

Hā Kūpuna National Resource Center for Native Hawaiian Elders
University of Hawai'i

Annotated Bibliography:
Aging, Health, Long-Term Care, and Caregiving in the Native Hawaiian Community
Updated 2017

AARP (2014). The AARP network of age-friendly communities: An Introduction. Retrieved from:

<http://www.aarp.org/livable-communities/network-age-friendly-communities/info-2014/an-introduction.html>

World Health Organization's Age-Friendly Cities and Communities Program was established in 2006 to address the need for age-accommodating communities. Twenty nations participated in the program, including three dozen communities in the United States. AARP is a lead affiliate of this program and assists in identifying cities for potential membership, increasing community member participation, guiding community leaders, and providing resources, to increase community livability for the elderly.

AARP Research and Strategic Analysis (2011). *Voices of 50+ Hawai'i: Dreams and Challenges*. Retrieved from: <http://assets.aarp.org/rgcenter/general/voices-america-dreams-challenges-hi.pdf>

AARP conducted a series of telephone surveys to assess the needs of adults fifty years of age and older. Random sampling methods were utilized to generate potential participants from the continental United States, Puerto Rico and the Virgin Islands, and responses were collected from 1,000 participants. Two primary needs were identified: (1) economic concerns, and (2) inadequate resources that were primarily health related and deemed necessary to support self-sufficiency in later life.

AARP Research and Strategic Analysis (2011). *Prepared to Care? Hawai'i AARP member opinions on caregiving and long term care*. Washington, DC: AARP

AARP conducted a survey of 1000 members residing on the islands of O`ahu, Kaua`i, Maui, and in Hilo and Kona on the Island of Hawai'i. Questions focused on the needs of older adults for long-term care, financial resources, and accessibility to health-related information. Study results found that accessing and affording home-based care ranked higher across all sampling locations compared to the ability to access or afford long-term nursing home care. Further, services that

assist with remaining in the home were of equal importance to both older adults and their caregivers. Additionally, nearly eight of ten (78%) participants stated it was extremely or very important to have a localized source for accessing health and service related information.

Administration on Aging, Administration on Community Living (2015). *A profile of older Americans 2015*. Washington, DC: US. Department of Health and Human Services.

This report summarizes data from the U.S. Census, National Center for Health Statistics, and the Bureau of Labor Statistics, on the topics of income, health, employment, housing, and education, for U.S. older adults, age 65+. Increasing to 46.2 million older adults, in 2014. Population growth is predicted to reach 98.2 million older adults 65+ by year 2060. Synonymous with the national trend, Hawai'i is experiencing a growing older adult population, with older adults accounting for 16.1% of the state's total population.

Analyses revealed a wide-range of gender differences for older Americans. In general, women tend to live longer, with the total female population becoming progressively larger than total male population. Other gender differences show women are 16% more likely to live alone, than their male counterparts. Data on poverty, ethnicity, and health revealed older adult women are significantly more likely to live in poverty, and older women of color face the highest risk for poverty. Health disparities were most prevalent between ethnic/racial groups, with whites self-rating personal health status better than other racial/ethnic groups. The the out-of-pocket costs older adults pay for medical services increased to 50%, with 14% of an older adult's monthly expenditures dedicated to medical care.

Administration on Aging, 2015. Aging Integrated Database (AGID). Retrieved from: <http://agid.acl.gov>

The Aging Integrated Database (AGID) is a multicomponent online data system produced by the Administration for Community Living (ACL). AGID data includes ACL program specific information, surveys, measurement tools, population demographics and census-based data. The AGID website is organized into four subsections: Data-at-a-Glance, State Profiles, Custom Tables, and Data Files. Data-at-a-Glance focuses on identifying key population features and providing information on a single element, produced from state-level data sets. State profiles provides data sets derived from Older Americans Act (OAA) programs. Interactive features allow users to compare data sets between states and find State Units on Aging, Area Agencies on Aging, and Tribal Organization locations and resources. Custom Tables features an online format for users to create personalized tables, graphs and data sets by utilizing AGID data. The final

section, Data Files, includes ACL-specific and census-based individual survey files along with other supportive collection tools and information.

Allison, A., Ishihara-Wong, D., Domingo, J., Nishioka, J., Tsark, J., & Braun, K.L., (2013) Helping cancer patients across the care continuum: The navigation program at The Queen's Medical Center. *Hawai'i Journal of Medicine and Public Health*, 72, 116-122. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3689506/>

Research suggests that cancer patient navigation improves care, but few reports describe the variety of patients managed by a hospital-based navigation program. Differences in navigated patients by the intensity (low, medium, or high) of navigation services they received were examined. The 835 clients seen by the navigators in a hospital-based cancer center were first stratified by quarter and by four ethnic groups. Randomized selection from each group assured there would be equal representation for analysis of Hawaiians, Filipinos, Japanese, and Whites and even numbers over all time intervals. Five professionals extracted data from these case records on demographics, type/stage of cancer, diagnosis and treatment dates, barriers, and navigator actions. Clients had breast (30.0%), lung (15.8%), esophageal (6.7%), colon (5.8%), ovarian (4.2%), prostate (3.3%), and other cancers (34.2%). The median number of actions taken on behalf of a client was 4 (range 1–83), and the median number of days a case was open was 14 (range 1–216). High intensity cases (those receiving more assistance over longer periods of time) were more likely than low-intensity cases to need help with education and reassurance, transportation, care coordination, and covering costs. Although there were no demographic differences across intensity groups, Neighbor Island patients from Hawai'i, Maui, Moloka'i, Lana'i and Kaua'i were more likely to need help with arranging travel, care coordination, and costs associated with getting treatment (all at $P=.05$), and patients on public insurance were more likely to have stage 4 cancer ($P=.001$) and to need help with costs ($P=.006$). Findings suggest that this hospital-based navigation program is filling a real need of patients across the cancer care continuum. A triage protocol and an integrated data capture system could help improve the targeting and documentation of cancer patient navigation services.

Alzheimer's Association (2016). *Hawai'i Alzheimer's Statistics: Fact Sheet*. Retrieved from: <http://alz.org.facts>

This Fact Sheet provides current [2016], and brief key information on Alzheimer's Disease (AD) in Hawai'i. Approximately 26,000 older adults age 65+ were diagnosed with Alzheimer's Disease in Hawai'i in 2016. Predictions suggest that 35,000 older adults will be diagnosed with

AD by 2025. Hawai'i's population of caregivers in 2016 was documented as more than 66,000 caregivers who provide over 75 million hours of unpaid care in 2016.

Americans with Disabilities (2015). *What is the definition of disability under the ADA?* Seattle, WA: ADA National Network. Retrieved on October 15, 2015 from <https://adata.org/faq/what-definition-disability-under-ada>

The American with Disabilities Act (ADA) serves to protect disabled individuals from discrimination in multiple areas of life including social, academic and employment. Under the ADA definition, a person is deemed to be disabled if having one or more mental or physical impairment which impedes functioning in area of life or more.

Angela-Cole, L., Ka'opua, L., & Busch, M. (2010). Issues confronting social workers in the provision of palliative care services in the Pacific Basin (Hawai'i and the U.S. Affiliated Pacific Island nations and territories). *Journal of Social Work in End-of-Life and Palliative Care*, 6(3-4), 150-163. <https://doi.org/10.1080/15524256.2010.529015>

In this article, the authors highlight the complex issues associated with providing end-of-life and palliative care services to people who make up the diverse cultural groups of the Pacific. Many people from all over the Pacific Basin come to Hawai'i, USA to obtain palliative care services, due to lack of adequate health care in many Pacific Island nations. However, many barriers exist that sometimes prevent optimal care. Some of these barriers are due to a misunderstanding of cultural differences, while others are systemic. Both are discussed, as well as how social workers can assist with the provision of palliative care services in a culturally sensitive manner.

Angela-Cole, L., Ka'opua, L.S., & Yim, Y.D. (2011). Palliative care, culture, and the Pacific Basin. In T. Altilio and S. Otis-Green (Co-editors), *Oxford Textbook of Palliative Social Work* (pp. 527-530). New York: Oxford.

This chapter describes the role of key cultural considerations in palliative care with/for Native Hawaiians and Pacific Islanders from the US territories and from the Compact of Free Association (COFA) nations. Based on actual cases, we describe issues related to family involvement, cultural preferences, and customary practices. Highlighted are social work strategies for navigating conflicts occurring between providers seeking to follow hospital policies/procedures and the preferences of Pacific Islander families. Emphasized are the social

work roles as patient/family advocate and as cultural mediator between culturally different family systems and conventional, western health care settings.

Blaisdell, R.K. (1989). Historical and cultural aspects of Native Hawaiian health. In E.L. Wegner (Ed), *Social Process in Hawai'i*, 32 (pp. 1-21).

This volume focuses on Native Hawaiian health status throughout the 1980s. This issue highlights multidisciplinary research on numerous contextual factors that are critical to the health of the Native Hawaiian population in modern day Hawai'i. These include rates of specific disease, poverty, living conditions, and overall population statistics about Native Hawaiians in the 1980's. Dr. Blaisdell's contribution highlighted is the significance of cultural and historical influences that provide context of the profound health and population changes in the Hawaiian population since western colonization.

Braun, K.L., & Browne, C. (1998). Perceptions of dementia, caregiving, and help seeking among Asian and Pacific Islander Americans. *Health and Social Work*, 23, 262-274.
<https://doi.org/10.1093/hsw/23.4.262>

The United States is becoming more ethnically diverse, and Asian and Pacific Islanders (APIs) are one of the most rapidly growing ethnic minority groups. Of interest to social workers is how the traditional values and practices of these cultures affect their perceptions of disease and use of health services. This article presents information on perceptions of dementia, caregiving, and help seeking for the API group as a whole, with additional information on five of the major API subgroups—Chinese, Japanese, Filipino, Vietnamese, and Hawaiian. Implications for practice, policy, and research are discussed.

Braun, K.L., Browne, C., Ka'opua, L.S., Kim, B.J., Mokuau, N. (2014) Research on Indigenous elders: From positivistic to decolonizing methodologies. *The Gerontologist*. 54 (1), 117-126.
<https://doi.org/10.1093/geront/gnt067>

Although indigenous peoples have lower life expectancies than the social majority populations in their countries, increasing numbers of indigenous people are living into old age. Research on indigenous elders is informed by a number of research traditions. Researchers have mined existing data sets to compare characteristics of indigenous populations with non-indigenous groups, and these findings have revealed significant disparities experienced by indigenous elders. Some investigators have attempted to validate standardized research tools for use in indigenous

populations. Findings from these studies have furthered our knowledge about indigenous elders and have highlighted the ways in which tools may need to be adapted to better fit indigenous views of the constructs being measured. Qualitative approaches are popular, as they allow indigenous elders to tell their stories and challenge non-indigenous investigators to acknowledge values and worldviews different from their own. Recently, efforts have extended to participatory and decolonizing research methods, which aim to empower indigenous elders as researchers. Research approaches are discussed in light of the negative experiences many indigenous peoples have had with Eurocentric research. Acknowledgment of historical trauma, life-course perspectives, phenomenology, and critical gerontology should frame future research with, rather than on, indigenous elders.

Braun, K.L., Fong, M., Gotay, C., Chong, C., & Pagano, I. (2005). Ethnicity and breast cancer in Hawai'i: Increased survival, but continued disparity. *Ethnicity and Disease, 15*, 453-460.

This study examines the ethnic variation in survival among 7722 women diagnosed with invasive breast cancer in Hawaii between 1990 and 2002 and extends previous multivariate analyses by adding a new prognostic variable: estrogen receptor/progesterone receptor (ER/PR) status. Compared to Caucasians, significantly smaller proportions of Japanese and Chinese women and larger proportions of Native Hawaiian and Filipino women were diagnosed in later stages of disease and at earlier ages. The four minority ethnic groups had higher rates of ER+PR+ tumors than Caucasians. For both causes of death, ethnic disparities in survival were reduced, but still existed, after controlling for age, stage, and ER/PR status. Japanese had the highest rates of survival for either cause of death. Native Hawaiians and Filipinos had the lowest rates of survival for breast cancer, and Native Hawaiians and Caucasians had the lowest rates of survival for other causes of death. Future studies should examine other reasons for continued ethnic differences in breast cancer survival in Hawaii, including socioeconomic status, access to insurance, adequacy of recommended screening frequency, comorbid conditions, treatment appropriateness and compliance, and genetic markers of tumor aggressiveness.

Braun, K.L., Fong, M., Ka'ano'i, M., Kamaka M., & Gotay, C. (2005). Testing a culturally appropriate, theory-based intervention to increase colorectal cancer screening among Native Hawaiians. *Preventive Medicine, 40*, 619-627.

This article summarizes an intervention based on social learning theory (SLT) to improve colorectal cancer (CRC) screening among Native Hawaiians, a group with low CRC screening rates. Sixteen Hawaiian civic clubs agreed to randomization. Eight control clubs received a culturally targeted presentation, a free Fecal Occult Blood Test (FOBT), and a reminder call.

Eight experimental clubs also received culturally targeted education and free testing; but, in line with SLT, education was delivered by a Native Hawaiian physician and Native Hawaiian CRC survivor, and members received an FOBT demo, were challenged to involve a family member in screening, and were telephoned multiple times to address change-related emotions and barriers. One hundred twenty-one members age 50 and older from 16 clubs participated. At the club level, screening rates were modestly increased in four experimental clubs and six control clubs. Although individuals in the experimental arm were more likely to rate the intervention as culturally appropriate, both arms realized similar and significant gains in CRC knowledge, attitudes, intent, and self-efficacy. For Native Hawaiian individuals belonging to a network of civic clubs, an intervention based on SLT delivered by a Native Hawaiian physician and CRC survivor was less effective at further increasing compliance than was a culturally targeted educational session delivered by a non-Hawaiian nurse. That CRC screening compliance was high prior to our intervention suggests that we targeted a very health conscious segment of the Native Hawaiian population. Future work should focus on underserved segments of this indigenous group.

Braun, K.L., Karel, H., & Zir, A. (2006). Differential response to end-of-life booklets by family caregiver stage and ethnicity. *American Journal of Hospice and Palliative Medicine*, 23, 269-276. <https://doi.org/10.1177/1049909106290243>

The authors developed and tested 5 educational booklets to improve end-of-life knowledge, attitudes, intention, and practices in a multiethnic sample of family caregivers of well, homebound, and institutionalized elders. Of 570 participants, 424 (74%) read at least 1 booklet and completed pretests and posttests. At 3-month follow-up, small improvements were seen in completion of advance directives, and significant increases were seen in proportions of caregivers with funeral or burial plans and willingness to consider hospice. The booklets had wide appeal, but end-of-life measures varied by caregiver stage and ethnicity, suggesting that these factors need to be considered in developing education interventions for family caregivers.

Braun, K.L., Kim, B.J., Ka'opua, L.S., Mokuau, N., Browne, C. (2014). Native Hawaiian and Pacific Islander elders: What gerontologists need to know. *Gerontologist*, 55(6), 912-919. <https://doi.org/10.1093/geront/gnu072>

The 2010 Census reports that approximately 1.2 million individuals identify as Native Hawaiian or Other Pacific Islander (NHOPI). This article, authored by researchers from Hā Kūpuna National Resource Center for Native Hawaiian Elders, discuss the increase in the number of elderly NHOPI, a population that continues to experience greater numbers of health disparities

compared to most other racial and ethnic groups in the U.S. Historical trauma, discrimination, changing lifestyles, poor health practices, economic insecurity, and exclusion of cultural values are cited as influencing longevity and quality of life for NHOPI elders. Increasing service accessibility through policy reform, implementing culturally informed programs, educating service providers, and more research without aggregated study populations are suggested methods to improve health outcomes.

Braun, K.L., LaCounte, C. (2015) The historic and ongoing issue of health disparities among native elders. *Generations*. 38, 60-69. Retrieved from <http://www.asaging.org/blog/historic-and-ongoing-issue-health-disparities-among-native-elders>

Prior to the arrival of Europeans, an estimated 5 million to 10 million individuals inhabited the land that now comprises the United States. They were organized in hundreds of communities, each with their own languages, cultures, economies, social institutions, and governance structures. Today, these groups are known as American Indians, Alaska Natives, and Native Hawaiians. In this article, we will refer to them collectively as Native Americans and, when talking about older Native Americans, as native elders. Today, about 5.2 million U.S. residents are full or part American Indian or Alaska Natives (AIAN), and another 527,077 are full or part Native Hawaiian (U.S. Census Bureau, 2012, 2013). Taken together, Native Americans of the United States now make up about 2 percent of the nation's population. With population aging, the number and proportion of native elders have grown. Yet, native peoples experience continued disparities in health, disability, and longevity (Anderson, Bulatao, and Cohen, 2004). This article presents data on demographic and health indicators of Native Americans, discusses possible reasons for relatively poor health outcomes, and makes recommendations for research and practice.

Braun, K. L., Look, M. A., Yang, H., Onaka, A. T., & Horiuchi, B. Y. (1996). Native Hawaiian mortality, 1980 and 1990. *American Journal of Public Health*, 86(6), 888–889. Retrieved from : <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1380415/>

Limited research on Hawaiian health indicates that Native Hawaiians have higher morbidity and mortality rates compared to other races in the state. While public health reports outside Hawaii rarely disaggregate the Asian and Pacific Islander American groups, even within the state, few disaggregate full and part Hawaiians.³/₄ As Hawaii is the only native home for the Hawaiian race and culture, the status of full Hawaiians is of global interest. Among the few empirical studies on Hawaiian health, a 1982 report by Look presented age-adjusted, standardized mortality rates per 100 000 for full Hawaiians, part Hawaiians, and all races for the decade years

1910 through 1980, which showed significantly higher mortality rates for full Hawaiians.⁵ Because the "all races" group included the full and part Hawaiians, the 1982 report presented a skewed comparison. Thus, this study recalculated mortality rates for 1980 for a "non-Hawaiian" group and added the 1990 rates for full, part, and non-Hawaiians.

Braun, K., Mokuau, N., & Browne, C. (2011). *Life expectancy, morbidity, and health practices of Native Hawaiian elders: A review of Hawai'i Surveillance Data 2010*. University of Hawai'i: Ha Kūpuna National Resource Center for Native Hawaiian elders.

Data sets from the Hawai'i Department of Health (DoH) were analyzed by researchers from Hā Kūpuna National Resource Center for Native Hawaiian Elders on Native Hawaiian elders, 60 years of age or older, residing in Hawai'i. Data collection tools included the 2005 Hawai'i Health Survey (HHS), the 2005-2007 Hawai'i Behavioral Risk Factor Surveillance System (BRFSS), and State of Hawai'i Vital Records. Together these data provided information about the underrepresentation of Native Hawaiian elders in the elder population, and the disparities in longevity, health practices, and health status that present challenges for them, their families, and society. Study results can be used to better inform future research, policy and service delivery.

Braun, K.L., Mokuau, N., Hunt, G.H., Ka'ano'i, M., & Gotay, C. (2002). Supports and obstacles to cancer survival for Hawai'i's native people. *Cancer Practice*, 10, 192-200.
<https://doi.org/10.1046/j.1523-5394.2002.104001.x>

Investigators have suggested that high cancer mortality rates among Native Hawaiians are due to fatalistic attitudes toward the disease, poor access to care, and lack of consideration of Native Hawaiian cultural values in Western approaches to healthcare. This study used qualitative methods to examine these factors in Native Hawaiian cancer survivors.

Eight focus groups were held on five islands, attracting 45 Native Hawaiian cancer survivors from both rural and urban locales. The focus groups explored survivors' experiences with cancer diagnosis, treatment, and recovery. Participatory research methods were used, with researchers gaining community input on study design, incorporating appropriate Native Hawaiian cultural protocols into the focus groups, and engaging participants in the interpretation of the data. Similar to cancer survivors of other ethnicities, these individuals demonstrated the following: success in accessing healthcare information, professionals, facilities, and insurance; the ability to overcome the barriers confronted; and proactive health behaviors regarding screening, diagnosis, and treatment. They also demonstrated ways in which they were sustained through the cancer experience by Native Hawaiian traditions, such as helping others, gaining strength from Hawaiian spiritual beliefs, and relying on family for personal support. Participants did not

respond passively to their cancer diagnoses, and they expressed few fatalistic attitudes. Participants did give numerous examples of other Native Hawaiians who did not seek screening or treatment for cancer because they lacked insurance, had poor access to care, or felt alienated by Western healthcare. The findings suggest that improving access to care and incorporating cultural values in health education and services can enhance survivorship and quality of life for Native Hawaiians with cancer. These themes may have applications for other minority groups.

Braun, K.L., Mokuau, N., & Tsark, J. (1997). Cultural themes in health, illness, and rehabilitation among Native Hawaiians. *Topics in Geriatric Rehabilitation, 12*(3), 19-37.

Increasing the cultural competency of health care providers requires an understanding of the cultural group being served. For Native Hawaiians, however, little is known about their participation in and views of rehabilitation. In this study, focus groups were conducted in which Native Hawaiian and non-Hawaiian rehabilitation professionals were asked to interpret utilization data and offer their perceptions of the rehabilitation experience of Native Hawaiians. Consistently noted were cultural values and traditions reflecting the importance of `aina (environment), `ohana (family), kuleana (specific responsibilities of family members), and kokua (mutual support and interdependence). Findings demonstrate the link between cultural values and health behaviors and provide guidelines that inform practice, policy, and research.

Braun, K.L., & Nichols, R. (1996). Cultural issues in death and dying. *Hawai`i Medical Journal, 55*, 260-264.

All people have, and will, experience death. But not all people view death or respond to death in the same way. As we increase our life expectancy' and our ability to prolong life artificially, issues surrounding death and dying become more controversial. How do different cultures look at death? What factors, besides culture, impact one's perceptions of issues like advanced directives, organ donation, suicide, euthanasia? These questions were asked in a qualitative study of death and dying in Honolulu among five Asian and Pacific Islander (API) groups—Chinese, Filipinos, Japanese, Native Hawaiians, and Vietnamese. Expanding knowledge of cultural issues in death and dying is important for two major reasons. First, as health care professionals, we need to understand and respect cultural differences if we hope to provide care that is relevant and acceptable to our clients. Second, as educators, we need to encourage individuals to share their differences with each other as our society develops policies and social structures related to end-of-life decision making. This is especially crucial given the recent decisions by the 2nd and 9th Circuit Courts supporting the right to physician-assisted suicide. Although the Supreme

Court has issued a stay on these decisions, many feel it is only a matter of time before assisted dying is legalized in the United States.

Braun, K.L., Onaka, A., & Horiuchi, B. (2001). Advance directive completion rates and end-of-life preferences in Hawai'i. *Journal of the American Geriatrics Society*, 49, 1708-1713. <https://doi.org/10.1046/j.1532-5415.2001.49284.x>

To estimate rates of advance directive completion, preference for in-home death and hospice services at life's end, and support for physician assistance in dying, questions were added to two statewide, random-sample telephone surveys—the 1998 Behavioral Risk Factor Surveillance System (N = 2,153) and the 1999 OmniTrak health survey (N = 700). Data were compared across age, ethnic, and gender groups. Overall, 29% of Hawaii residents had a living will, 22% had a healthcare power of attorney, 65% said they would prefer a home death, 60% would want hospice services, 64% believed a person had a moral right to end his or her life when faced with an incurable illness, and 63% felt doctors should be allowed by law to end a patient's life if the patient and his or her family requested it. Advance directive completion rates increased with age, desire for an in-home death varied by gender and ethnicity, and support of assisted-death options varied by ethnicity. Despite a large minority population, end-of-life preferences among the general population in Hawaii are similar to those of U.S. mainlanders. However, age, gender, and ethnic differences exist. Clinicians are encouraged to ask patients directly about their preferences as a first step toward improving end-of-life care.

Braun, K.L., Pietsch, J.H., & Blanchette, P.L. (Eds.). (2000). *Cultural issues in end-of-life decision making*. Thousand Oaks, CA: Sage Publications.

End-of-life decision making is one of the most difficult but crucial challenges faced by patients and their families. In most cases, resources or counselors providing guidance in these decisions are not available. This book is intended to prepare nurses, physicians, and other health care workers to fill this role, insofar as they are most frequently in contact with the patient and his/her family and significant others at the time choices must be made. In this informative, practical book, Braun, Pietsch, and Blanchette first review the medical, legal, and ethical context of the dying experience, discussing ethnic perspectives and religious issues. For example, providing culturally and spiritually sensitive care requires that nurses, physicians, social work and others know and understand the implications of family members beliefs about life and death, supportive rituals and other activities. This book does a creditable job of presenting the issues and a broad overview of culture and common religions in America.

Braun, K.L., Takamura, J., Forman, S., Sasaki, P., & Meinenger, L. (1995). Developing and testing outreach materials in Alzheimer's Disease for Asian and Pacific Islander Americans. *The Gerontologist*, 35, 122-126.

Compared to white people, minorities have similar rates of dementia but are less likely to use services. Native language videos and brochures that incorporated culturally specific perceptions of dementia, caregiving, and help-seeking for seven Asian and Pacific Islander American (APIA) groups were developed and tested. Findings suggested that these tools were culturally appropriate and, when used in combination with discussion, helped increase awareness of Alzheimer's disease and sources of help.

Braun, K.L., Tanji, V., & Heck, R. (2001). Support for physician-assisted suicide: Exploring the impact of ethnicity and attitudes toward planning for death. *The Gerontologist*, 41, 51-60.

The authors interviewed adults in five ethnic groups, used factor analysis to quantify attitudes toward planning for death, and used path analysis to test the relative influence of respondent characteristics, including ethnicity, and attitude factors (Advocacy to Discuss/Document Wishes, Trust in Family and Physician to Make Decisions, Reliance on Religious Guidance, Fears and Anxiety About Life's End, and Fatalism About Death's Timing) on support for physician-assisted suicide (PAS). Findings verified that attitude factors had a direct effect on PAS support but that, contrary to the hypothesis, ethnicity had a direct effect on support for PAS as well

Braun, K.L., Thomas, W., Domingo, J., Allison, A., Ponce, A., Kamakana, P.H., Aluli, N.E., Tsark, J.U. (2015) Reducing cancer screening disparities in Medicare beneficiaries through cancer patient navigation. *Journal of the American Geriatrics Society* 63(2), 365-370.
<https://doi.org/10.1111/jgs.13192>

Significant racial disparities in cancer mortality are seen between Medicare beneficiaries. A randomized controlled trial tested the use of lay navigators (care managers) to increase cancer screening of Asian and Pacific Islander Medicare beneficiaries. The study setting was Moloka'i General Hospital on the island of Moloka'i, Hawai'i, which was one of six sites participating in the Cancer Prevention and Treatment Demonstration sponsored by the Centers for Medicare and Medicaid Services. Between 2006 and 2009, 488 Medicare beneficiaries (45% Hawaiian, 35% Filipino, 11% Japanese, 8% other) were randomized to have a navigator help them access cancer screening services (experimental condition, n = 242) or cancer education (control condition, n = 246). Self-reported data on screening participation were collected at baseline and exit from the

study, and differences were tested using chi-square. Groups were similar in demographic characteristics and baseline screening prevalence of breast, cervical, prostate, and colorectal cancers. At study exit, 57.0% of women in the experimental arm and 36.4% of controls had had a Papanicolaou test in the past 24 months ($P = .001$), 61.7% of women in the experimental arm and 42.4% of controls had had a mammogram in the past 12 months ($P = .003$), 54.4% of men in the experimental arm and 36.0% of controls had had a prostate-specific antigen test in the past 12 months ($P = .008$), and 43.0% of both sexes in the experimental arm and 27.2% of controls had had a flexible sigmoidoscopy or colonoscopy in the past 5 years ($P < .001$). Findings suggest that navigation services can increase cancer screening in Medicare beneficiaries in groups with significant disparities.

Braun, K.L., Tsark, J., Santos, L., Aitaoto, N., & Chong, C. (2006). Building Native Hawaiian capacity in cancer research and programming: The Legacy of `Imi Hale. *Cancer*, 107 (8 Suppl), 2082-2090. <https://doi.org/10.1002/cncr.22157>

In 2000, cancer health indicators for Native Hawaiians were worse than those of other ethnic groups in Hawai'i, and Native Hawaiians were under-represented in research endeavors. To build capacity to reduce cancer health disparities, 'Imi Hale applied principles of community-based participatory research (CBPR) and empowerment theory. Strategies included: 1) engaging Native Hawaiians in defining cancer priorities; 2) developing culturally appropriate processes and products; 3) supplementing primary and secondary cancer prevention activities; 4) offering skills training and technical assistance; and 5) providing an infrastructure to support culturally appropriate research. Between 2000 and 2005, 'Imi Hale involved more than 8000 Native Hawaiians in education, training, and primary and secondary prevention activities; developed 24 culturally tailored educational products (brochures, curricula, and self-help kits); secured \$1.1 million in additional program and research funds; trained 98 indigenous researchers, 79 of whom worked on research projects; and engaged more than 3000 other Native Hawaiians as research participants and advisors. Evidence of empowerment was seen in increased individual competence, enhanced community capacity and participation, reduced barriers, and improved supports to address cancer in Hawaiian communities. Operationalizing CBPR and empowerment requires a commitment to involving as many people as possible, addressing community priorities, following cultural protocol, developing and transferring skills, and supporting an infrastructure to reduce barriers and build supports to sustain change. This approach is time consuming, but necessary for building competence and capacity, especially in indigenous and minority communities.

Braun, K.L., Yang, H., Look, M., Onaka, A., & Horiuchi, B. (1996). Age-specific Native Hawaiian mortality rates: A comparison of full, part, and non-Hawaiians. *Asian American and Pacific Islander Journal of Health*, 4, 352-362.

The purpose of this paper is to test if the previously identified disparity in mortality rates among full Hawaiians, part Hawaiians, and non-Hawaiians in the state of Hawaii has continued into the 1990s. The most striking finding was the significant differences in mortality rates in four age strata 45-54, 55-64, 65-74, and 75-84; with mortality rates highest for full Hawaiians, lowest for non-Hawaiians, and intermediate for part Hawaiians. Findings suggest that Native Hawaiians continue to be at greater risk of death compared with non-Hawaiians, with full Hawaiians at greatest risk. Asian and Pacific Islander Americans have been called the model minority. These data provide evidence that Native Hawaiians, especially full Hawaiians, have dramatically higher mortality rates than non-Hawaiians and merit special attention.

Braun, K.L., Yang, H., Onaka, A., & Horiuchi, B. (1996). Life and death in Hawai'i: Ethnic variations in mortality and life expectancy. *Hawai'i Medical Journal*, 55, 278-283, 302.

Life expectancy in Hawaii is among the highest in the nation. Past research, however, found significant ethnic differences in longevity. This study presents life expectancy estimates for 1980 and 1990, along with ethnic differences in mortality rates for specific causes of death. The findings suggest that ethnic differences continue, with Chinese and Japanese having the longest life expectancy and Native Hawaiians having the shortest.

Braun, K.L., Yang, H., Onaka, A., & Horiuchi, B. (1997). Asian and Pacific Islander mortality differences in Hawai'i. *Social Biology*, 44, 213-226.

In the United States, national health status data pertaining to Asian and Pacific Islander (API) Americans are rarely disaggregated. By aggregating API data, however, the poor health status of some API groups is often masked by the favorable health status of others. The purpose of this paper is two-fold: (1) to compare mortality rates of the five major ethnic groups in Hawaii (Caucasians, Chinese, Filipinos, Japanese, and Hawaiians) and (2) to explore methodological issues related to comparative studies of API health indicators. Standardized and age-specific mortality rates and 95 percent confidence intervals for major causes of death were estimated for 1990 based on Hawaii vital records and population data. In general, death rates were highest for Hawaiians and lowest for Japanese and Chinese, illustrating the importance of API data disaggregation and suggesting that special attention be paid to improving the health of

Hawaiians. Methodologically, the study demonstrated that, while some compromises in analysis are required, legitimate comparisons across API groups can be made if data sets are available.

Braun, K., Yee, B., Browne, C., & Mokuau, N. (2004). Native Hawaiian and Pacific Islander elders. *Closing the Gap. Washington, DC: Gerontological Society of America*, 47-67.

In this earlier article, information is presented on social, health, and economic data for Native Hawaiians, Samoans, and Chamorros, three distinct Native Hawaiian and Pacific Islander populations that historically were aggregated under the Asian Americans and Pacific Islanders (AAPI) demographic category. The examination of physical and mental health outcomes for these individual ethnic groups reveals a highly polarized spectrum, with Chinese and Japanese repeatedly presenting with the best overall outcomes, and Native Hawaiians and Pacific Islanders continuously having worse outcomes compared to most other U.S. ethnic groups. Study results show a need for more ethnically specific demographic categories, disaggregated data, and study of the effectiveness of culturally-informed services and service delivery.

Browne, C.V., Braun, K.L. (2017). Away from the Islands: Diaspora's Effect on Native Hawaiian Elders and Families in California. *Journal of cross-cultural gerontology*, 32(4), 395-411. <https://doi.org/10.1007/s10823-017-9335-3>

Native Hawaiians, the indigenous people of Hawai'i, were once a healthy and hardy people. But today they are affected by varying social and health disparities that have led to poor social and health outcomes. Most of the research on Hawaiians in general and Native Hawaiian elders in particular has been conducted in Hawai'i, even though the Hawaiian Diaspora has resulted in 45% of this population residing in North America and Alaska. This qualitative study used key informant interviews and focus group methods to examine reasons for migration and perspectives on aging and caregiving in a sample of Native Hawaiian elders and family caregivers residing in Southern California. Findings identified three general themes: discrimination was a factor in their migration from Hawai'i; similarly to non-Hawaiians, they are concerned about challenges associated with aging and caregiving; and Native Hawaiian cultural traditions and values continue to shape their caregiving and service preferences.

Browne, C.V., Braun, K.L., Mokuau, N. & McLaughlin, L. (2002). Developing a multisite project in geriatric and/or gerontological education with emphasis in interdisciplinary practice and cultural competence. *The Gerontologist*, 42, 698-704. <https://doi.org/10.1093/geront/42.5.698>

This 2-year, multisite, curriculum-development project aimed to increase the pool of professionals trained in geriatric and/or gerontological social work. Methods included (a) providing advanced training in aging, cultural competence, and interdisciplinary practice to social work professionals and masters degree students, (b) developing, implementing, and testing an innovative student curriculum based on standardized learning competencies identified by project participants, (c) revising the university curriculum to support such competencies, and (d) producing a practicum handbook. Project conceptualization, implementation, and evaluation are discussed together with approaches for its replication.

Browne, C. & Broderick, A. (1994). Asian and Pacific Island elders: Implications for social work practice and education. *Social Work, 39*, 252-259.

The highly diverse Asian and Pacific Island population in the United States doubled in size from 1980 to 1990 and is now the nation's fastest-growing minority group. This article describes Asian and Pacific Island elderly population and its ethnic diversity, geographic location, gender ratios, income and poverty, health status, service utilization, and cultural values and beliefs. Also presented are the specific challenges for social workers in practice settings in designing and providing culturally relevant services and programs. A number of suggestions for social work education to meet the needs of this growing aging population are offered, including the development of an ethnogerontological and multicultural social work curriculum and the critical need for data on this population.

Browne, C., Broderick, A., Fong, R. (1993). Lessons from the field: social work practice with multicultural elders. *Educational Gerontology, 511-523*.

<https://doi.org/10.1080/0360127930190604>

This article briefly reviews the present status of multicultural social work education and presents the results from a pilot study that explored educational strategies utilized by gerontology field instructors in multicultural settings. A variety of teaching strategies to foster culturally sensitive social work practice are identified. These strategies include the purposeful assignment of ethnic and minority clients to students, the use of role play, specific reading assignments, and the use of student-supervisory meetings as an arena in which to raise and discuss multicultural social work issues. Finally, this article offers suggestions for strengthening the class and field partnership in multicultural social work education.

Browne, C., Ka`opua, L.S., Jervis, L., Alborota, R., Trockman, M. (2016). United States Indigenous populations and dementia: Is there a case for culture based psychosocial interventions? *The Gerontologist*, 1-9. <https://doi.org/10.1093/geront/gnw059>

Dementia is an issue of increasing importance in indigenous populations in the United States. We begin by discussing what is known about dementia prevalence and elder family caregiving in American Indian, Alaska Native, and Native Hawaiian populations. We briefly highlight examples of culture-based programming developed to address a number of chronic diseases and conditions that disproportionately affect these communities. These programs have produced positive health outcomes in American Indian, Alaska Native, and Native Hawaiian populations and may have implications for research and practice in the dementia context of culture-based interventions. Evidence-based and culture-based psychosocial programming in dementia care for indigenous populations in the United States designed by the communities they intend to serve may offer elders and families the best potential for care that is accessible, respectful, and utilized.

Browne, C.V., & Mokuau, N. (2008). Preparing students for culturally competent practice with ethnic minority elders. *Journal of Educational Gerontology*, 34, 306-327. <https://doi.org/10.1080/03601270701834018>

The increase in the nation's present and projected multicultural aged population is both dramatic and well documented. One result of this growth is a sharpened focus on racial and ethnic disparities in health, health care access, and utilization of services that impact aging adults. This paper presents work conducted by a university-community collaborative project in gerontology. The thrust of the project is that cultural competency is a key ingredient for preparing social work students for work with ethnic minority elders and for potentially improving services to older minority populations. A brief description of the project is presented with highlights of the standards of cultural competencies that were developed for three specific populations: Japanese, Filipino, and Native Hawaiians. In general, standards organized around knowledge, values and skills consistently reflect the importance of the family system in caring for older adults.

Browne, C., Mokuau, N., & Braun, K. (2009). Adversity and resiliency in the lives of native Hawaiian elders. *Social Work*, 54(3), 253-261.

Native Hawaiian elders experience disparities across multiple arenas of life and health such as higher rates of poverty, disability, mortality, and lower rates of accessing available services. In this article, researchers from Hā Kūpuna National Resource Center for Native Hawaiian Elders call for more targeted attention and study on culturally informed services. The article addresses the need for social workers and other professionals to intervene at all levels of practice to reduce

disparities and increase service accessibility. The authors proposed a new practice model, *Ola Pono nā Kūpuna*, to increase effectiveness of working with Native Hawaiian elders by linking culturally relevant life markers with methods for increasing service responsiveness and utilization, and improving overall well-being of nā kūpuna.

Browne, C., Mokuau, N., Ka`opua, L.S., Kim, B.J., Braun, K. (2014). Listening to the voices of Native Hawaiian elders and `ohana caregivers: Discussions on aging, health, and care preferences. *Journal of Cross Cultural Gerontology*.
<https://www.doi.org/10.1007/s10823-014-9227-8>

Results from a qualitative designed study conducted by Hā Kūpuna National Resource Center for Native Hawaiian Elders are summarized in this article. This study utilized focus group meetings with elders and family caregivers on the islands of Hawai`i, Kaua`i, and O`ahu to examine their perspectives on age, health, and care preferences. The study drew from theoretical constructs from life course perspective, minority stress theory, and historical trauma to provide possible explanations for the increasing health disparities experienced by Native Hawaiian elders. Results emphasized the need for adequate income, more culturally informed services and service providers, and specific services which help elderly stay in the home.

Browne, C., Mokuau N., Braun, K., & Choy, L. (2008). *Assessing the health and long-term care needs of Native Hawaiian elders and their caregivers: Results from key informant interviews in Hawai`i*. University of Hawai`i: Hā Kūpuna National Resource Center for Native Hawaiian Elders

Hā Kūpuna National Resource Center for Native Hawaiian Elders conducted interviews with key informants--leaders in the Native Hawaiian health community--to gather their perspectives on the needs and health of Native Hawaiian elders. Utilizing a set of 6 standardized interview questions, researchers were able to identify a set of themes, based on patterns in participant responses. Thematic data aided in creating a conceptual framework about Native Hawaiian elders, health, and care services. Participants identified unmet needs, fitting 5 subcategories; health care, economic, social needs, family issues, and service issues. The economic subcategory, was the second most common identified need, with the ability to impact other health and quality of life outcomes. System issues, A wider array of accessible family support systems, were the themes identified for caregiving/caregivers. The desire for more Native Hawaiian and cultural services based on Native Hawaiian cultural values, was a focal point of participant's discussion on services

Carter, P. (2015). State of caregiving for people with dementia in Indian County, plenary address on October 15, 2015, *Inaugural National Conference on Alzheimer's Disease and Dementias in Native American Communities: Impact, Issues, and Next Steps*, Scottsdale Plaza Resort, Scottsdale, Arizona.

The National Resource Center on Native American Aging at the University of North Dakota presented their findings on the current status of Native American elders at this first Inaugural National Conference on Alzheimer's Disease and Dementia in North American Communities in 2015. The number of Native elders is increasing, and creating greater demands on family caregivers. Moreover, tribal lands typically reside in rural areas with limited service accessibility, resulting in caregivers having limited access for affordable formal care. A shortage of long-term care facilities and services has compounded the care issues around Native elder care. Further research is proposed due to increasing numbers of Native elders, tribal diversity, and a need and preference for individualized and culturally responsive care. This study has implications for work with Native Hawaiians due to their risks for dementia and other cognitive impairments.

Center for Disease Control and Prevention (CDC). (2010). *Behavioral risk factor surveillance system survey data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Center for Disease Control.

The Behavioral Risk Factor Surveillance System (BRFSS) was established by the Center for Disease Control and Prevention (CDC) in response to the limited state-level data available on individual health factors affecting mortality and disease. Data are collected monthly via telephone surveys in all 50 states, the District of Columbia, American Samoa, Palau, Puerto Rico, the U.S. Virgin Islands, and Guam. Survey questions are responsive to the current demographic health issues, as well as fixed questions which remain stable across surveyed years. In Hawai'i, the State Department of Health is the department in charge of collecting these data.

Choy, L.B., Mokuau, N., Braun, K.L., & Browne, C. (2008). Integration of cultural concepts in establishing Hā Kūpuna National Resource Center for Native Hawaiian elders. *Journal of Native Aging and Health*, 3 (1), 5-13.

This article describes Hā Kūpuna's program design that reflects important Hawaiian cultural concepts. Integration of these cultural concepts is demonstrated by project accomplishments

describes in the article. This approach can serve as a model for university community collaborations aimed at improving the health aimed at well-being of Native elders.

Ewalt, P.L. & Mokuau, N. (1995). Self-determination from a Pacific Islander perspective. *Social Work, 40*, 168-175.

Separation from external influences in one's decision making is so highly valued in the United States that autonomy is considered to be a benchmark of one's maturity. However, self-determination without consideration of group-oriented values is discordant with non-Western and some Western orientations. Using examples from Pacific peoples, this article highlights the complex loop of self-determination in which an emphasis is placed on group welfare in individual decision-making. Implications for social work practice are discussed.

Federal Interagency Forum for Aging Related Statistics (2016). *Older adults and Key Indicators of well-being*. Washington, DC: Federal Interagency for Aging Related Statistics.

The Older Adults: Key Indicators of Well-being Report is an annual publication by the Federal Interagency Forum for Aging Related Statistics that aims to promote progressive policy and service reform and better outcomes for older adults through the use of multiple federal data collection sites. Datasets summarize the older adult population's economic status, health outcomes, and health care utilization. Some of the report's highlights include the following. The older adult population is expected to reach 24% of the total population by 2030, with the largest increase in Hispanic elders. Heart disease continues to be the highest cause of mortality for older adults. Level of education is projected to increase in all racial/ethnic groups, with current statistics showing higher levels of education among Asian elders, and lowest in Hispanic elders. African American women and men were most likely to live alone in contrast to older Asian adults who typically reside with relatives. As a group, income data revealed a decrease in private pension funds, and increase older adults reporting social security as majority of income. Women continue to live longer than men, with Hispanic women having longer life expectancies and Black women having the shortest life expectancies compared to white women.

Fong, M., Braun, K.L., & Chang, M. (2006). Native Hawaiian preferences for informed consent and disclosure of results from genetic research. *Journal of Cancer Education, 21*(Suppl.), S47-S52.

Informed consent is generally waived when using anonymous stored specimens in research because individual harm is minimal; however, group harm may arise if specimens contain ethnic identifiers. This study assessed preferences for informed consent and disclosure of results from genetic research through a survey (N = 429, 83.2% Native Hawaiian). Native Hawaiians were more likely than non-Hawaiians to require informed consent for genetic research using personally identified (81% vs 77.8%), anonymous (40.9% vs 34.7%), and ethnically identified specimens (51.3% vs 33.3%). Most respondents wanted results reported to them (87.6%) and to their physicians (79.0%). Recognizing community preferences for informed consent and disclosure of research results may alleviate concerns about group harms inherent in genetic research.

Fong, M., Braun, K.L., & Tsark, J. (2003). Improving Native Hawaiian health through community-based participatory research. *Californian Journal of Health Promotion, 1*, 136-148. Retrieved from: http://www.cjhp.org/Volume1_2003/IssueHI-TEXTONLY/136-148-fong.pdf

Native Hawaiians, representing 20% of Hawai'i's population, have higher mortality rates and lower life expectancy than all other ethnic groups in Hawai'i and most ethnic groups in the United States. Although research is needed to reduce health disparities, past research abuses have led to feelings of distrust among many Native Hawaiians toward traditionally conducted research. 'Imi Hale—Native Hawaiian Cancer Awareness, Research and Training Network was established in 2000, one of 18 Special Population Networks funded by the National Cancer Institute (NCI), to build a sustainable infrastructure for cancer prevention and control based on principles of community-based participatory research (CBPR). These principles give community members a voice in directing research and provide opportunities for community members to gain from research projects. This paper describes the major structures and Mechanisms established by 'Imi Hale to assure community involvement and benefit. We also provide examples of how Native Hawaiians have impacted the design and conduct of specific research projects and how individuals and communities have benefited. 'Imi Hale advisors regularly complete a survey to gauge adherence to CBPR principles, and results from the 2002 survey are presented. The findings suggest that adhering to CBPR principles presents challenges to researchers, but that this approach is well received by the Native Hawaiians involved with 'Imi Hale, many of whom have seen positive benefits for themselves and their communities.

Gage, B. (2014). Building a long-term services and supports delivery system that works. *Public Policy and Aging Report*, 24, 56-59.

This article discusses the disparity between the need and availability for long-term care services available to the elderly population. Multiple government policies and directives have attempted to address the issue of creating affordable and economically feasible long-term support services. Many of the initiatives have focused on those who are low-income who compose a large population of increasingly aged individuals and their caregivers. However, not all low income elders meet the thresholds for income-based services, and may be left without any long-term care services.

Galinsky, A.M., Zelaya, C.E., Barnes, P.M., Simile, C. (2017) Selected health conditions among Native Hawaiian and Pacific Islander adults: United States, 2014. NCHS data brief, no 277. Hyattsville, MD: National Center for Health Statistics. Retrieved from <https://www.cdc.gov/nchs/products/databriefs/db277.htm>

This brief summarizes data from the Native Hawaiian and Pacific Islander National Health Interview Survey (NHPI NHIS) and the National Health Interview Survey. Data from this survey can be found at the above link. Historically it has been difficult to find reliable health statistics for Native Hawaiians and Pacific Islanders (NHPI) because they constitute .4% of the total U.S. population. Prior to the 2000 Census, NHPI data has been historically aggregated with Asian data to because disaggregated NHPI sample sizes were too small to calculate reliable statistics. In 2014 there was a relatively large sample of NHPI in the National Health Interview Survey (NHIS) that allowed for reliable estimates to be calculated. The results presented here highlight some of the important differences between the NHPI population and single-race Asian adults that are hidden in aggregated Asian Pacific Islander data.

Gellert, K., Braun, K.L., Starkey, V. & Morris, W. (2006, July). The `Ohana (Family) Day Project—A community approach to increase cancer screening. *Preventing Chronic Disease* [serial online]. Retrieved from : <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1637806/>

Native Hawaiians have higher cancer mortality rates and lower cancer screening rates compared with non-Hawaiians in Hawaii. People living in rural areas have particularly limited options for cancer services, especially for services that are culturally attractive and convenient. `Ohana Day, offered in a small, rural, and predominantly Hawaiian community, was designed to attract underserved Hawaiians to cancer screening. The year-long project involved a 1-day *ho`olaule`a* (community celebration) for families that featured 30-minute visits with a same-sex Hawaiian

physician (for adults), culturally relevant cancer education and brochures, Hawaiian music, and games for children. Recruitment and follow-up for screening and treatment were offered. Principles of community-based participatory research, Hawaiian values, and Kreuter's strategies guided the design of the event. Of the 73 participants, 10 had abnormal screening results, and all received follow-up screening, treatment, or both within 3 months. Six months after the event, the number of men current with prostate cancer and colorectal cancer screening and the number of women current with clinical breast examination and colorectal cancer screening increased significantly. In addition, the number of participants affiliated with the community's Native Hawaiian health care system and the number with health insurance increased significantly. Participant evaluations showed high overall satisfaction with the 'Ohana Day program. Previous studies have noted the barriers to increasing cancer screening among underserved minorities. Culture- and community-based strategies appear to be successful at overcoming these barriers.

Inouye, J., Li, D., Davis, J., & Arakaki, R. (2012). Ethnic and gender differences in psychosocial factors in Native Hawaiian, other Pacific Islanders, and Asian American adults with type 2 diabetes. *Journal of Health Disparities Research and Practice*, 5(3), 3.

Demographic, health, and social data were examined for Native Hawaiian Other Pacific Islander (NHOPI) and Asian adults diagnosed with Type 2 Diabetes in order to explore possible links between psychosocial factors, and Type 2 Diabetes. The measurement tools used included the Diabetes Quality of Life Questionnaire (DQOL) and Short Form -36® Health Survey (SF-36). Data was collected on 113 females and 94 men. 148 of participants identified as Asian, while 27 identified as NHOPI. Analysis of study data revealed a range of connections between psychosocial factors and Type 2 Diabetes. Participants identifying as multiple ethnicities had a significantly lower rate of depression compared to Japanese participants. Filipino participants engaged in more self-care activities than did Japanese participants. Educational attainment was lowest in NHOPI participants who had the highest rates of Type 2 Diabetes. However, the amount of worry related to diabetes diagnosis was lowest in NHOPI participants, while also reporting low self-efficacy and high insecurity regarding the ability to engage in disease management practices. Results found that NHOPI females with lower income and less education are more likely to be diagnosed with Type 2 Diabetes. The article revealed NHOPI participants reported a greater impact of the disease on their physical, mental, and emotional functioning compared to Asian American study participants. The disparity in perception and rates of Type 2 Diabetes calls for more culturally tailored health interventions in diabetic care.

Kaholokula, J.K., Look, M.A., Wills, T.A., de Silva, M., Mabellos, T., Seto, T.B., Ahn, H. J., Sinclair, K.A., Buchwald, D. (2017) Kā-HOLO Project: a protocol for a randomized controlled

trial of a native cultural dance program for cardiovascular disease prevention in Native Hawaiians. *BMC Public Health*, 17:321.

Native Hawaiians suffer from hypertension at rates of 3 to 4 times that of other US races and ethnicities. Hypertension is a major risk factor for cardiovascular and cerebrovascular disease (CVD). Effective, culturally-relevant interventions are needed to address CVD risk in this population. The Kā-HOLO Project aimed to develop a culturally relevant intervention using hula to increase physical activity and reduce CVD risk. This study offers implications for other indigenous populations globally for a sustainable, culturally-relevant means of addressing CVD disparities.

Kaholokula, J., Iwane, M., Nacapoy, A. (2010). Effects of perceived racism and acculturation on hypertension in Native Hawaiians. *Hawai'i Medical Journal*, 69(5 suppl 2), 11-15. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3158444/>

This article aims to examine the effects of perceived racism and acculturation on the hypertension status of Native Hawaiians. Cross-sectional data from 94 Native Hawaiian adults were obtained which included the following: 1) socio-demographic variables and self-reported hypertension status; 2) a 5-item Hawaiian cultural identity subscale (HCSS) and a 5-item American cultural identity subscale (ACSS); and 3) perceived racism based on a 6-item modified version of the 32-item Oppression Questionnaire (OQ). Based on logistic regression analysis, the ACSS scores and OQ scores had significant ($p < .05$) and independent effects on hypertension status, after considering the effects of age, sex, and education level, and HCSS scores. Of the variables examined, OQ scores had the greatest magnitude of effect on hypertension status. More perceived racism and a greater identification with the American mainstream culture were both, independently, related to self-reported hypertension in Native Hawaiians. These findings have important clinical and public health implications.

Kame'elehiwa, L. (1992). *Native land and foreign desires: Pehea lā e pono ai?* Honolulu: Bishop Museum.

Professor Lilikala Kame'elehiwa from the University of Hawai'i authored this book about the genealogy of family as they experienced the many political, economic and social shifts in Hawai'i. The author draws on the broader significance of Hawaiian identity and culture to restoring the health and well-being of the Native population.

Kamehameha Schools (2014). *Ka Huaka`i: 2014 Native Hawaiian educational assessment*. Honolulu: Kamehameha Publishing.

Published by Kamehameha Schools Strategic Planning and Implementation Division, the Ka Huaka`i is 300-page compilation of data on the Native Hawaiian population, across five different dimensions. Chapter One, `Ekahi, provides population data and projected estimates. Chapter Two, `Elua, provides information about social service utilization, assistance, poverty trends and livable income by age, family size, and education, and ethnicity. `Ekolu (Chapter Three) operationalizes social, emotional, and cultural well-being through rates of crime, single-motherhood, depression, and suicide. Chapter Four, `Ehā, continues this analysis of well-being and details physical health and health outcomes for the Native Hawaiian population. Beginning with prenatal and perinatal health markers, protective and harmful behavioral activities such as, physical activity, or smoking, and rates of disease amongst children, adults, and older adults. Chapter Five, `Elima, examines and operationalizes educational outcomes and trends across the lifespan. The five chapters are followed by additional appendices, references, and glossary of Hawaiian terms.

Kana`iaupuni, S.M. (2001) Census 2000 Highlights: Aging of the Aloha State. *Kamehameha Schools Policy Analysis and Systems Evaluation (PASE) Report: 2000-01(12)*. Retrieved from: http://www.ksbe.edu/_assets/spi/pdfs/reports/demography_well-being/00_01_12.pdf

This short report summarizes data from the 2000 Census on age, race and ethnicity and family structure in Hawai`i which largely found that the population in Hawai`i is aging, with the largest gains being in the 75-84 and 85 and older age ranges (60.7% and 68.9% respectively). There are some limitations in the way the race and ethnicity numbers because respondents were allowed to select more than one ethnicity as well as select specific ethnicities which sometimes resulted in duplicated counts. Hawai`i figures are compared to American national figures.

Ka`opua, L.S., Braun, K., Browne, C., Mokuau, N., & Park, C.B. (2011). Why are Native Hawaiians underrepresented in Hawai`i's older adult population? Exploring social and behavioral factors of longevity. *Journal of Aging Research*. 2011. <https://doi.org/10.4061/2011/701232>

This article addresses the gap in literature on health disparities and health outcomes for Native Hawaiian elders. This study, conducted by Hā Kūpuna National Resource Center for Native Hawaiian Elders, analyzed data from two statewide data collection survey methods and data from State of Hawai`i Vital Records. Findings revealed a number of disparities and poorer health outcomes for Native Hawaiian elders compared to other ethnic/racial groups in the State of

Hawai'i. Higher rates of mortality appear to be due to preventable diseases, smoking, obesity, diabetes, heart disease, but also the effects of historical trauma. Barriers to services also exist in the forms of poverty, inaccessible services, limited availability of culturally grounded services, and lack of ability to connect with needed resources.

Ka'opua, L.S., Goodyear-Ka'opua, N., Ka'awa, J.M., Among, S.K., Browne, C., Robles, A.S. (2016). Look to the source: Gathering elder stories as segue to youth action-oriented research. *International Journal of Public Health*, 8: 2.

An action-oriented curriculum was developed to increase knowledge about elders, foster deeper intergenerational connections and increase social action, all within a cultural context between Native Hawaiian youth and Native Hawaiian elders. The curriculum was piloted at a culture-based secondary school. One standardized measurement tool was used for changes in knowledge, participant written reflections and reports were also utilized to determine outcomes. Results showed when the children were exposed to learning through an elder community member, there was knowledge retention and an increased self-reflection on forging a better future for the Native Hawaiian community, including personal social and environmental responsibilities of community members.

Ka'opua, L.S., Mitschke, D.M., & Klozeman, K.C. (2008). Coping with breast cancer at the nexus of religiosity and Hawaiian culture. Perspectives of Native Hawaiian survivors and family members. *Journal of Religion and Spirituality in Social Work*, 26, 275-95.

Native Hawaiian women are at greater risk of developing breast cancer, and yet typically do not receive diagnosis until the later stages of the disease. This article explores the possibility of cultural influences that are serving as a barrier to reaching services. The focus of data analysis is on the roles of religion and culture-specific coping practices. Key findings include the core importance of family and the family unit, the need to incorporate Native Hawaiian cultural values into program design, and the benefits of drawing strengths from the community as a support and coping mechanism. Future applications of this knowledge could direct future service delivery.

Ka'opua, L.S., Park, S.H., Ward, M.E., & Braun, K.L. (2011). Testing the feasibility of a culturally tailored breast cancer screening intervention with Native Hawaiian women in rural churches. *Health & Social Work*, 36, 55-68.

Native Hawaiian women's disproportionate mortality rate from breast cancer may be due to a lack of engagement with routine health care services such as mammograms. This article explored the feasibility of and outcomes associated with an intervention to raise mammography participation through the incorporation of spirituality and faith, with study participants in rural settings. Results provided support for the use of three cultural/faith components in the intervention. Those three include personal testimonials of survivors and the families, education which included the effects of breast cancer on the family unit and the use of churches as the venue for service delivery. A primary theme of the study emphasized the need for family-centric interventions.

Ka'opua, L.S., Tamang, S., Dillard, A., Kekauoha, B.P. (2017). Decolonizing knowledge development in health research. Cultural safety through the lens of Hawaiian Homestead residents. *Journal of Indigenous Social Development*, 5 (2). Retrieved from: http://umanitoba.ca/faculties/social_work/media/V5i2-02_Kaopua_Tamang_Dillard_Kekauoha.pdf

Cultural safety is a strengths-based construct which aims to subvert unequal power relations, honor diverse ways of knowing in community-specific contexts, and acknowledge community as arbiter of 'how' safety is actualized. Published literature documents the benefits of culturally safe healthcare yet pays scant attention to culturally safe research praxis. Our team of practitioner researchers sought to uncover meanings of cultural safety in community-based health research with Hawaiian Homestead residents. Focus groups were conducted in three communities. Emic descriptions of cultural safety and non-resident researchers were elicited. Content analysis revealed trust (hilina'i) as the overarching theme fundamental to cultural safety. Cultural safety was demonstrated by practices that accommodate and engage community in their shared sense of place, history, ways of knowing, and capacity-building. Such practices likely mitigate perceptions of cultural imposition and promote relevant interventions developed with communities. Implications are enunciated in HILINA'I, a mnemonic for advancing knowledge decolonization and health equity.

Ke ola pono no nā kūpuna native Hawaiian elderly needs assessment (Rep.). ALU LIKE INC. (2005). Retrieved from <http://www.alulike.org/services/kumu/images/KOPP-Needs.pdf>

Data on Native Hawaiians 55 years of age and over were collected through numerous state health and senior service providers to identify unmet needs of the elderly Native Hawaiian population. Data sources for this study were secondary data of Native Hawaiian elderly population from the U.S. Census, Department of Human Services; Hawai'i State Department of Health; and the State

of Hawai'i Executive Office on Aging. Ke Ola Pono No Nā Kūpuna (KOPP), and non-Kopp participants identified numerous community needs and/or concerns for kūpuna. Topics ranged from insurance coverage, poor self-reported health outcomes, and feasible, adequate housing. Native Hawaiian participants gave housing concerns a higher priority, than other study populations. basic health insurance, poor self-reports of overall health, and higher rates of housing concerns compared to other elderly ethnic groups. Growing areas of concern included caregiver support, and mobility issues (transportation and physical mobility). Disability, was reported by approximately 1/3 of Native Hawaiian elders, as causing a restriction on mobility and limiting to daily tasks. These findings assist in providing recommendations to address the concerns and unmet need of Native Hawaiian elders. Proposed methods should focus on housing assistance, a second focus on health education, and utilizing a team approach to coordinate services for disabled elders. Appreciation of kūpuna as a valued resource of support and knowledge they in turn give to the communities around them should drive improvement of social and health services provided to them.

Klest, B., Freyd, J.J., & Foynes, M.M. (2013). Trauma exposure and posttraumatic symptoms in Hawai'i: Gender, ethnicity, and social context. *Psychological Trauma*, 5, 409-416.

Researchers examine personal exposure to traumatic events and rates of reported traumas including high and low betrayal gradings. Native Hawaiian populations regardless of gender had increased rates of High Betrayal traumas, a term that describes an acute awareness to feelings of mistrust and adverse psychosocial outcomes, resulting from a trauma, in this context, a social and cultural trauma. Low Betrayal traumas would indicate less awareness or even blindness to past wrongdoings and future effects on the victim. Exposure to trauma also significantly increased mental health symptoms. Social context also appears to play a key factor in both rates of exposure to trauma and the impact of this stress on individuals.

Kolonel, L.N., Henderson, B.E., Hankin, J.H., Nomura, A.M., Wilkens, L.R., Pike, M.C., Stram, D.O., & Koseki, L. (1996). A study of utilization and satisfaction: Implications for cultural concepts and design in aging services. *Journal of Aging and Social Policy* 8, 1, 59-75.

This article describes the utilization and satisfaction patterns of Native Hawaiian elders with a program funded under Title VI-B of the Older Americans Act called Ke Ola Pono No Na Kūpuna. This unique, culturally-specific program points to policy consideration in designing more effective elder support services for ethnic minorities. Data were collected on self-administered questionnaires. Involving ethnic minorities more in program design is one way to work towards culturally relevant and appropriate services and may increase a sense of

personal ownership and responsibility for the program by those involved with its design. Another way to address some of the current barriers to service delivery and ethnic minority program utilization may be to federally mandate aspects of programs to provide for greater flexibility in providing culturally programs.

Koseki, L., & Reid, S. (1995). Health status, life satisfaction and health practices: A study of Pacific Asian and Native Hawaiian elderly cohorts. *Asian Pacific Journal of Public Health* 8 (2), 95-101.

This article was an early attempt to start building a database or baseline for data on life satisfaction and health practices of Pacific Asian and Native Hawaiian elders. The data were gathered from two groups of elders enrolled in an elderly self-care education program in Hawai'i from 1989 - 1992. The findings generally reflected favorable self-ratings of health status, high life satisfaction levels, and positive health practices for both of these minority elderly groups.

Lunalilo Home (2015). *King Lunalilo*. Honolulu: Lunalilo Home. Retrieved from <http://lunalilo.org/king-lunalilo/>

Lunalilo Home located in Honolulu, Hawai'i, originated from the charitable donation of land by King Lunalilo aimed to provide Native Hawaiians who are low income and/or elderly with homes and land to protect against homelessness and destitution. The services of Lunalilo Home services have expanded and modernized, providing adult day care, residential homes, and supportive services for caregivers. support for low income individuals and prevent destitution. Subsidies for care are offered to low income applicant with preference given Native Hawaiian kupuna. Providing older adults and caregivers with services on a continuum of the level of care promoted care which is consistent, comprehensive, and accessibility.

Mau, M. (2010). Health and healthcare for NHOPI older adults. In V.S. Periyakoil (Ed.), *Stanford campus*. Retrieved from: http://Geriatrics.stanford.edu/ethnomed/Hawaiian/pacific_islander/

Based in Stanford University's School of Medicine, a field of study known as Orthogeriatric aims to provide culturally relevant and easily accessible information about older adults and health care. Curricula on specific cultural groups from a series of web-based modules provide information on population demographic, health risk, mortality, delivery of care and available resources. This module is dedicated to Native Hawaiian and other Pacific Islander elders, with

the goal is to promote cultural competency within healthcare fields, leading to better treatments and services and overall improved well-being.

McLaughlin, L., & Braun, K.L. (1998). Asian and Pacific Islander cultural values: Considerations for health care decision-making. *Health and Social Work, 23*, 116-126.

As the United States becomes more ethnically diverse, health care practitioners must learn about the perspectives and values of a variety of cultural groups. Of interest is how these cultural values intersect with those of the dominant culture, especially in the healthcare arena. This article explores the values that influence decision making among Asian and Pacific Islander cultures, with specific illustrations from six of these cultures. The literature, along with our observations as health professionals and researchers working in Hawaii, suggest potential areas of conflict between the more collectivist values of Asian and Pacific Islander cultures and the more individualist orientation of the U.S. healthcare system. Implications for practice and research are presented.

MetLife Mature Market Group and National Alliance for Caregiving (2010). *Study of Working Caregivers caring for their parents*. New York: MetLife.

MetLife in cooperation with the National Alliance for Caregiving and the Center for Long Term Care Research and Policy, New York Medical College, conducted this study to explore the financial and health costs of being a working adult caregiver to a parent. The elder caregiving population has tripled in a little over a decade. Poorer health and financial outlooks are associated with providing long term as an adult caregiver regardless of employment status, with the population of elderly parents in need of support growing, the importance of the support for their caregivers through policies and in the workplace increases as well. This report is not specific to Hawai'i but has relevant data on caregivers with implications for Native Hawaiians.

Miller, B.A., Chu, K.C., Hanky, B.F., & Ries, L.A.G. (2008). Cancer incidence and mortality patterns among specific Asian and Pacific Islander populations in the U.S. *Cancer Causes and Control, 19*, 227–256. <https://doi.org/10.1007/s10552-007-9088-3>

This article reports on cancer rates in the U.S. among Asian and Pacific Islander populations. Researchers found that cancer rates were in fact lower in most Asian and Pacific Islander populations compared to white non-Hispanic populations, apart from Native Hawaiian women.

Common among these higher rates of cancer were breast, colon, and prostate among others. The authors conclude by stating that epidemiological studies may be investigated on these groups.

Mokuau, N. (2011) Culturally-based solutions to preserve the health of Native Hawaiians. *Journal of Ethnic & Cultural Diversity in Social Work, 20*, 98-113. Revised 4-17-14

Health is that quality of life in which there is an absence of disease, and a presence of general well-being. For many Native Hawaiians, health encompasses a holistic perspective whereby all parts of the individual (biological, psychological, cognitive, social, spiritual) and world (individual, family, community, environment) are considered. Culturally based solutions for Native Hawaiians draw upon the strengths of the culture, with core elements including spirituality, and cultural values and practices, and the inclusion of Native Hawaiians in the design, implementation, and evaluation of interventions. The promotion of culturally based solutions does not imply the abandonment of all Western interventions of health care; rather, it suggests a need to expand our repertoire of knowledge on health and to learn from many sources. Examples such as Aloha 'Āina (caring for the land) and 'Ohana Intervention (working with families) illustrate new possibilities to complement Western interventions of health care. This article examines culturally based solutions to preserve the health of Native Hawaiians. Specifically, the discussion focuses on (1) cultural competence, (2) elements of culturally based solutions for Native Hawaiians, and (3) illustrations of culturally based solutions for Native Hawaiians.

Mokuau, N. (2013). Native Hawaiians and other Pacific Islanders. In *Social Work Encyclopedia*. Washington, D.C.: National Association of Social Workers.
<https://doi.org/10.1093/acrefore/9780199975839.013.262>

Native Hawaiians and other Pacific Islanders (NHOPI) comprise 0.3% of the total U.S. population, with the largest groups being Native Hawaiians (401,000), Samoans (133,000), and Chamorros or Guamanians (93,000). Core cultural values and traditions have sustained NHOPI as they confront cultural changes and challenges to their health and well-being. Directions for social work require accurate assessments of the problems challenging NHOPI based on information that both disaggregates NHOPI from other populations, and includes NHOPI in the design and delivery of culturally based solutions to resolve problems.

Mokuau, N. (2002). Culturally based interventions for substance use and child abuse among Native Hawaiians. *Public Health Reports*. 117(Suppl 1), S82–S87. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1913704/>

This article presents an overview of child abuse among culturally diverse populations in Hawaii, substance use among culturally diverse students in Hawaii, and culturally based interventions for preventing child abuse and substance abuse in Native Hawaiian families. Native Hawaiians accounted for the largest number of cases of child abuse and neglect in Hawaii between 1996 and 1998. Alcohol and other drugs have increasingly been linked with child maltreatment. Native Hawaiian youths report the highest rate of substance use in Hawaii. Cultural factors such as spirituality, family, and cultural identification and pride are important in interventions with Native Hawaiians. Human services should continue to emphasize interventions that integrate "mainstream" and culturally-specific approaches.

Mokuau, N. (1996). Health and well-being for Pacific Islanders: Status, barriers and resolutions. *Asian American and Pacific Islander Journal of Health*, 4(1-3), 1-24.

The purpose of this chapter is to present information that enhances an understanding of Pacific Islander health and thereby contributes to greater health equity for these people. Specifically this information is organized around four major areas: (1) a descriptive profile of Pacific Islander peoples, (2) an overview of their health status, (3) an identification of barriers to improved health, and (4) resolutions that will lead to health equity. Creating greater health equity for Pacific Islanders requires that public health professionals act on all health practice, policy, and research decisions in a culturally competent manner and use cultural information to guide the development of accurate assessments and responsive programs of intervention.

Mokuau, N. (1990). A family-centered approach in native Hawaiian culture. *Families in Society: The Journal of Contemporary Human Services*, 71(10), 607-613.

One strategy for advancing culturally sensitive family practice is to identify family-centered approaches indigenous to the culture. The author describes a family-centered approach in native Hawaiian culture and encourages human service professionals to conceptualize family-centered models that utilize cultural values and processes.

Mokuau, N. (1990). The impoverishment of native Hawaiians and the social work challenge. *Health and Social Work*, 15(3), 235-242. <https://doi.org/10.1093/hsw/15.3.235>

Native Hawaiians, the people indigenous to the Hawaiian Islands, are impoverished in quality of life. Only recently has the myth that native Hawaiians are a carefree people living in a tropical paradise been dispelled. The number of health and mental health problems confronting native Hawaiians is alarming; their general health status is far below that of other U.S. population groups. It is urgent that social workers begin to examine the unique circumstances of native Hawaiians and encourage professional support for the planning of culturally appropriate services for this population.

Mokuau, N., & Braun, K.L. (2007). Family support for Native Hawaiian women with breast cancer. *Journal of Cancer Education, 22*(3), 191-196.

A cancer diagnosis affects not only the individual but the entire family. Despite the growing body of literature on family support as a resource in cancer care, there is very little research on how cancer affects families in non-Western cultures. A minority population that experiences a disproportionate burden from cancer is Native Hawaiian women. In this study, 8 Native Hawaiian women with breast cancer and 17 family members of other Native Hawaiian women with breast cancer participated in focus groups examining family support. Specifically, types of support provided by the family (eg, informational, emotional, and tangible), changing dynamics of family roles, and recommendations for health care providers, with attention paid to the influence of culture on family support, were topics that were examined. Similarly to other populations, Native Hawaiians viewed the family as the most important source of emotional and tangible support for women with cancer, and identified a need for increased informational support for both patients and families in the face of cancer. However, their reference to specific cultural values and practices within the 'ohana (family) [eg, *haku* (family liaison) and *ho'omana* (spirituality)] reflects a uniqueness that has implications for clinical work with this population. Consideration of cultural values and practices may enhance health care services for this population.

Mokuau, N., Braun, K.L., Wong, L., Higuchi, P., & Gotay, C. (2008). Testing the feasibility of a family intervention for Native Hawaiian women with cancer: A pilot study. *Social Work, 53*(1), 9-19. <https://doi.org/10.1093/sw/53.1.9>

Native Hawaiian women have high cancer rates and low survival rates. As with other women, a major source of support for Native Hawaiian women is their families. This pilot study reports on the feasibility of providing and measuring a culturally appropriate intervention designed to help Native Hawaiian women and their families deal with cancer. The feasibility evaluation indicated that a major strength of the intervention was its incorporation of Hawaiian values and practices,

and a major limitation reflected the difficulties in recruiting Native Hawaiians for research studies. Despite the small sample size, the six Native Hawaiian women and their 10 family members in the intervention group showed improved self-efficacy and coping when compared with the four Native Hawaiian women and their eight family members in the control group. Pilot study data established the feasibility and potential effectiveness of this culturally tailored intervention for Native Hawaiians, and feasibility findings will be useful in designing follow-up studies. Steps taken to incorporate cultural values into an intervention also provide a model for other social workers in developing culturally appropriate interventions for minority populations.

Mokuau, N., Braun, K.L., & Daniggelis, E., (2012). Building family capacity for Native Hawaiian women with breast cancer. *Health and Social Work, 37*, 216-224.

<https://doi.org/10.1093/hsw/hls033>

Native Hawaiian women have the highest breast cancer incidence and mortality rates when compared with other large ethnic groups in Hawai'i. Like other women, they rely on the support of their families as co-survivors. This project explored the feasibility and effects of a culturally tailored educational intervention designed to build family capacity by improving the knowledge and skills of the woman and her family in dealing with breast cancer, particularly in the latter stage of recovery care. Twenty-nine Native Hawaiian women with breast cancer, along with a close family member, were randomly assigned to the intervention ($n = 15$) or a wait-list control group ($n = 14$). The authors assessed the knowledge, self-efficacy, and coping skills of women and their family members and the recovery care behaviors of the women at baseline and at four months (after the intervention or control period). The intervention group made significant improvements in self-efficacy and coping; the wait-list control group did not. Evaluation of the intervention suggests that it was well received by participants. This work has relevance for social workers wanting to design and test culturally appropriate interventions for minority groups.

Mokuau, N., & Browne, C. (1994). Life themes of Native Hawaiian female elders: Resources for cultural preservation. *Social Work 39* (1), 43-49.

A oral history study of Native Hawaiian elderly women residing in a care facility in Honolulu found common life themes and cultural values with implications for cultural preservation, policy development, and research.

Mokuau, N., Browne, C., & Braun, K.L. (1998). Nā Kūpuna in Hawai'i: A review of social and health status, service use, and the importance of value based interventions. *Pacific Health Dialog, Journal of Community Health and Clinical Medicine for the Pacific*. 5, 2, 282-289

Available health-related research and information on Native Hawaiian elders residing in Hawai'i is summarized and reviewed in this earlier article published in the *Pacific Health Dialog*. This literature review provides an overview of Native Hawaiian elder socio-economic status, health status, and service utilization. Native Hawaiian values and view of spirituality are discussed and suggested as a useful approach when incorporated into interventions and policies. Most important was Social Security and public housing assistance, followed by programs providing in-home daily living assistance, home meal delivery, case management, and care homes.

Mokuau, N., Browne, C.V., Braun, K & Choy, L. (2008). Using a community-based participatory approach to create a resource center for Native Hawaiian elders. *Education for Health*. 20(3), 1-10. Retrieved from <http://www.educationforhealth.net/text.asp?2008/21/3/174/101550>

Historically, Native Hawaiian elders have been recognized as the major sources of wisdom and transmitters of knowledge and training to younger generations. Yet, concerns exist today for these elders who experience shorter life expectancies, poorer health and greater disability than elders in other ethnic groups in Hawai'i. Hā Kūpuna: National Resource Center for Native Hawaiian Elders, was established at the University of Hawai'i to address these and other health disparities and improve the access and delivery of services to these elders. Using principles of community-based participatory (CBP) research with its unique emphasis on culturally competent practice, Hā Kūpuna has applied a CBP approach in the following steps: community engagement; development of an infrastructure; implementation and dissemination of research and technical assistance projects; and evaluation. The CBP approach is highly relevant for Native Hawaiians because of its alignment with cultural values, the mobilization of the community and the emphasis on reducing health inequities through social change. In adhering to a CBP approach to improve the health of elders, Hā Kūpuna seeks to perpetuate the culture through the transmission of hā (breath) from older to younger generations.

Mokuau, N., Browne, C.V., Higuchi, P., Sweet, K.M., Ka'opua, L.S., Braun, K.L. (2015) Native Hawaiian grandparents: Exploring benefits and challenges in the caregiving experience. *Journal of Indigenous Social Development*. 4(1), 1-19. <http://hdl.handle.net/10125/37626>

Increasingly, U.S. grandparents are raising their grandchildren. In Hawai‘i, 12% of Native Hawaiian grandparents live with grandchildren, compared to 7% of grandparents in all races combined in the state, and to 3.6% of grandparents in the total U.S. Although strong family-centric cultural values may provide Native Hawaiian grandparents with caregiving benefits, a generally poor health profile suggests they may also face challenges in this role. In this study, we talked to Native Hawaiian grandparents raising grandchildren (GRG) about the benefits and challenges of their caregiving experiences. Method: Three focus groups were conducted with Native Hawaiian grandparents (n=33) in Hawai‘i who were 55 years of age or older and caregivers to their grandchildren. The most prevalent themes voiced by grandparents spoke of the benefits of being a grandparent caregiver (the greatest being the experience of mutual, unconditional love) and the enjoyment of passing on “life lessons” to their grandchildren. Grandparents identified concrete examples of what they provided to grandchildren and also spoke of their role in transmission of Native Hawaiian cultural values, practices, and stories to their grandchildren. A number of challenges pertaining to grandparent caregiving were identified along with needed services—respite care, financial assistance, children’s programs, and information on grandparent legal rights. Despite these challenges, grandparents preferred to seek help from extended family rather than from formal supports. Our results support previous research on a number of universal GRG needs and services (i.e., legal rights of GRG) but also suggest potential directions to meeting the needs of Native Hawaiian GRG that are responsive to indigenous cultural values and preferences. Given the number of unmet needs expressed, further research is needed to design interventions for this population of grandparents raising grandchildren.

Mokuau, N., DeLeon, P., Kaholokula, J.K., Soares, S., Tsark, J., & Haia, C. (2016). Challenges and promise of health equity for Native Hawaiians. Discussion paper, National Academy of Medicine, Washington, DC, <https://nam.edu/wp-content/uploads/2016/10/Challenges-and-Promise-of-Health-Equity-for-Native-Hawaiians.pdf>

This paper details various health disparities for Native Hawaiians, despite the fact that Hawai‘i as a whole is reputed to be the “healthiest state in America” (United Health Foundation, 2014). This paper reviews population characteristics, identifies prominent health and social disparities, presents programs that show promise for health equity, and concludes with recommendations for the future. The include the need for the University to make a commitment to training sufficient numbers of Native Hawaiians in all fields to address health disparities; the establishment of a culturally relevant health system that affirmatively seeks out Native Hawaiian patients and a greater appreciation at the policy level for the complexity of Native Hawaiian culture.

Mokuau, N., Garlock-Tuialii, J., & Lee, P. (2008). Has social work met its commitment to Native Hawaiians and other Pacific Islanders?: A review of the periodical literature. *Social Work, 53*(2), 115-121.

Native Hawaiians and other Pacific Islanders (NHOPIs) were recognized in the 2000 U.S. census as a distinct racial minority group, with unique histories, values, and traditions. The profession of social work, with its historical commitment to social and cultural diversity, has begun to establish a knowledge base on this population in the periodical literature. In a review of literature published from 1995 to 2004, 32 articles were found in 23 journals. This represents 0.64 percent of the more than 5,000 articles published in these journals. Much of this literature, however, combined information on this population with that of Asian Americans, thereby masking the distinctiveness of Pacific Islanders. These results suggest that although social work has demonstrated a commitment to NHOPIs by beginning to establish a knowledge base, refinement and expansion of knowledge is still needed. The authors recommend three steps to refine this knowledge base: (1) increase the number of publications, (2) disaggregate data so that Asian Americans will be considered separately from NHOPIs, and (3) ensure that information on this population be anchored in cultural values and culturally based models of practice.

Mokuau, N., Hishinuma, E. & Nishimura, S. (2001) Validating a measure of religiousness/spirituality for Native Hawaiians. *Pacific Health Dialog: Journal of Community Health and Clinical Medicine for the Pacific, 8*(2), 407-416. Retrieved from: <http://pacifichealthdialog.org/fj/Volume208/No220The20Health20of20the20Hawaiians/Ulieo20Koa20Program20Reports/Validating20a20measure20of20religiousnessspirituality20for20Native20Hawaiians.pdf>

Religiousness and spirituality are integral to the human experience. There is emerging literature that shows that religiousness and spirituality are associated with various mental and physical health outcomes. Yet, the development of measures to accurately assess these phenomena in health settings is still in its early stages. The difficulties in developing standardized definitions and measures relate to varying interpretations of religiousness and spirituality, a reluctance to utilize a scientific approach to understand an existential and personal experience, and multicultural distinctions. The potential for designing health interventions in which religiousness and spirituality are integrated rests upon the development of measures that are psychometrically sound. This paper reports on preliminary research that empirically assesses one measure of religiousness and spirituality for Native Hawaiians--a group besieged with an array of health problems. The measure is the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS) developed by the National Institute on Aging and the Fetzer Institute. This instrument

has shown to have appropriate reliability and validity scores. A modified BMMRS was administered to 15 Native Hawaiians who underwent a cultural intervention of exercise, diet, and education in a program called Uli'eo Koa (warrior fitness). The BMMRS was slightly modified based on the literature and earlier research to be more specific to Native Hawaiians. Overall, measures of internal consistency supported the reliability of the BMMRS. The strongest subscales included the domains of "daily spiritual experiences," "religious and spiritual coping," and "religious support." Low internal consistency estimates for the items, "watches/listens to religious programs," "family makes demands," and "significant loss in faith," suggest that these items do not measure the same concept for participants. Although the intercorrelations among the subscales were generally low and with wide variability, 10 of the 17 subscales/single items were moderately to highly correlated with one another, indicating concurrent validity. These subscales, some of which assessed, "daily spiritual experiences," "religious and spiritual coping," and "organizational religiousness," suggest that core ideas on spirituality and religiousness for these participants, broadly reflect both "personal" and "organizational" viewpoints. Caution should be used in interpreting the results of the study because of limitations in the study's design. However, despite these limitations in design, this study provides empirical support for future research on religiousness and spirituality for Native Hawaiians.

Mokuau, N., Hughes, C. & Tsark, J. (1995). Heart disease and associated risk factors among Hawaiians: Culturally responsive strategies. *Health and Social Work, 20*(1), 46-51. <https://doi.org/10.1093/hsw/20.1.46>

The incidence of heart disease is disproportionately large among the Hawaiian population. This article discusses the prevalence of heart disease and associated risk factors among Hawaiians and identifies barriers to health care, including accessibility and the acceptability of services to this population. Case examples are provided. Culturally responsive strategies to address these problems are described, and implications for social work are discussed.

Mokuau, N. & Matsuoka, J. (1995). Turbulence among a native people: Social work practice with Hawaiians. *Social Work, 40*(4), 465-472. <https://doi.org/10.1093/sw/40.4.465>

This article discusses the culturally based social problems caused by a long history of oppression experienced by Hawaiians, the indigenous population of Hawaii. Culturally appropriate prescriptions for empowerment are derived from an analysis of historical and current social problems. Current movements to re-establish native sovereignty and an indigenous community-based economy are described as efforts to help solve these social problems.

Nakatsuka NJ, Esquivel LM, Levin MJ, Browne CV, Braun KL. Identifying the unique challenges facing kānaka maoli kūpuna residing outside of Hawai'i. (2013). Hūlili: Multidisciplinary Research on Hawaiian well-Being Vol. 9. Kamehameha Schools. http://www.ksbe.edu/assets/spi/hulili/hulili_vol_9/6_2013_Vol9_Nakatsuka_Esquivel_Levin_Browne_Braun.pdf

Though 36% of Native Hawaiian elders live outside of Hawai'i, almost no data are available on their well-being. This paper presents data analyzed from the 2000 Census as well as 2010 Public Use Microdata Samples. Key informant interviews were also conducted of kūpuna living in Hawai'i and Los Angeles. While those living on the US continent tended to be doing better socioeconomically, they had much less access to cultural activities and less family support.

Nishita C, Browne, C. 2013. Advancing Research in Transitional Care: Challenges of Culture, Language and Health Literacy in Asian American and Native Hawaiian Elders. *Journal of Health Care for the Poor and Underserved* 24(1): 404-418. <http://muse.jhu.edu/article/496958>

As America's population ages and is becoming increasingly ethnically diverse, a need to optimize transitions from a nursing facility to home is emerging. Addressing the interrelationships between health literacy and cultural-linguistic factors is a complex undertaking. This paper discusses how differing health profiles and cultural-linguistic values can affect the type of care and support needed and preferred. A conceptual framework is proposed with a six-point research agenda that includes family assessments of health literacy abilities, exploring the relationship between culture, health, and decision-making, and the development/adaptation of transition planning tools.

Nishita, C., Browne, C., Tom, T., Nihipali, J., & Trockman, M. (2013). *Population of Older Adults in Hawai'i Factsheet*. Honolulu, HI: University of Hawai'i Center on Aging

This reference is the first of three factsheets produced by the University of Hawai'i at Mānoa Center on Aging. Factsheet One covers demographic information on Native Hawaiian older adults. Information on expected projection of the population and life expectancy are the primary data sets for this factsheet.

Nishita, C., Browne, C., Tom, T., Nihipali, J., & Trockman, M. (2013). *Race and ethnic characteristics of older adults in Hawai'i Factsheet*. Honolulu, HI: University of Hawai'i at Mānoa Center on Aging

Factsheet two in a series of three published by the University of Hawai'i at Mānoa Center on Aging summarizes the ethnic and racial composition of Hawai'i's older adult population. Data on population is disaggregated by age group and racial/ethnic status.

Nishita, C., Browne, C., Tom, T., Nihipali, J., & Trockman, M. (2013). *Health and Welfare of Older Adults in Hawai'i Factsheet*. Honolulu, HI: University of Hawai'i Center on Aging.

The final factsheet in a series of three published by University of Hawai'i at Mānoa Center on Aging further details the health status of the Native Hawaiian population. Health markers are noted comparing Native Hawaiian elders to those in the rest of the continental United States. Data on Alzheimer's rates and caregiving is presented. Lastly, information on the poverty and disability rates of Native Hawaiian elders are presented as graphs and percentages.

Ortman, J.M., Velkof, V.A., Hogan, H. (2014). An aging nation: The older population in the United States. Population estimates and projections. *Current Population Reports*, P25-1140. Washington, DC: US. Census Bureau.

The United States Census Bureau regularly reports on the demographics of the older population in the United States (U.S.). Based on 2012 population data and trends, the nation's older population is expected to over double its current size of 43.1 million. Concerns for resources for this ever-growing population remain a needed focus for future policies

Park, C.B., Braun, K.L., Horiuchi, B.Y., Tottori, C., & Onaka, A.T. (2009). Longevity disparities in multiethnic Hawai'i: An analysis of 2000 life tables. *Public Health Reports*, 124(4), 579-584.

The average age of mortality in Hawai'i is 80.5 years, but disaggregated by racial/ethnic group reveals serious longevity disparities. Chinese Americans, for example, have the longest life expectancy in the State and live an average of 15 additional years compared to Samoans with the shortest life span. The 15 year longevity gap was not seen in first-generation immigrants. The Life Tables reveal that first-generation immigrants in the ethnic groups with the shortest life-span overall do not follow the same patterns and the subsequent generations. Data revealed trends in longevity and mortality that are most likely explained by contextual and behavioral factors.

Redfoot, D., Feinberg, L., & Houser, A. (2013). *The aging of the baby boom and the growing care gap: A look into future declines in the availability of family caregivers*. Washington, DC: AARP Public Policy Institute. In brief 1B 213.

The AARP Public Policy Institute published this brief summary of trending data on adult caregiver availability. This is measured in a “Caregiver Support Ratio” that the authors track to predict caregiving levels by 2050. Their predicted model indicated that this support ratio may fall as low as 2.9 from a current level of 6.69 caregivers with implications for a much needed increased focus and support of family-centered policy in the future. This report is not specific to Hawai`i but provides relevant information about caregiving and family caregivers.

Reinhard, S., & Houser, A. (2011). *Long-term care in Hawai`i: A long way to go for people who need services and supports*. AARP Public Policy Institute, Washington DC: AARP.

AARP commissioned a survey of its members living in the State of Hawai`i to better understand resources wanted and needed for caregivers of its members. Opinions on long term care, home based care, cost of care, and the perspective of caregivers themselves were reflected in the survey. The survey highlights high personal value of independence in Hawai`i’s AARP member population, as well as the high demand for case management resources for caregivers to this older population.

Reinhard, S., Kassner, E., Houser, A., & Mollica, R. (2011). *Raising expectations: Executive Summary. A State scorecard on long-term services and supports for older adults, people with physical disabilities and family caregivers*. Hawai`i: 2011 State Long term service and supports scorecard Results. Scorecard AARP and SCAN Foundation, Washington, DC: AARP.

The authors of this report created and implemented a multidimensional scorecard to assess the performance of support services to elderly and disabled adults in all 50 U.S. states. Using this scorecard, data trends among higher performing states have policies in place that improve information access, needed services, and caregiver resources. These rankings of state performance give increased context to what may help future policy changes across states. This report is specific to Hawai`i.

Richards, M., Browne, C.V., and Broderick, A. (1994). Teaching clinical social work with Asian and Pacific Island elders: Strategies for the classroom. *Journal of Gerontology and Geriatric Education*, 14(3), 49-64.

The increasing ethnic and cultural diversity of the nation's aging population has resulted in the need for specialized education for social workers to work with the changing demographic profile. The infusion of ethnically and culturally relevant gerontological content is a key component for this effort toward providing ethnic-competent practice. This article suggests strategies for effecting social work students' attitudes and teaching gerontological information and intervention skills for working with older adults in general, and with Asian and Pacific Island elders in particular.

Sentell, T., Baker, K.K., Onaka, A., & Braun, K. (2011). Low health literacy and health outcomes in Asian Americans and Pacific Islanders. *Journal of Health Communication*, 16, 279-294.

Researchers collected data on the health status of Asian, Latino and Pacific Islanders within the state of California. The groups were surveyed on their health status, English literacy level, and health literacy level. Analysis revealed a connection between health status and literacy levels. Individuals with high English literacy and high health literacy, tended to report better health outcomes, than those who reported low levels of literacy. The authors stipulate that these findings highlight potentially high risk health groups, but note that variations in race/ethnicity exist.

Sentell, T., Dela Cruz, M.R., Heo, H.H., Braun, K.L. (2013) Health literacy, health communication challenges, and cancer screening among rural Native Hawaiians and Filipino Women. *Journal of Cancer Education*. 28(2), 325-34.
<https://doi.org/10.1007/s13187-013-0471-3>

Native Hawaiians and Filipinos are disproportionately impacted by cancer and are less likely to participate in cancer screening than whites. Limited information exists about health information pathways and health communication challenges as they relate to cancer screening in these groups. Six focus groups (n=77) of Native Hawaiian and Filipino women age 40+ years were conducted to investigate these research gaps. Participants noted many health information challenges. Challenges were both practical and interpersonal and included both written and oral health communication. Practical challenges included "big" words, complexity of terms, and lack of plain English. Interpersonal issues included doctors rushing, doctors not assessing comprehension, and doctors treating respondents as patients not people. Women noted that they would often not ask questions even when they knew they did not understand because they did not want the provider to think negatively of them. Overarching themes to improve cancer

communication gaps included: (1) the importance of family and community in health information dissemination, (2) the key role women play in interpreting health information for others, (3) the importance of personal experience and relationships to the salience of health information, and (4) the desire for local cultural relevance in health communication. Findings are discussed in light of the 2010 National Action Plan for Health Literacy.

Sentell, T. L., Valcour, N., Ahn, H. J., Miyamura, J., Nakamoto, B., Chow, D., ... & Shikuma, C. (2015). High Rates of Native Hawaiian and Older Japanese Adults Hospitalized with Dementia in Hawai'i. *Journal of the American Geriatrics Society*, 63(1), 158-164

Disaggregated data sets for Asian and Pacific Islanders discharged from a Hawai'i hospital are examined by ethnicity and age group in Hawai'i. Groups were compared based on the reported rates of inpatient hospitalizations with a diagnosis of dementia. Information was collected through ICD-9 coding between 2006-2010 for Hawai'i-based hospitals. Examination of the data sets revealed clear disparities in the ethnic/racial group that were had not been clear with available aggregated data sets. Native Hawaiian populations experienced inpatient hospitalizations for dementia at a higher rate than other groups. Native Hawaiians also were hospitalized more frequently in the 18-59 age range compared to other examined ethnic groups. The lowest rates of inpatient dementia care were seen in Japanese Americans.

Shi, L., & Stevens, G. D. (2010). *Vulnerable populations in the United States* (Vol. 23). Jossey-Bass.

In six chapters, this book provides a cogent introduction to the topic of vulnerable populations in the United States. Not specific to Hawai'i, this book nonetheless provides relevant information in work with and on behalf of racial/ethnic populations. In Chapter One: A General Framework to Study Vulnerable Populations, The topic and study of vulnerable populations is introduced together with the relevance of studying minority ethnic and racial groups, and those with low socioeconomic status. Both populations are vulnerable from a health care and economic framework. Eight modes for studying vulnerable populations are discussed. The authors propose a new conceptual framework that they believe is more inclusive and comprehensive. Three primary attributes of vulnerable populations include racial/ethnic minority groups, the uninsured, and the chronically ill.

Chapter Two: Community Determinants and Mechanisms of Vulnerability. Detailed race, ethnicity, socioeconomic, and demographic characteristics are provided. A number of methods are discussed to identify and measure the vulnerabilities associated with trends and patterns seen

in the health and outcomes of minority groups. Income, poverty, employment status and level of education are measurable variables for research purposes. The chapter concludes with frameworks for conceptualizing and researching community contexts including health service accessibility, cohesion, and safety.

Chapter Three: The Influence of Individual Risk Factors. The third chapter discusses the health status and disparities of vulnerable populations. Data are grouped by age, gender, infant mortality rates, health insurance coverage, quality of services, self-reported health outcomes, and risk factors by race and ethnicity. Mental illness rates by SES, education and employment is graphed along with health behaviors including causal links to specific mortalities.

Chapter Four: The Influence of Multiple Risk Factors. The frequency of co-occurring health issues, disparities, and outcomes is the focus of this chapter. Three risk factors regularly influence each other is an individual's minority status, low SES, and lack of medical insurance coverage. The data present the high likelihood that populations vulnerable to one health disparity typically experience a cluster of others, and this relationship is strongest in certain at-risk ethnic and racial groups. The frequency of multiple risk behaviors and negative health outcomes are demonstrated in areas of general health, chronic illness, vaccinations, dental care, and health literacy rates. These factors share a strong correlation with overall mortality rates within a specific ethnic/racial group.

Chapter Five: Current Strategies to Serve Vulnerable Populations. In this chapter, programs and community service models are outlined and critiqued for efficacy and feasibility. The option of privatization of health care services and programs is briefly discussed with the chapter ending with the examination of federal programs and organizations which serve to reduce health disparities in ethnic minority groups and low SES populations. Programs and policies aimed at improving health and reducing income inequality are discussed.

Chapter Six: Resolving Disparities in the United States. The sixth and final chapter begins with a discussion about current state and federal health initiatives including the *Healthy People Initiative*, *Healthy People 2020*, and the federal framework for achieving national time-bound health goals. The authors return to their proposed framework to address disparities that includes social and medical determinants on health and wellbeing, and recommend a number of policy and community based interventions. Participatory action research is viewed as a research approach that can help to implement programs effectively. Finally, barriers to service delivery and service accessibility are a segway into a proposed ten-step action plan.

Sugihara, N., Watanabe, M., Tomioka, M., Braun, K.L., & Pang, L. (2011). Saving money through exercise: Estimating the investment-to-return ratio of an elderly exercise program on Kauaʻi. *Hawaiʻi Medical Journal*, 70, 116-120.

The elderly consume a disproportionate amount of health care resources, and the recent trend in obesity will only escalate costs. EnhanceFitness® (EF) is an exercise program designed to increase the strength, flexibility, and balance of older adults. A comprehensive controlled study in Washington state of an elderly population has shown that participants who attend at least one EF class per week reduce healthcare costs by 20% per year. The present study reports the costs and potential benefits of replicating EF on Kauaʻi. For Kauaʻi the annual cost of an EF pilot program for 132 clients would be \$204,735. Attendance records of the Kauaʻi program showed that 96 (73%) of those enrolled attended at least weekly. Based on national reports of healthcare costs for the elderly, averting 20% of the costs for these 96 elderly would save \$344,256 per year. The expected investment to return ratio, I–R ratio, for EF on Kauaʻi is about 1–1.8. On economic grounds, a case can be made to support and expand these types of programs. In these times of budget cuts, cost-benefit analysis provides a common economic “language” to prioritize among different programs.

State of Hawaiʻi Department of Hawaiian Home Lands [DHHL] (2015). *Hawaiian Homes Commission Act 1920*. Honolulu: DHHL. Retrieved July 1, 2015 from http://www.capitol.hawaii.gov/hrscurrent/vol01_ch0001-0042f/06-Hhca/HHCA_.htm

The Hawaiian Commission Act of 1920 aims to provide sections of land to qualifying Native Hawaiians in order to restore the loss of land and ability for self-sufficiency for and with the Native Hawaiian people. Two additional aims of the Act are to foster Native Hawaiian culture through the preservation of traditional cultural practices and values, and to establish the rights of Native Hawaiians to receive financial support, and be provided with access to the necessities needed to sustain life and security.

State of Hawaiʻi, Department of Health (2011). *Self-reported confusion and memory loss among adults aged 60 + and older. A Fact Sheet*. Honolulu, Hawaiʻi: Department of Health.

This Fact Sheet presents summary data on declines in cognitive function and associated difficulties in adults age 60 and over in Hawaiʻi. Using the State’s Department of Health (DoH) Behavioral Risk Survey to examine rates of increased confusion or memory loss, respondents were found to have varying rates of increased confusion over the 12 months prior to receiving

the survey. Some highlights of the data include a higher weighted percentage of confusion or memory loss in adults age 60-64 (44%) than in adults age 65-70 (29%).

State of Hawai'i, Executive Office on Aging, Department of Health (2015). *Alzheimer's Disease Task Force*. Honolulu: Executive Office on Aging.

The State of Hawai'i Alzheimer's Disease Task Force developed a statewide plan to address the increasing needs of older adults with Alzheimer's/Dementia. Plans include aligning with federal plans and goals established by the [U.S.] National Plan to Address Alzheimer's Disease. A key focus of Hawai'i's plan to address the increasing health need for elders, families and society is to provide greater availability of supportive efforts and resources to family [informal] caregivers who provide over \$910 million worth of unpaid caregiving annually in the State. Other directives set by the Hawai'i Task Force include: 1) prevent and effectively treat Alzheimer's disease by 2025; 2) enhance care quality and efficiency; 3) expand supports for people with Alzheimer's disease and their families; 4) enhance public awareness and engagement, and 5) improve data to track progress. The Executive Office on Aging (EOA) is directed with coordinating and implementing the statewide plans to address this public health crisis.

State of Hawai'i, Executive Office on Aging, Department of Health (2014). The feasibility of long-term services and supports and social insurance program for Hawai'i: A report to the Hawai'i State Legislature. Retrieved: http://www.hawaiiadrc.org/site/465/ltss_financing.aspx

Published by the State of Hawai'i Department of Health in 2014, this report examines the Feasibility of Long Term Services and Social Insurance Program for Hawai'i. Highlighting current and future limitations of funding mechanisms for long term care, the authors report on who could be impacted by a state-funded Long Term Care Program. The article provides estimates for the financing of a state-funded program, along with insurance options for the state's population.

State of Hawai'i, Executive Office on Aging, Department of Health (2013). *Profile of Successful Aging Among Hawai'i's Older Adults*. Honolulu: Executive Office on Aging.

The EOA-DOH report on successful aging for Hawai'i's elders provides summary information on successful aging specific to Hawai'i, and also provides comparative data of elders in Hawai'i to those in the Continental U.S. The primary two factors related to healthy and successful aging in Hawai'i are quality of life and social capital. Quality of life is conceptualized into six

domains: economic, health, education, housing/transportation, environmental, and social well-being. Hawai`i data are compared to national averages for a broader view of aging in the State.

State of Hawai`i, Executive Office on Aging, Department of Health (2013). Executive Summary, *Hawai`i 2025: Hawai`i State Plan on Alzheimer's Disease and related Dementias, December.*

The EOA-DOH published a summation of the Hawai`i State Plan to address the needs of individuals with Alzheimer's Disease and other Related Dementias (ARD) and their families. Hawai`i's 2025 plan consists of five goals, each containing between 1-9 strategy options. The plan aims to improve the way individuals and caregivers, living with ARD, navigate support in the community. Additional aims are to improve the quality and efficiency of care, the expansion of available supports for those with ARD, and their families, and lastly, increase public awareness and engagement, and improve data tracking process.

State of Hawai`i, Executive Office on Aging, Department of Health (2011). *Hawai`i State Plan on Aging, October 1-2011-September 30, 2015.*

The Hawai`i State Plan on Aging is a detailed plan developed by the State Executive Office on Aging to address the needs of the growing elderly population in Hawai`i. The report is divided into four chapters; background information, Hawai`i's aging population, goals and strategies, and a budget overview. Targeted areas to improve the lives of older adults include elder empowerment, sustaining independence, development and expansion of a comprehensive Aging and Disability Resource Center, and elder abuse protection.

State of Hawai`i, Executive Office on Aging, Department of Health (2007). Report to the twenty-Fourth Legislature State of Hawai`i . Honolulu: Executive Office on Aging.

This report provides summary data on a statewide study that examined elder, family, and community needs to promote elder care in Hawai`i. Focus groups were held on the islands of Hawai`i, O`ahu, Maui and Kaua`i to better understand met and unmet needs provided by Kūpuna Care, the state funded elder support program. Elders hope to "age in place" regardless of level of disability; elder care at home (home and community based care) may bring cost savings to the State in comparison to institutional care; a serious and unaddressed issue is the limited availability of Direct Care Workers; numerous hurdles and disincentives exist for new businesses

in elder care; and the need for government to examine strategies to fund the long-term care system.

State of Hawai‘i, Office of Hawaiian Affairs (2015). *Native Hawaiian data book*. Maui ola. Honolulu: Author. Accessed on Oct. 1, 2015 <http://www.ohadatabook.com/>

Through the website of the Office of Hawaiian Affairs (OHA), the public can access an online data book, detailing the current status of Hawaiians in the State. Book sections appear as website link, covering the topics of demographic data, economic self-sufficiency, land and water, education, governance, culture, health, and legacy. Each topic presents data in the form of graphs, tables, and raw values, and typically includes the last 20 years. The most current data sets, from each topic, are grouped into a separate section, for later integration into data book’s regular sections. The 2015 data revealed over 42,000 Native Hawaiian applicants are currently waitlisted for homestead land/houses. In the homelessness, housing sub-section, results showed 24.6% of the total emergency shelter participants listed Native Hawaiian as primary ethnicity, only surpassed by Caucasian consumers (32.2%). Rates of diabetes and obesity have also steadily increased over the past 5 years that call for more preventive health actions and education..

State of Hawai‘i, Statewide GIS Program, Hawai‘i State Office of Planning. Retrieved from: <http://planning.hawaii.gov/gis/>

Geographical Information System (GIS) is operated and maintained by the State Office of Planning. The primary goal of GIS is to improve the efficiency and effectiveness of governmental decision making. An open data base operated through the GIS website is a portal to a variety of maps, data sets, and other open databases. The majority of information GIS collects and disseminates is geological, and includes information on current environmental levels, climate status, oceanography, and man-made and naturally occurring land and land structures. Through a GIS link, census data is accessible that is formatted into maps, graphs, and raw data sets. An interactive census map is also maintained by GIS that allows for an open search of census data.

Sugihara, N., Watanabe, M., Tomioka, M., Braun, K.L., & Pang, L. (2011). Cost-Benefit estimates of an elderly exercise program on Kaua‘i. *Hawai‘i Medical Journal*, 70, 116-120. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3233394/>

The elderly consume a disproportionate amount of health care resources, and the recent trend in obesity will only escalate costs. EnhanceFitness® (EF) is an exercise program designed to increase the strength, flexibility, and balance of older adults. A comprehensive controlled study in Washington state of an elderly population has shown that participants who attend at least one EF class per week reduce healthcare costs by 20% per year. The present study reports the costs and potential benefits of replicating EF on Kaua‘i. For Kaua‘i the annual cost of an EF pilot program for 132 clients would be \$204,735. Attendance records of the Kaua‘i program showed that 96 (73%) of those enrolled attended at least weekly. Based on national reports of healthcare costs for the elderly, averting 20% of the costs for these 96 elderly would save \$344,256 per year. The expected investment to return ratio, I-R ratio, for EF on Kaua‘i is about 1–1.8. On economic grounds, a case can be made to support and expand these types of programs. In these times of budget cuts, cost-benefit analysis provides a common economic “language” to prioritize among different programs.

Thomas, K.S., & Applebaum, R. (2015). Long term services and supports (LTSS): A growing challenge for an aging America. *Public Policy and Aging Report*, 25, 2, 56-62.

The older adult population is projected to double in size in the next twenty years increasing the need for LTSS. The current LTSS system is unprepared to adequately provide for a population growth of this degree. Six service gaps are identified, along with proposed recommendations for improvement. A number of currently unresolved issues include: limited and unaffordable LTSS insurance coverage, limited caregiver resources, and a shortage of qualified formal caregivers. While not specific to Hawai‘i and Native Hawaiians, a number of recommendations at the federal level around governmental funding, education and resources for informal caregivers, and the need for more research on LTSS have important implications to the State.

Tomioka M., Braun, K.L. Examining sustainability factors for organizations that adopted Stanford’s Chronic Disease Self-Management Program. (2015) *Frontiers in Public Health Education and Promotion*. 2:140. <https://doi.org/10.3389/fpubh.2014.00140>

In 2006, funds were received to replicate Stanford’s Chronic Disease Self-Management Program (CDSMP) among eldercare providers in Honolulu. This case study, conducted 1 year after the close of the initial 3-year replication grant, explored factors for sustaining the delivery of CDSMP, with an aim to create guidelines for cultivating sustainability. Face-to-face semi-structured interviews were conducted with one representative from each of eight eldercare agencies, with the representative specified by the agency. Representatives discussed the presence and strength (low, medium, or high) of sustainability factors, including readiness, champions, technical assistance, perceived fit of CDSMP with their agency, CDSMP modifiability,

perceived benefits of CDSMP, and other. Only three of the eight agencies (38%) were still offering CDSMP by the end of 2010. Agencies who sustained CDSMP rated higher on all sustainability factors compared to those that did not sustain the program. Additional factors identified by representatives as important were funding and ongoing access to pools of elders from which to recruit program participants. When replicating evidence-based programs, sustainability factors must be consciously nurtured. For example, readiness must be cultivated, multiple champions must be developed, agencies must be helped to modify the program to best fit their clientele, evaluation findings demonstrating program benefit should be shared, and linkages to funding may be needed.

Tomioka, M., Braun, K.L. (2012) Implementing evidence-based programs: A four-step protocol for assuring replication with fidelity. *14*(6). Retrieved from <http://europepmc.org/articles/PMC4697267>

Health care providers are challenged to replicate evidence-based programs in their communities. These programs may be adapted to fit new communities, but the key components must be delivered with fidelity. This article describes a four-step fidelity assurance protocol developed by the Hawai'i's Healthy Aging Partnership as it adapted and replicated evidence-based health promotion programs for Hawai'i's older adults. The four steps are the following: (a) deconstruct the program into its components and prepare a step-by-step plan for program replication; (b) identify agencies ready to replicate the program, and sponsor excellent training to local staff who will deliver and coordinate it; (c) monitor the fidelity of program delivery using standardized checklists; and (d) track participant outcomes to assure achievement of expected outcomes. The protocol is illustrated with examples from Hawai'i's Healthy Aging Partnership's experience replicating EnhanceFitness, a senior exercise program. This protocol is transferrable to other communities wanting to adapt and replicate evidence-based, public health programs.

Tomioka, M., Braun, K.L., Ah Cook, V., Compton, M., Wirten, K. (2014) Improving behavioral and clinical indicators in Asian Pacific Islanders with diabetes: Findings from a community clinic-based program. *Diabetes Research & Clinical Practice*. *104*(2), 220-225. <https://doi.org/10.1016/j.diabres.2013.12.035>

This project tested the six-month impact of Stanford's Diabetes Self-Management Program (DSMP), adapted for Asians and Pacific Islanders (APIs), on behavioral and clinical indicators. Participants attended DSMP workshops at a community health center. Employing a one-group, pre-post-test design, data were collected at baseline and six-months. Ninety-six eligible API adults were enrolled. All attended four or more of the six weekly sessions, and 82 completed data

collection. Measures included body mass index, blood pressure, blood lipids, blood glucose, HbA1c, as well as health behaviors. Data were analyzed by descriptive statistics and paired *t*-tests. Adaptations to DSMP were minimal, but critical to the local acceptance of the program. At six-months, significant behavioral improvements included: (1) increased minutes in stretching and aerobic exercise per week ($p < 0.001$); (2) reduced symptoms of hypoglycemia and hyperglycemia ($p < 0.001$); (3) increased self-efficacy ($p < 0.001$); and (4) increased number of days and times testing blood sugar levels ($p < 0.001$). Significant clinical improvements included: (1) lower BMI ($p < 0.001$); (2) lower HbA1c ($p < 0.001$); (3) lower total cholesterol, triglycerides, and LDL ($p < 0.001$); and (4) lower blood pressure ($p < 0.001$). Findings suggest that the DSMP can be successfully adapted to API populations and can improve clinical measures as well as health behaviors.

Tomioka, M., Braun, K.L., Compton, M., Tanoue, L. (2012) Adapting Stanford's Chronic Disease Self-Management Program to Hawaii's multicultural populations. *The Gerontologist*. 52(1), 21-132. <https://doi.org/10.1093/geront/gnr054>

Stanford's Chronic Disease Self-Management Program (CDSMP) has been proven to increase patients' ability to manage distress. This article describes how CDSMP was replicated in Asian and Pacific Islander (API) communities. The "track changes" tool was used to deconstruct CDSMP into its various components (e.g., recruitment and staffing) and the "adaptation traffic light" to identify allowable modifications to the original program. Local leaders' fidelity of delivery of CDSMP and participants' attendance, satisfaction were monitored and traced, as well as 6-month outcomes. Between July 2007 and February 2010, 584 completed a CDSMP workshop. Baseline and 6-month data were available for 422 (72%), including 53 Caucasians, 177 Asians, and 194 Pacific Islanders. All 3 groups realized significant decreases in social and role activity limitations and significant increases in communication with physicians. Asians and Pacific Islanders also realized significant increases in self-rated health and time spent engaging in stretching/strengthening exercise. Asians also reported significant reductions in health distress and self-reported physician visits and increases in time spent in aerobic exercise, ability to cope with symptoms, and self-efficacy. This study suggests that CDSMP can be modified for increased cultural appropriateness for API communities while maintaining the key components responsible for behavior change.

Tomioka, M., Braun, K., Honma, M., Nobuhara, H., Kubota, T., & Sakai, H. (2017) Perceptions of Factors Impacting Longevity among Hawai'i Older Adults. *Hawai'i Journal of Medicine and Public Health*, Vol 76(3):71-76
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5349114/>

This paper examines older adult perceptions regarding various factors impacting longevity, including genetics, lifestyle, and the environment. As life expectancy increases, people will need more education about the factors contributing to healthy aging. Cutting across ethnic categories, more than half of the participants felt that eating habits, exercise, health information, health care, and the environment had great impact on lifespan. Findings suggest that older adults' perceptions of factors that affect lifespan are shaped by cultural values and experiences. Findings in this paper can help guide health professionals in tailoring health messages to be most effective with older adults in different ethnic groups.

Tomioka, M., Sugihara, N., Braun, K.L. (2012) Replicating the EnhanceFitness physical activity program in Hawai'i's multicultural population: 2007-2010. *Preventing Chronic Disease*. 9. <https://doi.org/10.5888/pcd9.110155>

Despite evidence of the benefits of regular physical activity, many older adults are not physically active. Health professionals are challenged to replicate evidence-based programs to address low levels of physical activity among members of their communities. EnhanceFitness is an evidence-based group exercise program developed in Seattle to increase the strength, flexibility, and balance of older adults. Hawai'i's Healthy Aging Partnership supported the rural island of Kaua'i to select, adapt, implement, and evaluate EnhanceFitness to increase physical activity among older adult residents (75% Asian/Pacific Islander [API]). Evaluation measures of the replication of EnhanceFitness included fidelity of EnhanceFitness delivery and participants' attendance, satisfaction with the program, confidence to exercise regularly, and pre-post fitness check measures of physical performance (chair stands, arm curls, and the up-and-go test). Between July 2007 and December 2010, 223 Kaua'i residents enrolled in EnhanceFitness; 178 (80%) participated at least 4 months and completed the 4-month fitness checks. EnhanceFitness classes were offered with a high degree of fidelity, and both API and white participants significantly improved their physical performance (chair stands, $t = -11.06$, $P < .001$; arm curls, $t = -6.66$, $P < .001$; and up-and-go test, $t = 6.56$, $P < .001$). Participants reported high satisfaction with the program and instructors and high confidence to continue to exercise regularly. EnhanceFitness is replicable in Hawai'i and increased physical performance among API and white older adults. This case study outlines a replication process that other communities can follow.

Tomioka, M., Tom, T., Higuchi, P., Kidani, S., Pendleton, N., Yamashita, B., Braun, K.L. (2009) The Hawai'i Healthy Aging Project: building capacity to assure program success. *Hawai'i*

Journal of Public Health. 2(1), 20-31. Retrieved from <http://health.hawaii.gov/hjmph/files/2013/09/Volume2.1.pdf>

Significant attention has been given to implementing evidence-based interventions. Previous studies suggest challenges to replicating evidence-based programs, including lack of knowledge and skills among planners and providers. This paper describes a 3-phase cycle trialed by the Hawai'i Healthy Aging Partnership (HHAP), illustrating the usefulness of partnership development and capacity-building activities in helping service networks prepare for the replication of evidence-based programs in their communities. HHAP built community capacity to implement evidence-based interventions by: 1) bringing partners from state and county offices on aging and service agencies together to develop a 5-year strategic plan on healthy aging; 2) providing and evaluating training in needs assessment, evidence-based programming, grant writing, and evaluation; and 3) providing funds and technical assistance to pilot evidence-based programs. Program stakeholders were engaged in partnership development and completed a strategic plan in 2004. Training helped trainees gain awareness, confidence, and understanding of needs assessment and evidence-based planning concepts. Partners applied new knowledge and skills by piloting evidence-based programs in 2005. These planning, training, and pilot programming activities enabled program partners to successfully win a federal grant in 2006 to replicate evidence-based programs. Members reported applying skills to other job areas, generally improving community programs and health. Continued resource sharing, commitment, and supportive environments were key elements to motivate community partnership development. The time and resources required to build capacity are good long-term investments. This case study provides an example to communities in building capacity to replicate evidence-based programs.

Tsark, J., & Braun, K.L. (2001). Ten-year changes in breast cancer knowledge, attitudes, and practices in Native Hawaiian women. *Pacific Health Dialog*, 8, 280-289.

Compared to women in other ethnic groups, Native Hawaiian women have the highest breast cancer mortality rates in the state of Hawai'i. Nationally, the five-year relative survival rate for Native Hawaiian women is 9% shorter than for Caucasians and all races. This poor outcome has been attributed, in part, to late-stage detection of cancer in Native Hawaiians, and data suggest that breast cancer screening rates for Native Hawaiian women are relatively low. This study examined breast cancer knowledge, attitudes, and practices (KAP) among Native Hawaiian women, reached through their friendship, community, and organizational networks. Response to an initial KAP survey in 1989-1990 was rewarded by a voucher for a free mammogram. Participation in both the survey (n = 903) and mammogram offer (n = 496) was high. The initial, Time 1 participants were re-surveyed in 1999-2000, yielding a sample of 117 women who

completed KAP surveys at both time points. After 10 years, changes in women's knowledge and attitudes were minimal. However, remarkable improvements in breast health practices were seen, with 62% of women reporting compliance with American Cancer Society guidelines for mammogram screening in 1999-2000, compared to only 14% in 1989-1990. Findings suggest that breast health practices can be improved through appropriate outreach; encouragement by health professionals; and policies and programs that increase access and affordability.

University of Hawai'i, Center on Aging (2015). *Making Honolulu an Age-Friendly City: An Action Plan*. Honolulu: University of Hawai'i.

To address the needs of Honolulu's growing population of older adults, a collaboration between the City and County of Honolulu Office of the Mayor, in consultation with the University of Hawai'i Center on Aging, produced a multifaceted action plan to make Honolulu an age-friendly city. Six key areas; Outdoor Spaces & Buildings Transportation Housing Communication & Social Involvement Civic Participation & Employment Community Support & Health Services, are addressed in this action plan. Input obtained from the six workforce groups, interviews/focus groups, public input, and survey data, helped establish 4-6 goals per key area, current status report, strengths, gaps, challenges, and recommendations. Findings indicate the largest challenge is adequate fundings, primarily for adapting or building to accommodate the housing, transportation, and environmental needs of an aging community. This report details gaps in the accessibility and affordability of social and health services, and recommends a continuation of supportive services, from in-home to total care, is needed. Findings also indicated that while Honolulu's public bus system is nationally acclaimed, service to rural areas is limited, and Handi-Van services are lacking. The report covers environmental and structural spaces are currently not age-friendly, stating disability access is limited, and amenities to meet the needs of elders is lacking. Both are challenged with the funds to update and/or build new spaces, and the land for building is limited and costly. The plan addresses key areas including housing, transportation, and community support services. Work groups were assigned to each focus, and collected information to formulate a comprehensive plan.

University of Hawai'i Center on the Family (2016). Homeless service utilization report Hawai'i 2015. Retrieved from:

http://uhfamily.hawaii.edu/publications/brochures/789af_HomelessServiceUtilization2015.pdf

First published in 2006, the University of Hawai'i Center on the Family's *Homeless Service Utilization Report* is a compilation of demographic, programmatic, and outcome data detailing homeless individuals, and the programs/initiatives that provide services. This report covers

changes from 2014 to 2015, and provides in-depth data analysis for 2015. The majority of homeless individuals were between the age of 40-59, and this group had the highest influx of those accessing services for the first time. Native Hawaiian was the highest reported ethnicity (30.5 %), followed by Caucasian (29.9%). Rapid rehousing has the highest success rates of interventions that help clients obtain permanent housing (73%).

University of Hawai‘i, Public Administration, Organizational Learning Institute, College of Social Sciences (2013). State of Hawai‘i Executive Office on Aging Strategic Plan: *Hawai‘i 2020-Towards an Aging Future*. Honolulu: University of Hawai‘i.

This report aims to address the needs of the growing population of older adults in Hawai‘i. Under the direction of the State Executive Office on Aging (EOA), the University of Hawai‘i Organizational Learning Institute was contracted to focus on a broad range of legislative, structural, social, and environmental changes that are or should support the State’s growing aging population. Two catalysts of change, the Affordable Care Act and its potential for providing long-term services and supports (LTSS), and the creation of Aging and Disability Resource Centers (ADRCs) are highlighted for policy and community reform and expansion. Five priorities are listed, serving to focus and guide the creation and implementation of policy and social directives. The five priorities include: forging strategic partnerships and alliances, EOA’s leadership in supporting AAAs, developing a statewide ADRC, developing LTSS social financing options, and maximizing opportunities for seniors to age in place.

U.S. Census Bureau, FactFinder (2015). Washington, DC: U.S. Government Printing Office.

Fact Finder is a website resource created and maintained by the U.S. Census Bureau, a federal agency apart of the Department of the Interior. It offers a number of interactive features, spanning across a variety of topics, agency-focused, and federally-focused resources. Previous and current census data are accessible through multimodal formats. Raw data sets, topic-specific, population-specific, and geographically focused, information is provided and can be accessed individually, or used comparatively with other variables. To promote a user-friendly format, complex statistical information is condensed into an interactive format, allowing users to explore basic demographic information, referred to as Quick Facts.

U.S. Census Bureau, P23-212 (2014). *65+ in the United States: 2010*. Washington, DC: U.S. Government Printing Office

A collaborative effort between the U.S. Census Bureau, U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Aging, U.S. Department of Commerce, and the Economics and Statistics Administration resulted in this special report, detailing data on the U.S. older adult population. Descriptive population characteristics for 2010 are used in conjunction with longitudinal analyses, capturing population trends and changes. The report is organized into five chapters, and provides information on population growth, longevity, health outcomes, income, social support, and population density by location. Ethnicity, age, and gender is the most common method of stratification. National trends are used to help analyze possible extraneous variables. Significant trends of increasing rates of diseases related to behavioral patterns (diabetes, cancer, heart disease) are evident in all older adult populations in developed nations. Declining economic stability is also highlighted as a significant factor associated with overall outcomes for older adults. Discussion on contextual, historical, and structural factors impacting trends, such as service accessibility and employment status, are examined. Predictions on various characteristic reveal policy, structural, and social factors that need reform.

U.S. Census Bureau (2010). *The Native Hawaiian and other Pacific Islander population: 2010*. Washington, DC: U.S. Government Printing Office.

This government publication provides census data on Native Hawaiians and other Pacific Islanders (NHPI) residing in the United States from 2000 to 2010. The total population experienced one of the nation's highest increases compared to other U.S. population groups. Moreover, the NHPI population saw an increase in individuals who reported their ethnicity as two or more. Distribution of NHPI offers detailed information by state, city, and county. Overall, west coast U.S. continental states had the highest increase in NHPI population, while those reporting residence as Hawai'i saw a decrease. Disaggregated data are also provided, specifying population information on specific groups within the category NHPI. Data on Native Hawaiians revealed a decline in individuals reporting Native Hawaiian as their sole ethnicity/race, with an increase in those reporting mixed (2 or more ethnicity/racial groups), and those identifying as mixed, with primary ethnicity as Native Hawaiian.

U.S. Congress (1993), Public Law 103-150, *Acknowledging the 100th Anniversary of the January 17, 1893. Overthrow on behalf of the United States and to Offer an Apology to Native Hawaiians on behalf of the United States*, 103d Congress Joint Resolution 19, November.

This document is the original apology from the U.S. government to Native Hawaiians for the illegal assimilation and "take over" into the United States. The apology details the chronological

events which led to the overthrow and procurement of the Hawaiian Islands, including the impact those actions have had on the Native Hawaiian population related to include population decline, forced religious reform, and loss of cultural identity. The document includes five separate apologies, and states the need for reconciliation between the United States and Hawai`i.

U.S. Department of Health and Human Services (DHHS), Office of Minority Health (2013). *National Standard for cultural and linguistic appropriate Services (CLAS)*. Washington DC: Department of Health and Human Services, Office of Minority Health.

The Office of Minority Health (OMH), U.S. Department of Health and Human Services, developed standardized culturally and linguistically appropriate services (CLAS) for healthcare settings. CLAS is meant to address the inconsistencies in service delivery, and positively and impact health outcomes for culturally diverse populations. A total of 14 standards are proposed, directed at all levels of health care settings. Identified standardized practices include continuous employee education programs and trainings, revisions of complex documents to simplify content, and providing interpreting services at no cost those accessing services. Specific methods for implementing each standard is provided, addressing reform at a policy, organizational and community level.

Weiner, J. (2012). *Long-term care reform in Hawai`i: Report of the Hawai`i Long Term Care Commission; Final Report*. The Hawai`i State Legislature January 18.

The focus of this report, produced for the State of Hawai`i Long Term Care Commission and the Hawai`i Legislature by the RTI research group (DC), conducted key informant interviews and examined a range of issues related to long-term care services in Hawai`i for older people. Issues are spread across a variety of micro and macro contexts, including federal and state inactivity in initiating and funding services addressing long-term care, lack of financial options for payment, and developing outreach methods to raise public awareness and support for reformation activities. Recommendations and implementation methods are discussed for each identified issue. Comparisons allow for the examination of contrasting approaches to address issues, and explore positive and negative outcomes associated with each proposed approach.

Wu, Y.Y., Braun, K.L., Horiuchi, B.Y., Tottori, C., Wilkens, L., Onaka, A.T. (2017) Life expectancies in Hawai`i: A multi-ethnic analysis of 2010 life tables. *Hawai`i Journal of Medicine and Public Health*. 76(01), 9-14. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5226016/pdf/hjmph7601_0009.pdf

The objective of this study is to examine longevity disparities in Hawai'i by race/ethnicity and gender based on age-specific death rates in 2010. Abridged life tables for Chinese, Japanese, Filipino, Hawaiians, and Caucasians in Hawai'i are presented for the age groups: <1, 1-4, every 5-year interval from 5-84, and 85+ years for the year of 2010. Death data were provided by the Hawai'i Department of Health Office of Health Status Monitoring, and population data were based on 2010 Census modified based on ethnicity estimates from the Hawai'i Health Survey. Life expectancy at birth in Hawai'i has increased consistently from 69.5 years in 1950 to 82.4 years in 2010. Longevity disparities seen in past decades continue to persist between the longest-living groups, Japanese and Chinese, and the shortest-living group, Native Hawaiians, with a gap of approximately 10 years. In addition, females lived 6 years longer than males on average. Racial/ethnic disparities in longevity can be partially explained by differences in socioeconomic status, health behaviors, health care access, and racism. Native Hawaiians continue to have the shortest life expectancy of the ethnic groups examined, requiring expanded efforts to address Native Hawaiian health across the life course. Our findings also support more ethnic-specific research to understand the health care needs and utilization patterns of each group.

Zahirun, J., & Zan, H. (2016). *Hawai'i's older adults: A demographic profile*. Honolulu, HI: University of Hawai'i Center on the Family.

A broad brush illustration of older adults in Hawai'i, examination of racial/ethnic diversity, basic indicators of older adult socio-economic status in Hawai'i, and demographic projections.