-profits to state agencies), HFH had strong network of resources through which it could accomplish many of its core goals. By increasing awareness and testing and linkage-to-care, HFH has been able to reduce the burden of viral hepatitis for the people of Hawai'i, especially those who are Asian Americans, Native Hawaiians, and other Pacific Islanders.

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**Ho`okele i ke Ola Cancer Patient Navigation Program**

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**(1) Program/Project: *Briefly describe your program/project in one paragraph.***

Ho`okele i ke Ola Cancer Patient Navigation Training Program is a 48-hour culturally tailored training program that aims to provide a foundation of knowledge and practical skills base to assist cancer patients and their families through the cancer care continuum. The training was designed to increase cancer knowledge, knowledge of cancer services and providers, and enhance communications skills with patients, families, and cancer care providers. In addition to the trainings, annual conferences and continuing education sessions are offered to the network of cancer patient navigators to further increase their cancer knowledge and skill sets. `Imi Hale provides continuing educations and an annual conference to support the navigation network. We have also been program evaluators for several cancer patient navigation projects.

**(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

The project primarily focuses on improving cancer care services to Native Hawaiians, other Pacific Islanders, and rural populations who often suffer from disparities in cancer mortality. The training was geared towards lay health outreach workers who work with these populations. However in the last couple years, navigators operating in the clinical settings and who work with the general population of cancer patients have increased.

**(3) Evidence-Base: *How did you develop this program? Was it community specific or did your follow examples from other places?***

Imi Hale completed a literature review of other cancer patient navigation programs, the first being created in Harlem, New York by Dr. Harold Freeman in 1990. Imi Hale held key informant interviews and focus groups with Native Hawaiian cancer patients and family members, cancer care providers and community outreach staff to learn more about cancer care barriers and to identify needed knowledge and skills for navigators. More than 200 people participated from Hawai'i, Maui, Kaua'i, Moloka'i, and O'ahu. The program also was assisted by consultants from Native American Cancer Research in Colorado, PATH for Women in Los Angeles, and Gila River in Arizona.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

Imi Hale has several evaluation objectives regarding patient navigation. The effectiveness of our training is tested using pre/post tests to assess knowledge gain. As well, all students demonstrate their ability to help patients by working through mock cancer cases to identify barriers, informational needs, and appropriate resources. To measure the usefulness and effectiveness of cancer patient navigation services, Imi Hale has developed a Cancer Patient Navigation database that captures data on the patient needs, services they receive, and the impact of navigation on the patients' access to timely cancer care. We also evaluation patient satisfaction with surveys at pilot navigation sites.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

Finding ways to sustain cancer patient navigation training and navigator positions after short term funding has ended is a primary challenge. Through partnerships with other health care organizations and applying for funding from varying sources, such as OHA to HRSA, we have been able to sustain Ho'okele since 2006.

Capturing the data on cancer patient navigation services is necessary to understand how each program's navigation model works and the impact that navigation has on patient's cancer care. Data collection has been difficult for several reasons: 1) it's time consuming for navigators to enter data, 2) some patients are less willing to share their personal information and some need more help in getting their cancer care records, and 3) designing a database with the variables that can accurately capture the programmatic outcomes and outcomes in patients cancer care is challenging. Imi Hale has done a review of other navigation databases worked with navigators, provided in-services and continuing educations to support their comfort with data entry. We discussed early on, with program managers, about the importance and requirements for data entry. We share program evaluation reports with the programs as often as possible. Responding to the needs of the navigator network and individual programs in order to provide relevant continuing educations and appropriate evaluation is important and challenging. We constantly solicit input from the navigators and our partners to understand their issues and patients' issues regarding cancer patient navigation.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

Ho'okele addresses health equity by having culturally attuned navigators target patients who face the most barriers to accessing and using the medical system for their cancer care. Through data collection, case study documentation and constant feedback from practicing navigators, we attempt to document the outcomes of navigation services and make recommendations to improve it. We seek to establish and promote quality standards for Patient Navigation in Hawai'i, with hope that this service will be reimbursable and therefore available to help patients with screening, treatment, and survivorship, who might otherwise have avoided the healthcare system or fallen through the system cracks.

## **Hooulu Aina, ROOTS**

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### **(1) Program/Project: *Briefly describe your program/project in one paragraph.***

Kokua Kalihi Valley has two interwoven projects that address the Social Determinants of health and Chronic Disease in unique ways. **Ho'oulu Aina** addresses the health needs of Kalihi valley by strengthening the connection between people and land. Through four interwoven program areas, that community comes together to create a 100 acre upland resource of forest, food, knowledge, spirituality, and healthy activity. Roots, centered at Ho'oulu 'Aina, uses the framework of "Grow, Prepare, and Share" to promote social relationships as a key to health. Roots strives to bring community members together as part of a larger social network. Centering around food as a source of nourishment, identity and connection, project activities build bonds between community members as they cultivate food and medicine, cook together, share traditional practices for food preparation, and eat together in common spaces

### **(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

Our programs are unique in that we are part of a health center that has 9 sites in Kalihi. Kokua Kalihi Valley (KKV) is a community-organized and community-operated non-profit corporation serving the residents of Kalihi Valley through a philosophy of "Neighbors being neighborly to neighbors." It was formed in 1972 as a 501 (c) (3) organization by community leaders in response to the absence of accessible and appropriate health services for the valley's growing Asian and Pacific Island immigrant populations. Current health data shows that chronic disease such as diabetes, obesity, and heart disease are rising epidemic rates in our Samoan, Filipino, Hawaiian, and Micronesian communities.

### **(3) Evidence-Base: *How did you develop this program? Was it community specific or did your follow examples from other places?***

Our programs were developed using community input and following cultural foundations throughout Kalihi's diverse population. While many projects that address chronic disease focus on healthy diet and exercise, adding the depth of ancestral knowledge and the uplifting spiritual effect of working on the land in forest and garden settings. Social determinants framework can often set up a wealth-poverty continuum that highlights all too familiar barriers to health; however, the value-system that puts culture, family, and land-access above the dollar creates enclaves of health, vitality, and self-empowerment.<sup>4)</sup>

### **(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

So far, our data on the effects of this work with diabetes patients has been phenomenally successful. However, we believe this to be true for all patients suffering or at risk for any chronic disease. Our outreach impacts even the very young for preventative education measures.

### **(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

Initial challenges included sustainable and long-term funding as well as a buy-in from many in the traditionally western medical field. Ironically, the two challenges have each become a support for the other. As the success of the project grew, more long-term commitments surfaced, and as more long-term funding commitments surfaced, more advocates from the traditional western medical model surfaced, and as more advocates from the traditional western

medical model surfaced, more funding opportunities arose. It has been an interesting development to witness.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

Take away messages: Ho'oulu 'Aina - The breath of the land is the life of the people. Roots - Food, culture, and community connected. The promising practices are finding the land and food are ancient answers to new diseases. The two bring people together, build peace and equity among cultures and classes, and address the social determinants of health through community-motivated and people-empowered actions of togetherness.

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**Ke `Ano Ola: Molokai & Lanai's Community-Based Healthy Lifestyle Modification Program**

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**(1) Program/Project: *Briefly describe your program/project in one paragraph.***

Community members at various health screening events and receiving blood glucose and hypertension monitoring services at Na Pu`uwai requested a weight-loss program that could be community driven and be sustained long term. In 2008, 72.8% of Moloka`i's residents were overweight and obese. A community-based 12-week healthy lifestyle program, Ke Ano Ola (KAO), was developed to decrease risk factors for chronic disease through nutrition, physical activity and specific chronic disease prevention education, in a support group setting. The program was expanded to Lanai, where Na Pu`uwai has a satellite office, Ke Ola Hou O Lana`i.

**(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

Although the problem of obesity is not limited to one age group, this program focused on the adult population, who experienced or were at high risk for chronic disease, because of the results of being obese. It was felt that people, especially the Native Hawaiian and other minority groups residing on Moloka`i and then on Lana`i would benefit from this comprehensive risk reduction program, through learning to live a healthy lifestyle. Participants would then become healthy lifestyle leaders amongst their own families and communities.

**(3) Evidence-Base: *How did you develop this program? Was it community specific or did you follow examples from other places?***

The Na Pu`uwai staff, epidemiologist, registered dietician, medical director, psychologist, registered nurses, community health workers, and community members met to develop this program. The program was community specific to Moloka`i, but used research from other sources to incorporate key components of successful lifestyle interventions. These components included: social support, group support, and community involvement. A previous study evaluated mediators of lifestyle behavior change in Native Hawaiians, and found that social support was a key factor in moving participants from the pre-action stage of change to the action/maintenance stage, for improvements in dietary fat intake and exercise. Another study looked at group support as a component of weight loss and maintenance programs and found recruiting and treating teams of three (3) friends, with a strong social support intervention, decreased the number of dropouts and markedly increased the percentage of participants who maintained their weight loss over the six (6) month follow-up period. Another component of lifestyle interventions, designed for Native Hawaiians, included solicitation of community input, at all stages of the program. The Partnership for Improving Lifestyle Interventions (PILI) project

was designed to improve lifestyles of Native Hawaiians, using community-based participatory research.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

The outcome monitoring plan for the program was to conduct health assessments pre and post program measuring weight, height, body fat, body mass index (BMI), blood pressure, blood glucose, and blood lipids. In addition, satisfaction surveys were completed after every class. One of KAO's greatest successes was a low attrition rate, with 89% of the seventy-four (74) predominantly Native Hawaiian (62%) community participants attending all twelve (12) sessions. There were also statistically significant improvements for weight, systolic blood pressure, diastolic blood pressure, total cholesterol, and blood glucose. KAO findings showed a successful healthy lifestyle program, in a predominantly Native Hawaiian community, required strong commitment and positive role modeling from program leaders, social and group support, and community support through increasing awareness among other community members.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

As mentioned before, KAO findings showed a successful healthy lifestyle program, in a predominantly Native Hawaiian community, required strong commitment, positive role modeling from program leaders, social and group support, and community input and feedback. Evaluations revealed that participants satisfied with KAO were more likely to use a "buddy system" as support and also exhibited significant improvements in clinical outcomes, including blood glucose, blood pressure, and blood lipid control, as well as weight reduction. Participants with diabetes also reflected an improvement in their hemoglobin A1c. A challenge recognized is that of a continuing commitment to maintenance efforts. This proved to be one of the major issues for both staff and participants. There have been trials in the maintenance groups' commitment to meet and continue KAO. One solution was to have members of the maintenance group included in the new KAO session, serving a two-fold resolution: role model to new participants and while allowing ongoing support for maintenance.

**6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

KAO findings suggest that a successful healthy lifestyle program, required strong commitment and positive role modeling from program leaders that uses a multi-disciplinary team approach (i.e. RN, RD, Psychologist, Physicians etc.), social and group support, group and individual care, and community input and feedback. In order to continue the level of success for the participants, past, present, and future, it is important to incorporate the evaluations from past participants who expressed positive results and their recommendations for continued success, including using a buddy system for mutual support. Continued success would reflect a promising practice through significant improvements, in clinical outcomes, including blood glucose, blood pressure, and blood lipid control, as well as weight reduction. Additionally, ongoing behavioral health support such as motivational interviewing, problem solving, and managing emotional eating proved to be important to increase success for participants.

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**Land, Food and Health**

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**(1) Program/Project: *Briefly describe your program/project in one paragraph.***

Land Food & Health is an innovative intervention for diabetes-self management. The 6 month long intervention combines a once a month culturally-informed diabetes self-management education class based on the American Association of Diabetes Educators (AADE) guidelines with backyard or communal gardening as a physical activity. The gardening component was built on the Pacific value of relationship to land and group activities. This initiative has been implemented in four sites in Hawai'i.

**(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

The initiative was specifically designed for the cultural values and practices of Pacific Peoples including: Filipino, Samoan, Chuukese and Native Hawaiians. These populations have a disproportionate prevalence of diabetes.

**(3) Evidence-Base: *How did you develop this program? Was it community specific or did you follow examples from other places?***

This initiative was identified as an area of community need and interest. It was developed as a community-based educational intervention for people with diabetes. The development and implementation approach incorporates an indigenous educational theoretical framework, community and cultural preferences, and a best practices structure based on a literature review of diabetes self-management programs.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

An evaluation of participants at the longest established site, Kokua Kalihi Valley's Healthy Eating and Lifestyle Program (HELP), reported a reduction of hemoglobin A1C, from before to after the intervention, by an average of 1.34, which was shown to be statistically significant. HbA1C is one of the markers used to diagnose and monitor diabetes.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

Commitment and vision is needed to implement and evaluate an intervention. Often the most difficult part is recruitment of patients. The program needs to be innovative, resourceful and persistent to get initial participation. After the first 18-24 months a reputation is established internally and externally and recruitment requirements are less resource intensive.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

By formulating an intervention that is strength-based through identifying a relevant culturally practice such as 'relationship with land' combined with best-practices in patient education new levels of effectiveness can be reached.

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## **Life's Simple 7/My Life Check**

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**(1) Program/Project: *Briefly describe your program/project in one paragraph.***

The American Heart Association for the first time has defined ideal heart health using seven easy to understand measures known as **Life's Simple 7** (LS7). LS7 simplifies healthy living down to seven things to measure and track; positive changes in these areas can improve quality of life and increase life span, as well as dramatically reduce the financial burden of the Medicare-eligible population. **My Life Check** is a free online tool that provides an accurate assessment of how you are doing in the seven areas. Its based on the knowledge and

expertise of medical experts from the American Heart Association. This tool doesn't just provide a heart health score, but directs an individual to a specific action plan that will identify and teach which behaviors to change and move the person closer to individual health goals. Healthcare professionals will be supported in their prevention efforts by knowing the definition and utilizing it to track and measure health progress. It will also be useful to offer the online tool that will allow individuals to take responsibility of own heart health.

**(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

All ages from 2 years to 99 years. Parents can enter info for children. Cardiovascular diseases and risk factors often develop early in life, so prevention becomes vital in changing health for the better for decades to come. In a survey of adult Americans, the American Heart Association found 39 percent said they thought they had ideal heart health, however, 54 percent of those (and 70 percent of all respondents) said a health professional had told them they had a risk factor for heart disease and/or needed to make a lifestyle change to improve their heart health. These findings indicate most people don't associate important risk factors, such as poor diet and physical inactivity, with cardiovascular diseases. This emphasizes the need for a measurable definition for progress and a tool to support those who choose to make healthier changes.

**(3) Evidence-Base: *How did you develop this program? Was it community specific or did you follow examples from other places?***

The AHA National Board of Directors appointed the AHA Goals and Metrics Committee, a subcommittee of the AHA Statistics Committee, to develop the definition of cardiovascular health. The Goals and Metrics Committee formally explained how they'd defined cardiovascular health in a paper that was published in *Circulation* in January 2010.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

According to information from the Centers for Disease Control and Prevention, although progress has been made in reducing overall death rates from cardiovascular diseases (CVD), progress has not been as significant with reducing the major risk factors. In some cases, like obesity, rates have actually increased, which may result in reversing any progress made of reducing death rates from CVD. The first step in improving heart health is to establish metrics to track the population's movement toward better health. The definition developed by AHA and the online tool (My Life Check) allows for tracking youth and adults, including disparately-affected populations. This definition is based on the following key ideas:

- Primordial Prevention: Preventing risk factors from ever developing in the first place. This is important because CVD and risk factors often develop early in life.
- Population-wide approaches focusing on the whole population
- "High-risk" approaches focusing on individuals at greatest risk

It is critical for primary care physicians, cardiologists, and other professional healthcare providers know and utilize the definition of ideal heart health. It will be helpful to utilize the online tool to support individuals to take responsibility for their own heart health.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

Less than one percent of Americans (nationally) falls into the 'ideal health' category. Less than 17 percent have optimal blood pressure, cholesterol, blood glucose and are non-smoking. Although AHA does not expect everyone to achieve ideal health as defined, it is more important to get people to move in a positive direction for each of the seven measures. Research reports now tell us that for men and women who reach 50 years old with no risk factors, life expectancy is at least another 40 years free of heart disease and stroke. Regardless of what an individual's heart score is, making small changes can result in a longer, better life.

**(6) Takeaway: What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?**

For the first time, the American Heart Association has defined poor, intermediate and ideal cardiovascular health — using seven easy-to-understand measures known as **Life's Simple 7**. Improvements in these areas can improve quality of life and increase life span, as well as dramatically reduce the financial burden of the Medicare-eligible population. Those health measures are:

- ✓ Never smoked or quit more than one year ago;
- ✓ Body mass index less than 25 kg/m<sup>2</sup>;
- ✓ Physical activity of at least 150 minutes (moderate intensity) or 75 minutes (vigorous intensity) each week;
- ✓ Four to five of the key components of a healthy diet consistent with current American Heart Association guideline recommendations;
- ✓ Total cholesterol of less than 200 mg/dL;
- ✓ Blood pressure below 120/80 mm Hg;
- ✓ Fasting blood glucose less than 100 mg/dL.

AHA has developed a new online resource to help people assess their health and develop unique steps to change behavior and improve their heart health goals – **My Life Check** ([www.heart.org/MyLifeCheck](http://www.heart.org/MyLifeCheck)). The short assessment easily identifies the seven goals for ideal health and notes how a person's health measures up. Additional tools and information offer specific action steps to improve the health test results and track personal progress toward better health.

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**Medical-Legal Partnership for Children in Hawai'i**

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**(1) Program/Project: Briefly describe your program/project in one paragraph.**

The Medical-Legal Partnership for Children in Hawai'i ("MLPC Hawai'i") is an innovative collaboration between the William S. Richardson School of Law ("WSRSL") and Kokua Kalihi Valley Comprehensive Family Services ("KKV") to improve the living conditions of low-income children and families in Kalihi Valley by providing free legal services at a community health center. The goal is to prevent the continuation or escalation of social-legal problems that affect the health and well-being of families by working together as lawyers and doctors to practice "preventive law," address social determinants of health, and engage in systemic advocacy.

**(2) Audience: What population(s) or audience does the program/project focus on? Why focus on this population?**

MLPC Hawai'i primarily serves the patient-families of KKV health center and families living at Kuhio Park Terrace, the state's largest public housing complex. We focus on assisting children and their extended families, including grandparent caregivers, young working families, and mothers struggling to leave unsafe relationships. Most of our clients are recent Micronesian migrants, Samoan, Filipino and other families with young children, living below Federal Poverty Level, and having limited English proficiency. In addition to assisting KKV families, MLPC Hawai'i also serves the KKV staff and other Kalihi Valley service providers by conducting trainings about how to identify legal needs of the families they serve.

**(3) Evidence-Base: *How did you develop this program? Was it community specific or did your follow examples from other places?***

MLPC Hawai'i is based on a model developed in 1993 by the Boston Medical Clinic when pediatrician Dr. Barry Zuckerman hired an attorney to "address the social determinants that negatively impact the health of vulnerable populations." Medical-legal partnerships are "a healthcare delivery model that integrates legal assistance as a vital component of patient care." (see [www.medical-legalpartnership.org](http://www.medical-legalpartnership.org)) Today there are over 80 medical-legal partnerships at 235 health institutions in 38 states. MLPC Hawai'i is the first and only partnership in Hawai'i and began working with the National Center for Medical-Legal Partnership in 2007. In 2009, MLPC Hawai'i began its regular Legal Advocacy Clinics, co-located with the KKV Pediatrics Clinic.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

While measuring health outcomes following legal interventions remains challenging, MLPC Hawai'i serves approximately 150 families each year, from one-time encounters and "curbside consultations" to on-going legal advocacy and representation. We address legal issues relating to public housing, public benefits, domestic violence, paternity and child support, education, and other social-legal matters. MLPC Hawai'i has assisted grandparent caregivers to obtain legal guardianships, secured healthcare benefits for working parents, and worked extensively to support state-funded Medicaid benefits for Micronesian migrants. Upon securing a significant rent reduction and credit for overpayment, one single father told us, "Without you, my family would be homeless." We believe that these material improvements for low-income families—as well as the significant reduction in their stress—improve the health outcomes, including chronic disease burdens, of the families we serve.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

While not surprising, the overwhelming demand for free and accessible on-site legal services in Kalihi Valley keeps our small MLPC Hawai'i team extremely busy. Families living in poverty face seemingly endless challenges while seeking their basic needs. Families we serve often become homeless, live doubled-up, and lack regular phone access. We therefore rely heavily on the KKV doctors and health providers to stay in contact with our client-families. For example, legal advocates can flag issues in client-patients' medical charts, engage staff interpreters to assist with follow-up, and meet with families alongside doctors to address the social determinants affecting their health.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

MLPC Hawai'i believes social factors influencing children's health often can be addressed through enforcement of laws and legal rights. We also believe that if you (doctors) ask about basic needs, patients will talk about them. MLPC Hawai'i frequently builds on the trust already established between doctors and families. So, this unique partnership allows doctors and lawyers to inquire and uncover basic needs (the social determinants of health) and work side-by-side to provide early legal interventions to address the problems before they escalate and negatively impact the health and well-being of families.

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**The Micronesian Health Advisory Coalition (MHAC) Interpreter/Translator Training Project**

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**(1) Program/Project: *Briefly describe your program/project in one paragraph.***

Under the auspices and financial support of the Pacific Center of Excellence in the Elimination of Disparities (Pacific CEED), the Micronesia Health Advisory Coalition (MHAC) developed and implemented the MHAC Interpreter/Translator Training Project. The overall goal of the project was to help eliminate health disparities in the Micronesia communities in Hawai'i by providing quality language access for the Micronesians in need of translation and interpretation services. The MHAC, funded by Pacific CEED and in partnership with the UH-CTIS, developed the first program for professionally certifying individuals in Community Medical Interpreting in Chuukese and Marshallese. After the participants complete their final exams they will be Certified in Community Medical Interpreting from the University of Hawaii, and would also receive a Professionally Qualified Certificate in Medical Interpretation from the National Board of Certification for Medical Interpreters (NBCMI). Upon completion of the final examination the project will produce the first 4 certified medical interpreters, 2 in Marshallese and 2 in Chuukese. This project was designed to address crucial service gaps that inhibit Compact of Free Association (COFA) migrants from accessing both courts and health services especially with the current Compact Impact.

**(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

The focus population is the migrants to Hawai'i under the COFAs. The COFA are treaties between the USA and the Republic of the Marshall Islands, the Republic of Palau, and the Federated States of Micronesia (the states of Chuuk, Kosrae, Pohnpei and Yap). Many of the COFA migrants move to Hawai'i with limited English skills and are unable to effectively communicate with service providers including medical, health, legal, courts, education and other social/human services. Interpretation and translation services have been previously limited to uncertified community interpreters/translators, relatives and friends. COFA migrants also have an excess burden of chronic and infectious diseases requiring health and medical services.

**(3) Evidence-Base: *How did you develop this program? Was it community specific or did your follow examples from other places?***

Although there are many programs used elsewhere for translation/interpretation training this project was developed locally based on the needs of the COFA migrants, existing translation/interpretation resources, training programs, Compact Impact implications and the health environment of Hawai'i. It will be the first time that Marshallese and Chuukese interpreters will be professionally certified by a nationally recognized certification organization.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

There have been 4 participants, 2 Chuukese speakers and 2 Marshallese speakers, which have completed all the course work required. The NBCMI has approved the criteria for certification including the process for written and oral examinations. While waiting for the exams to be finalized the trained interpreters/translators have put their skills to use by interpreting and translating for Hawai'i based courts, health and medical surveys for researchers, health clinics, community organization, legal documents, and other social services documents. In addition, this project provides a response to 2 recommendations from the Department of the Attorney General's 2009 report of the COFA Task Force: 1) "Identify and encourage COFA migrants in Hawai'i to take leadership in efforts to empower members of their community, including developing a pool of interpreters from within the migrant community." and 2) "Develop

coordinated language translation and interpreter resources that are generally accessible and can be utilized by all the State and private agencies and service providers.”

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

A key challenge that has delayed the completion of the project has been finalizing the written and oral examination. There are two components to this challenge: 1) Finding individuals with sufficient English, Chuukese or Marshallese, and medical knowledge to be examiners. 2) The timely process of getting the project certified by the NBCMI. Both of which have been overcome by patience and networking. The trained interpreters/translators will complete their examination before December 2011. Further challenges include misconceptions and stereotypes of the COFA migrants from the general public and service providers; for example, some think there is just one Micronesian language. Another challenge includes the lack of understanding at the state agency level and other social services on how to access trained, professional interpreters/translators. Finally, establishing contractual agreements with medical providers has been difficult due to the worries over liability and insurance of the translators/interpreters. These challenges are overcome through formal and informal education and training.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

The project has created a program in which other interpreters can be trained and certified. This has been a ground breaking project establishing a systematic and sustainable program to address the language access needs for populations of people experience many health disparities. Marshallese and Chuukese are only 2 of the numerous languages spoken by COFA migrants. The project could easily be repeated for other languages including Kosraean, Yapese, or Pohnpeian. The project address both social determinants of health and health equity. It addresses access to health care services by increasing the ability of patients to communicate to health care providers in a systematic and sustainable manner. The project didn't just train interpreters but developed a system for the certification of future interpreters. It also fills a gap in health care services for a population marginalized because English proficiency levels, social economic status, education levels and migrant status.

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**Mighty Milers - Kea'au Elementary School**

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**(1) Program/Project: *Briefly describe your program/project in one paragraph.***

Mighty Milers is a fitness program sponsored by the New York Road Runners' Club for elementary-aged children. Students are encouraged to get healthy and stay fit by running a mile or more per week. Their mileage is entered by their teachers into a national database and they are able to earn prizes for their efforts. Schools apply for membership and accepted schools that have a high count of students in poverty will be able to participate for free.

**(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

Elementary aged students are the focus of Mighty Milers. I've been an elementary classroom teacher for fourteen years, and for the last six years, I have had my students participate in a fitness program focused on running. When I discovered the Mighty Milers program, it seemed to be a perfect compliment to the program I had created on my own. Joining made it possible to provide incentives for free and I was able to receive support by way of an online database for tracking mileage.

**(3) Evidence-Base: *How did you develop this program? Was it community specific or did your follow examples from other places?***

Running is an exercise that is natural for human beings. It requires little to no specialized or expensive equipment, machines, or locations. It can involve a small to huge group of people at a given time. It allows for varied paces and abilities without the stress of competition. Seven years ago, I wanted to create a program that combined exercise with our other academic curriculum. To compliment our studies of the California Missions, we measured the distance between the Missions and then the students ran miles until they reached that total distance. Along the way, we tracked where we would be virtually and learned about that location. The program mushroomed from there. We then ran across the United States from CA to D.C. After that, we ran the Pacific Crest Trail. Upon moving to Hawaii, my students measured the perimeter of each of the main Hawaiian Islands and ran the total distance of their perimeters. We have now become so proficient at running and encouraging our students, that we are running over 10,000 miles a year as a student-body.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

We know that this program is working for many reasons. Students' excitement is evident every time we announce it is time for running. Their enthusiasm while out on the course carries over to their conversations at home. The overall stamina and speed improves over the year as proven through the students' mile times. Students go from running/walking a mile with difficulty in August to running two to four miles in one 40 minute session by the Spring of that same school year. Track and Field participation has drastically improved at our local middle school as more of our Grade Five Mighty Milers enter that school. State test scores in Grade Five rose substantially last year after a year of running 10,000 miles.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

Starting small, with my own homeroom, was the key to success. It allowed me to work out the kinks of course maps, manage lap counts, track progress, graph mile times, and keep students motivated with incentives. As I became more confident, I solicited participation from my other grade level colleagues. This worked well to build a community spirit while running together every Wednesday. Teachers ran with the students, students raced one another, and classes worked together to accumulate the greatest number of miles.

One challenge this created was the boom in popularity. Our school population is roughly 800 K-5 students. 630 students have now signed up to run each week during school. We've had to create a schedule and measure out several courses to share. The management of the teachers, the students, the laps they accrue, the logging in of all those laps in the database, and the sheer size of this endeavor is a bit overwhelming. However, more adults have stepped up to help facilitate the program, and this type of challenge is something I have dreamed about, rather than feared.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

Walking/Running is the everyman's sport. It can be done barefooted, in rubber slippers, in sandals, or in shoes. It can be done in any weather and for a short or long period of time. There is no waiting for a turn, wasted time, or monies required for equipment. Heart rates are up, calories are burned, muscle is built, and students feel great about their accomplishments. We have healthier students in our classrooms which help with academics and social behaviors. It is a win-win for all.

## **Person-Centered Integrated Health Care Home Project**

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Dept. of Health, Office of Health Equity & Multicultural Services

### **(1) Program/Project: *Briefly describe your program/project in one paragraph.***

Primary Care/Behavioral Health (Bidirectional) Integrated Health Care Home Approach to reduce behavioral health and chronic disease disparities among Department of Health's "safety-net" population. This bidirectional integrated health care approach would not only improve access to mental health services for underserved groups, but also provide a better framework for the overall health and well-being of all consumer groups, especially since people with serious mental illness and substance abuse tend to have chronic health issues such as diabetes, heart disease, obesity, and cancer.

### **(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

This project focuses on individuals with severe and persistent mental illness (SPMI) served by the Dept. of Health. Research has shown the people with SPMI die 25 years earlier than the general population because of chronic health care issues that go untreated.

### **(3) Evidence-Base: *How did you develop this program? Was it community specific or did you follow examples from other places?***

Research has suggested that individuals who have a history of depression were four times as likely to suffer a heart attack as those not suffering from depression. Also, we have found that the mentally ill had a 53% increase in the odds of being hospitalized for diabetes in a given year as compared with those who did not have mental illness. We feel that a person-centered integrated health care home model would reduce these alarming statistics.

### **(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

We feel this approach will reduce health disparities among diverse groups because many local residents with mental illness (or substance abuse issues) prefer going through the primary care door rather than the mental health door and so this approach will not only increase access to services but it will allow the primary care physician to easily refer the client to a behavioral health practitioner. Moreover, primary care services in the behavioral health settings would allow for easier coordination with the primary care staff.

Note: The Health Care Home model has been around for a while but never really got off the ground until Obama's health care reform initiative invited health care professionals to change the way we look at health. With new possibilities in payment reform, information exchange, and health care incentives the states are looking for promising practices that improve health, reduce costs, and improve the health care experience for consumers. This integrated bidirectional (primary care and behavioral health) approach is one way to ensure that we are improving health outcomes, reducing costs, and improving the consumer's experience of receiving our healthcare services.

### **(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

NA – we are in the talking stages but have already formed partnerships.

### **(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

There are certain pathways that lead to chronic disease. We argue that stress can be a significant pathway in two ways. One is behavioral -- people under stress sleep poorly and are less likely to exercise; they adopt poor eating habits, smoke more and don't comply with medical

treatment. Second, stress also triggers a response by the body's endocrine systems, which release hormones that influence multiple other biological systems, including the immune system. These effects of stress on regulation of immune and inflammatory processes have the potential to influence depression, infectious, autoimmune, and coronary artery disease, and at least some (e.g., viral) cancers. Simply, if people can manage their stress levels and/or effectively treat their mental health issues, they are more likely to avoid chronic disease. Mental health treatment is an upstream approach to address the social determinants of health.

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## **PILI `Ohana Project**

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### **(1) Program/Project: *Briefly describe your program/project in one paragraph.***

The PILI `Ohana Program (POP) is a community-based participatory research (CBPR) partnership between Kula no na Po`e Hawaii at the Hawaiian Homestead communities of Papakolea, Kewalo, and Kalawahine Streamside, Hawaii Maoli at the Association of the Hawaiian Civic Clubs, Kokuia Kalihi Valley Comprehensive Family Services, Ke Ola Mamo Native Hawaiian Health Care System (Oahu), and the Department of Native Hawaiian Health (DNHH) at the John A. Burns School of Medicine of the University of Hawai'i. CBPR is "a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings." The PILI `Ohana community-academic partnership successfully designed, implemented, and tested the efficacy of a community-informed, -based, and -led weight loss maintenance program for Native Hawaiians and Pacific Peoples. The long-term mission of the POP is to integrate community wisdom and expertise with scientific methods to conduct research on health disparities with a specific emphasis on obesity in Native Hawaiians and Pacific Peoples.

### **(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

Among Pacific-based populations such as Native Hawaiians, Samoans, Filipinos, and other Pacific Island Peoples, the prevalence of overweight and obesity has been rising. For Native Hawaiians and Filipinos the prevalence of overweight/obesity (BMI  25) is 75.9% and 75.9% respectively. The prevalence of obesity alone among Samoans and Micronesians as a group has been estimated to be as high as 65.6% and 65.1%, respectively. Not surprisingly, medical complications associated with overweight/obesity, such as diabetes, heart disease, and some forms of cancer, loom large as a major health problem that threatens to overwhelm US health care resources. The PILI `Ohana Project, a community-academic partnership, was formed to conduct CBPR activities aimed at eliminating health disparities and, in particular, obesity disparities in NHs and PPs.

Additionally, using a CBPR approach, the POP aimed at increasing community and academic partners' capacity to address the needs of their communities and establish a successful long-term working relationship.

### **(3) Evidence-Base: *How did you develop this program? Was it community specific or did your follow examples from other places?***

The PILI `Ohana Lifestyle Intervention (POLI) was developed based on the Diabetes Prevention Program (DPP) lifestyle intervention. The DPP was a multi-center clinical research trial that found a lifestyle intervention that promoted dietary change and increased physical activity to be more effective at preventing or delaying diabetes onset as a prescription drug, metformin. To address obesity in NH/PIs, the POP culturally adapted the DPP-lifestyle intervention for NH/PI communities and implemented the intervention and examined its effectiveness in promoting weight loss in NH/PI participants. Each community organization conducted focus groups and

informant interviews to obtain information from community residents, leaders and health professionals to inform the adaptation of the lifestyle intervention.

The POP analyzed and interpreted the qualitative data which informed adaptation of the intervention to NH/PI communities which included simplifying the language, incorporating local examples, themes, and strategies and reformatting for group learning and interaction.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

The community organizations pilot tested the POLI, which includes 8 lessons lasting approximately 1-1/2 hrs delivered over 12 weeks. 239 participants were enrolled in this program. A statistically significant improvement was observed in all of the clinical and behavioral measures. The mean change in weight (-1.5 kg) from baseline for the entire group was modest. Mean systolic (-6.0 mmHg) and mean diastolic blood pressure (-2.8 mmHg) measures also were lower at 12 weeks. Similarly, mean physical functioning improved as measured by an increase in distance traveled (42 ft) during the 6 minute walk test. In all, 26% and 11% of the participants lost  $\geq 3\%$  and  $\geq 5\%$  of their baseline weight, respectively, at the end of 12 weeks. For the 128 participants who attended all 8 POLI lessons, they achieved a significantly higher mean weight loss of -1.8 kg than participants who completed less than 8 lessons (-0.70 kg). An additional 6-month, family and community focused weight loss maintenance program was also developed and test by the POP. After completing a 12-week weight loss program, participants (N = 144) were randomly assigned to either a family and community focused program (n = 72) or standard behavioral follow-up (n = 72). Successful weight maintenance was defined as participants' post-intervention weight change remaining  $\leq 3\%$  of their pre-intervention mean weight. Among participants who completed at least half of the sessions, the family and community focus intervention participants were 5 times more likely to have maintained their initial weight loss than the standard behavioral follow-up participants.

Another prominent and promising result of the PILI 'Ohana program is the creation of a strong co-equal environment in which communities have successfully demonstrated their ability to be fully integrated into the scientific research progress. The communities have been involved as equal partners in all steps of this collaborative project; from budgeting and assessment to participant retention and data dissemination. The community partners control their own budgets and recruit and deliver the intervention as they see fit. All POP decisions effecting the partners and partnership are made jointly and community partners are encouraged to budget for trainings and conference travel. Since the beginning of the POP, the community partners have been successful in obtain other federal research grants, improved their research skills, returned to school to further their education, and increased the number or types of services that they are able to provide to their communities. The POP continues to expand through establishing more partners, including the outer islands and the US Pacific Basin Jurisdictions, test the weight loss maintenance intervention in other populations, and pilot other culturally adapted interventions.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

There were several challenges during the pilot study that we have been able to address in subsequent studies. These included participant recruitment and retention. Word of mouth has helped to publicize the program and its benefits thus in later recruiting efforts, communities have been able to recruit without too much effort. We addressed retention issues by adding more contact time, specifically community group events that keep people interested and involved.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

While the results are preliminary, they suggest that CBPR approaches of this type may be a promising option to conducting scientifically rigorous translational research in high risk minority populations. This finding points to the benefits of the PLP in preventing not only weight regain in

people who lost excessive weight but perhaps its potential for preventing excessive weight accumulation over time in people most at risk for overweight and obesity. By engaging communities, we may be helping to eliminate health disparities and promoting health equity for all.

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**Project SUCCESS (Spirometry-Urged Cessation through Counseling Education and Sustained Support)**

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**(1) Program/Project: *Briefly describe your program/project in one paragraph.***

We provide lung health clinics in connection with WE: a hui for health at various locations throughout the state. This provides participants with individualized health information about their current health as well as resources for additional services and information. The free services we offer include blood pressure monitoring, free lung function testing, carbon monoxide testing, smoking cessation counseling, and resources and information about all of the foregoing. We also offer support group meetings, an annual education day and continuing education for healthcare professionals.

**(2) Audience: *What population(s) or audience does the program/project focus on? Why focus on this population?***

We focus on the underserved populations of our state, including Haleiwa, Waianae, Kahaluu, Waimanalo, the Big Island, Maui, Kauai, Molokai and now Lanai. We particularly try to reach smokers and former smokers, since they are at greatest risk of lung disease like emphysema, chronic bronchitis and chronic asthma. They are also populations of great interest to WE: a hui for health.

**(3) Evidence-Base: *How did you develop this program? Was it community specific or did your follow examples from other places?***

We consulted with national experts and used standards developed by American Thoracic Society, NIOSH, and other recognized national experts for our equipment and lung testing protocol. We use best practices in tobacco cessation in doing our smoking cessation outreach and counseling. Similar programs around the world and country do not have the level of follow up our program does and do not have a smoking cessation component.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

Many of the people we are reaching have NEVER before had any of the resources and information we are providing. We have found people with very high blood pressure and have helped them obtain additional care. We are also finding people with very low lung function that have never before had any lung testing. We get the test results interpreted and sent to the participant and designated healthcare provider.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

Challenges include resources and publicity. We have overcome these by working together with WE: a hui for health so that we can have larger wellness events that offer many services to the participants instead of many silos. This has helped all of us leverage our limited resources so we can support one another and refer to other providers at the same event that are of interest to participants. This also allows us to publicize for these events more effectively through our various channels.

**(6) Takeaway: What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?**

It has been shown time and again that those with the fewest resources are having the worst health issues, including lung disease (see the Burden of COPD in Hawaii 2010 Report). It has also been shown that Native Hawaiians have high smoking rates (see Hawaii Community Health Needs Assessment, Community Voices on Health December 2010).

Our clinics outreach to the communities that have high rates of smoking and lung disease and we are finding many participants with low lung function and helping them get information that they can share with their healthcare provider for improved personalized treatment.

Many of our clinics are with WE: a hui for health, to share and stretch our limited resources so that together we can extend our reach and resources.

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**Tai Chi with the Paukukalo Kupuna**

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**(1) Program/Project: Briefly describe your program/project in one paragraph.**

Approximately 8 months ago tai chi chuan was begun with the Alu Like Kupuna program at Paukukalo homes one morning a week. Initially the sessions were 5 to ten minutes long; currently we are at 15 to 20 minutes. The Long form of Tai Chi is about 22 minutes in duration when practiced by accomplished practitioners. It may take years for someone to become able to do the entire form with out stopping in sequence. The objective in the present class is to present a slow movement and focused balancing exercise that will increase stability and confidence in the participants at Paukukalo. While fall prevention is the overarching long term objective, the immediate objective is to get the Kupuna out of their chairs while at their day time activity program. The hope is that the tai chi is so simple in the movements that the Kupuna can practice any place or time without need of anyone or anything else besides their bodies. Since many of the concepts of tai chi movement are similar to hula, the participants understand the basic premise of slow exercise in rhythmic movements with coordination of hands and feet. This makes the tai chi an excellent adjunct to their activities at the site. The class is presented on Weds. morning at 9:00 by the Health Educator and Epidemiologist from the Maui District Health Office.

**(2) Audience: What population(s) or audience does the program/project focus on? Why focus on this population?**

The population is the Kupuna participating in the Alu Like Kupuna program at Paukukalo homes recreation center. We began the tai chi at the request of the Kupuna. Additionally it is a good opportunity to experiment with the adaptability and acceptability of tai chi as component of their activity programs, and its usefulness in increasing their physical balance, stability and confidence.

**(3) Evidence-Base: How did you develop this program? Was it community specific or did you follow examples from other places?**

This program was developed based upon the ancient Chinese art of Tai chi chuan, and was adapted to fit the needs of the Kupuna. Tai chi has been researched extensively and shown repeatedly to improve balance, coordination, confidence and posture in persons of all ages and cultures. We did not really follow any other examples, but rather have been teaching the Tai Chi as we our selves have been taught, while at the same time adapting it to the time frame and physical abilities of the Paukukalo participants.

**(4) Outcomes: *How do you know the program/project works? (e.g. outcome or impact) How were you able to address health equity and/or reduce chronic disease?***

This is a long term project to increase balance, stability and confidence and overall well being. There was no pre or post testing. The Kupuna have readily accepted the tai chi, and everyone present participates including the program coordinators. The Kupuna practice the tai chi at other times during the week just for fun. We have taken the degree of acceptance and continuing enthusiasm as indication that the program is working. Several Kupuna have reported to us that they have noticed improved balance in their daily activities since starting the program. So, our only measures really are what the Kupuna tell us, and how they behave. One of the benefits of Tai chi practice is that it tends to lower blood pressure when the practitioner reaches the meditative state required for the slow rhythmic movements. It is hoped that our practice with the Kupuna will lead to this and other benefits such as falls prevention and overall improved health and wellness. We will depend upon reports from the Kupuna as we are not doing any measurements.

**(5) Challenges/Lessons Learned: *What are the challenges/lessons learned and how did you overcome them?***

Because many of the Kupuna are not fully mobile we have adapted the tai chi so that they can do modified movements in their chairs. We also have learned that by introducing and practicing a movement several times before including it in the sequence that the Kupuna feel confident doing the movement when we include it in the sequence. Accuracy is less important than flow and steadiness of movement. So we focus less on precise placement of hands and feet and more on stability and confidence in moving from one stance to another. When we do kicks, we have the participants slide their feet and not lift them until they are feeling confident, if ever. We make other adaptations and built up slowly which is not the traditional manner of practicing Tai chi but is the way that we have found is best with this group.

**(6) Takeaway: *What is the key takeaway message on how your program/project demonstrates a promising practice? How do you incorporate the social determinants and health equity into public health practice?***

Hawaiian Kupuna are eager to learn new ways to improve their health, and will participate in tai chi when it is presented in a way that fits their needs. We know that Hawaiian Kupuna are at a higher risk of many health conditions because of disparities. By increasing their access to a simple, inexpensive physical activity that they can do when ever and where ever they want, they can actively work toward decreasing their risk of falls, and other conditions. Tai chi is not an activity that is traditionally incorporated into the Alu Like program and yet it has easily been incorporated and become an important part of their routine.