Adventist Health Castle

2019 Community Health Plan Annual Update

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Adventist Health Overview

Adventist Health Castle is an affiliate of Adventist Health, a faith-based, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii.

OUR MISSION:
Living God's love by inspiring health, wholeness and hope.

OUR VISION:
We will transform the health experience of our communities by improving health, enhancing interactions and making care more

Adventist Health entities include:

- 20 hospitals with more than 3,200 beds
- More than 280 clinics (hospital-based, rural health and physician clinics)
- 13 home care agencies and seven hospice agencies
- Four joint-venture retirement centers
- Compassionate and talented team of 35,000 associates, medical staff physicians, allied health professionals and volunteers

We owe much of our heritage and organizational success to the Seventh-day Adventist Church, which has long been a promoter of prevention and whole person care. Inspired by our belief in the loving and healing power of Jesus Christ, we aim to bring physical, mental and spiritual health and healing to our neighbors of all faiths. Every individual, regardless of his/her personal beliefs, is welcome in our facilities. We are also eager to partner with members of other faiths to enhance the health of the communities we serve.

Our commitment to quality health care stems from our heritage, which dates to 1866 when the first Seventh-day Adventist health care facility opened in Battle Creek, Michigan. There, dedicated pioneers promoted the "radical" concepts of proper nutrition, exercise and sanitation. Early on, the facility was devoted to prevention as well as healing. They called it a sanitarium, a place where patients—and their families—could learn to be well.

More than a century later, the health care system sponsored by the Seventh-day Adventist Church circles the globe with more than 170 hospitals and more than 500 clinics, nursing homes and dispensaries worldwide. And the same vision to treat the whole person—mind, body and spirit—continues to provide the foundation for our progressive approach to health care.

Aloha,

At Adventist Health Castle, we are committed to advancing the health and wellbeing of all the communities we serve. From Waimanalo to Lā`ie, our priority is to provide you with top quality care, close to home. To serve you well, we must understand your health needs.

Resident feedback pertaining to the health status of the community is integral to planning and executing interventions, programs and services. Our hospital and clinics work with neighboring organizations to maximize the benefits Adventist Health Castle can provide to you and your `ohana. We appreciate your assistance in improving the quality of life in Windward O`ahu. Our work extends far beyond the walls of our hospital. Mahalo for entrusting us to care for you.

Sincerely,

Kathryn A Raethel

Kathy Raethel, MHA, FACHE

President

Adventist Health Castle

Number of Hospital Beds: 160

Kathryn Raethel, President and CEO
Joyce Newmyer, Chair, Governing Board
640 ʻUlukahiki Street
Kailua, Hawaiʻi 96734
808-263-5500

Existing healthcare facilities that can respond to the health needs of the community:
For Hawaii, we assess the community needs as a state effort, and below is a list of the facilities participating in the CHNA coordinated by the Healthcare Association of Hawaii. These organizations can respond to the health needs of the community and this not a comprehensive list as there are other healthcare facilities that serve the community as well.

- Adventist Health Castle
- Kāhi Mōhala
- Kahuku Medical Center
- Kaiser Foundation Hospital - Honolulu
- Kapiʻolani Medical Center for Women & Children
- Kuakini Medical Center
- Kula Hospital
- Lānaʻi Community Hospital
- Maui Memorial Medical Center
- Molokai General Hospital
- North Hawaiʻi Community Hospital
- Pali Momi Medical Center
- The Queen's Medical Center
- The Queen's Medical Center - West Oʻahu
- Rehab Hospital of the Pacific
- Shriners Hospitals for Children
- Straub Medical Center
- Wahiawā General Hospital
- Wilcox Medical Center

Community Health Development Team

Tracie Ann Tjapkes

Director; Wellness and Lifestyle Medicine

Jesse Seibel

Director, Mission Integration & Spiritual Care

Derek Dickard

Castle Physician Network/Outpatient Clinic

Kate Saavedra

Director; Castle Health Group

CHNA/CHP contact:

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Request a paper copy from Administration/President's office. To provide comments or view electronic copies of current and previous community health needs assessments go to: AdventistHealth.org/communitybenefit or https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx

Invitation to a Healthier Community

Fulfilling the Adventist Health Mission

Where and how we live is vital to our health. We recognize that health status is a product of multiple factors. To comprehensively address the needs of our community, we must consider health behaviors and risks, the physical environment, the health system, and social determinant of health. Each component influences the next and through strategic and collective action improved health can be achieved.

The Community Health Plan (Implementation Strategy) marks the second phase in a collaborative effort to systematically investigate and identify our community's most pressing needs. After a thorough review of health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address using our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission, "to share God's love by providing physical, mental and spiritual healing."

Identified Community Needs

The results of the CHNA guided the creation of this document and aided us in how we could best provide for our community and the most vulnerable among us. As a result, Adventist Medical Castle has adopted the following priority areas for our community health investments for 2017-2019:

- Diabetes
- Access to health services

Additionally, we engage in a process of continuous quality improvement, whereby we ask the following questions for each priority area:

- Do our interventions make a difference in improving health outcomes?
- Are we providing the appropriate resources in the appropriate locations?
- What changes or collaborations within our system need to be made?
- How are we using technology to track our health improvements and provide relevant feedback at the local level?
- Do we have the resources as a region to elevate the population's health status?

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly though, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities we all want for ourselves and our families.

2019 Community Benefit Update

In 2016 Adventist Health Castle conducted a community health needs assessment and was followed by a 2017 Community Health Plan (Implementation Strategy) that identified the priority needs listed below. The prioritized needs were chosen based on community health data and the voices of our community. Working together with our community is key to achieving the necessary health improvements to create the communities that allow each member to have safe and healthy places to live, learn, work, play, and pray. Below you will find an inventory of additional interventions supporting the health of our communities.

Priority Need - Diabetes The Wellness and Lifestyle Medicine Center receives referrals for children, adolescents, and adults diagnosed with obesity and/or diabetes. On a continual basis throughout the year, a morning and evening 5-week Self-Management Education Diabetes Program class was offered.

- Number of Community Members Served: 1,166 diabetic patient encounters were served in our American Association of Diabetes Educators accredited program

In 2019, we continued to work on increasing awareness and engagement of participants. We reached out to our community to encourage enrollment in the Self-Management Education Diabetes Program where participants learn to adopt healthy behavior changes. We also encourage family referrals. As way of serving the community and creating greater awareness of the services available, we participated in community events including *Veg Fest, I Love Kailua Town Party, and Convoy of Hope.* At *Convoy of Hope,* 1,319 people were provided health services over the course of a single day. In late 2019, we revised our referral forms so physicians may select to have medical management for their patients by our Nurse Practitioner who is a Certified Diabetes Educator. In 2019, we expanded access to classes beyond Kailua to include a Kaneohe location throughout the year. Having more than one location has been well received, and we will continue to have classes in both the Kailua and Kaneohe locations.

- Number of Community Members Served: 254 unique patients Our 2019 goal was to increase from a completion rate of 87% to a 90% completion rate and we successfully had a completion rate of 91%. with at least 300 unique patients.

We mailed a post card to community residential addresses and have received a positive response from patients who directly want to enroll in classes. We are continuing this communication on a quarterly basis.

- Number of Community Members Served: 55,000 homes every quarter

Our social media presence expanded by 80% on Instagram (IG) and Facebook #castlewellnesshawaii to reach new and existing participants.

- Number of Community Members Served: from 350 followers in 2018 to 640 followers in 2019 with a goal of 1,000

We are working to proactively reduce the number of readmissions related to diabetes. As of October 2017, we hired a Certified Diabetes Educator (CDE) who is a Nurse Practitioner (NP) and she receives referrals for all diabetes and prediabetes patients' inpatient and outpatient. The CDE/NP establishes an introduction

between the patient and his/her family with our diabetes program, and as of 2019 a clinic follow-up appointment with the NP is scheduled at bedside before the patient returns home. This "real time" scheduling has decreased the barrier of delayed education post hospital discharge. Additionally, before the patient leaves the hospital, the NP is prescribed a glucometer, learns how to use the glucometer, and given a glucose a food log. For the patient, education begins bedside and there is a bridge to outpatient education.

- Number of Community Members Served: 1,258 diabetes patients

Partners

- American Diabetes Association
- American Association of Diabetes Educators
- Castle Health Group
- Endocrinologist Steven Lum, MD Castle Health Group

Program outcomes

	2016	2017	2018	2019
A1C improvement	1.05	1.2	1.05	1.24
BMI change	1.15	.96	1.05	1.04
Weight loss	6.9 lbs	5.8 lbs	6.6	5.7
Body Fat %	n/a	n/a	n/a	.61
Patient encounters	1058	1180	1121	1166

We have traditionally evaluated body mass index (BMI) and weight to determine obesity and health status. In 2019 we began to record and report on body composition which gives a more accurate way of estimating fitness levels and health risk. Thus, the addition of body fat % above.

Beyond receiving high patient satisfaction scores, it is important that patient's feel confident they can control their diabetes. 87% of our diabetes education patients feel their diabetes is controllable. In 2019, 34% of the participants felt their diabetes was more controllable at the end of the 5-week diabetes program. For those that do not feel an improvement in control they are encouraged to join our diabetes support group. This support group is a new addition as of 2019. A1C continues to have > 1.0 in improvement and average weight loss is 6 lbs.

We met with Castle Health Group primary care providers (PCPs) and their staff to streamline the process to scheduling new patients. We continue to address our gaps and seek new opportunities to better deliver diabetes education and improve management of diabetes.

Priority Area - Access to Health Services

Intervention: Added ENT, Cardiology, and Dental services to our Rural Health Clinic in Laie.

- Number of Community Members Served: 2,432 unique people were served in our Rural Health Clinic

Intervention: Hired 1 Interventional Cardiologist to serve the Windward Community.

- Number of Community Members Served: 875 people were able to be served for same day visits

Partners

Castle Health Group

Castle Health Group has had a focus on access and worked with physician members to expand office hours including evenings and weekend hours. This has been very successful and allowed community members to seek care outside of their normal working hours. We have also partnered with local Urgent Cares to ensure notes on patients are sent to the primary care providers to coordinate care.

What was the impact in 2019 for your priority area? In 2019 We had 26,696 Office visits throughout our clinics. By continuing to have same day access that we implemented in 2018, we have increased our visits by 6,282.

We continued to have a focus of increasing A1C compliance along with controlling blood pressure. In 2019, we had 79% compliance with our patients with A1C and we increased our blood pressure compliance rate from 65.1% in 2018 to 68.8% compliance rate in 2019.

Other Community Benefits –

Through a Hawaii Community Foundation Grant, we provided tobacco treatment counseling to 115 participants who were primarily low-income, low-education, or unemployed (important, vulnerable groups who have higher tobacco use prevalence and may face additional barriers to quitting tobacco). If appropriate, these people were provided with grant-funded tobacco treatment medications. Additionally, tobacco support groups are provided on and off campus. Outreach and care to expectant moms who smoke was provided with continued grant support for a program called Baby and Me Tobacco Free. Our tobacco treatment program has a 34.1% quit rate for at least 30 days or more as compared to the national benchmark of 30%.

- Number of Community Members Served: 115 participants.

The Center provides inspiration, and behavior change skills to help participants build a healthy, body, mind, and spirit through programs including tobacco cessation, therapeutic massage, nutrition counseling, monthly cooking demonstrations called *Eat Well for Life*, and free monthly speaker series called *In Sickness & In Health*.

- Number of Community Members Served: 195 nutrition encounters

9 different types of fitness classes with 15 classes per week year including beginning/easy classes such as yoga and pulmonary fitness and moderate level intensity activity.

- Number of Community Members Served: 9,114 fitness contacts

The Wellness Center receives referrals for children and adolescents diagnosed with obesity or diabetes. *Healthy Weight and Your Child* is a family-based program provided in a partnership with YMCA and Hawai'i Pacific Health. This 25-session program focuses on healthy eating, physical activity, confidence building, and stronger family connections.

- Number of Community Members Served: 625 encounters to families

We partnered with the *University of Hawai'i* to provide a free skill building class centered on teaching basic nutrition, meal planning, food safety, budgeting, along with some physical activity.

- Number of Community Members Served: 80 encounters

In our fifth year partnering with the *Boys and Girls Club of Kailua*, Castle provided resiliency training to middle school girls.

- Number of Community Youth Members served: 88 encounters

Castle continues to offer massages provided by licensed massage therapists to our associates and the community.

9 different community support groups (Alzheimer's caregivers, Grief Support, Hospice, Mamma Hui, National Association for Mental Illness, Parkinson's, Pulmonary Fibrosis, Tobacco Cessation) met regularly,

- Number of Community Members Served: 957

The Aloha Kidney Class, taught by nephrologist Ramona Wong, M.D., served individuals who have stage 3, 4, or 5 chronic kidney disease but who are not on dialysis.

- Number of Community Members Served: 112 individuals

Additionally, we hold free education seminars called *In Sickness in Health* and cooking classes *Eat Well for Life*

- Number of Community Members Served: 417 educational seminar encounters and 11 cooking classes with 342 cooking encounters

Partners –

- Aloha Care
- Aloha Kidney
- Aloha United Way
- Alzheimer's Caregivers' Group
- American Diabetes Association
- American Heart Association
- Boys and Girls Club of Hawai'i
- Hawai'i Nutrition and Physical Activity Coalition
- Hawai'i Independent Physicians Association
- Hawai'i Medical Service Association
- Hawai'i Primary Care Association
- Hawai'i State Department of Education
- Hawai'i State Department of Health
- Healthy Hawai'i Initiative, Tobacco Settlement Project
- Mental Health America of Hawai'i
- National Association for Mental Illness
- Navian (formerly Hospice Hawai'i)
- Parkinson's Disease Foundation
- University of Hawai'i Cancer Center

Changes in 2019

Findings and conclusions from the statewide Community Health Needs Plan in 2019 were reviewed and new priority areas (2.2 and 3.2 refer to the table on the following page) were selected for our 2020 focus and was updated in the Community Health Implementation Strategy.

STATEWIDE PRIORITIES	Hawai'i	Maui	Moloka'i	Lāna'i	O'ahu	Kaua'i
GOAL 1 - FOUNDATIONS : Provide the basic foundations so that people can have more control over their own health						
1.1 **Address financial insecurity**. Create coordinated and systemic opportunities for communities and families to make good food and housing realistically accessible, develop workforce skills, create new economic opportunities, build financial assets, and reestablish active lifestyles.	●	●	●	●		
1.2 **Work together for equality and justice**. Work alongside affected populations to address inequitable treatment and opportunity.	●	●			●	●
1.3 **Strengthen families**. Create the conditions and opportunities for families to be healing forces for its own members, including addressing financial stress that will enable more healthy time together.		●	●		●	●
1.4 **Prepare for emergencies**. Mitigate future health impacts by engaging people, increasing understanding of the most vulnerable populations, building food systems, and strengthening relationships and community cohesion.			●			
1.5 **Build good food systems**. Establish access to nutritious food so that it is available to all.	●			●	●	●
GOAL 2 - COMMUNITY : Preserve, nurture, expand, and employ the healing properties of community						
2.1 **Restore environment and sense of place**. Better protect Hawai'i's natural resources, prepare adequately for climate change, develop good design and integration of the built environment, and reduce the negative environmental impacts of the visitor industry.		●			●	●
2.2 **Nurture community identity and cohesiveness**. Support community led efforts through shared activities and events, active organizing around shared purposes, and instilling community pride to foster greater trust and connectivity.	●	●	●	●	●	
2.3 **Invest in teenagers and healthy starts**. Invest in health and education at the earliest stages of life. Support school-based structures, community-based activities, and youth empowerment for pre-teens and teens.	●	●	●			●
2.4 **Shift kūpuna care away from "sick care."** Build a new paradigm of aging so that healthy aging is available to more. Combat the grave threats of boredom, loneliness, purposelessness, inactivity, and other social and emotional hardships of aging.		●	●	●		
GOAL 3 - HEALTHCARE : Improve the relationship between people and the healthcare system						
3.1 **Strengthen trust in healthcare**. Rebuild and strengthen trust through listening, empathy, compassion, and treating the whole person, while also paying attention to the use of language and cultural nuances.	●	●	●			
3.2 **Provide accessible, proactive support for those with high needs.** Identify, develop, and strengthen outreach, early intervention, free healthcare services, mental health, and oral health for those who are struggling with houselessness, mental illness, and addiction.	●	●	●	●	●	●

Important island priorities marked with "●"

Highest need areas on island in RED Note: *all* statewide priorities are significant on all islands

Connecting Strategy and Community Health

As hospitals move toward population health management, community health interventions are a key element in achieving the overall goals of reducing the overall cost of health care, improving the health of the population, and improving access to affordable health services for the community both in outpatient and community settings. The key factor in improving quality and efficiency of the care hospitals provide is to include the larger community they serve as a part of their overall strategy.

Health systems must now step outside of the traditional roles of hospitals to begin to address the social, economic, and environmental conditions that contribute to poor health in the communities we serve. Bold leadership is required from our administrators, healthcare providers, and governing boards to meet the pressing health challenges we face as a nation. These challenges include a paradigm shift in how hospitals and health systems are positioning themselves and their strategies for success in a new payment environment. This will impact everyone in a community and will require shared responsibility among all stakeholders.

Population health is not just the overall health of a population but also includes the distribution of health. Overall health could be quite high if the majority of the population is relatively healthy—even though a minority of the population is much less healthy. Ideally such differences would be eliminated or at least substantially reduced.

Community health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

1) The distribution of specific health statuses and outcomes within a population;
2) Factors that cause the present outcomes distribution; and
3) Interventions that may modify the factors to improve health outcomes.

Improving population health requires effective initiatives to:

1) Increase the prevalence of evidence-based preventive health services and preventive health behaviors,
2) Improve care quality and patient safety and
3) Advance care coordination across the health care continuum.

Our mission as a health system is to share God's love by providing physical, mental and spiritual healing and we believe the best way to re-imagine our future business model with a major emphasis of community health is by working together with our community.

OUR MISSION:
To share God's love by providing physical, mental and spiritual healing

Community Benefit

Our community benefit work is rooted deep within our mission, with a recent recommitment of deep community engagement within each of our ministries.

We have also incorporated our community benefit work to be an extension of our care continuum. Our strategic investments in our community are focused on a more planned, proactive approach to community health. The basic issue of good stewardship is making optimal use of limited charitable funds. Defaulting to charity care in our emergency rooms for the most vulnerable is not consistent with our mission. An upstream and more proactive and strategic allocation of resources enables us to help low-income populations avoid preventable pain and suffering; in turn allowing the reallocation of funds to serve an increasing number of people experiencing health disparities.