"It starts with ʻAloha…'" Stories by the Patient Navigators of *Ke Kuʻuna Naʻau* Program at The Queen's Medical Center

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Abstract

The Ke Kuʻuna Naʻau *(KKN) navigators were first hired in 2016 at The Queen's Medical Center (QMC) in Honolulu, Hawaiʻi, with a focus on reducing hospital readmissions for socially and economically vulnerable Native Hawaiian adults. To our knowledge, QMC was the first acute care hospital in the state to implement the use of community health workers into the health care system as navigators for patient needs in the community following discharge. This article tells the story of our experiences as the 5 patient navigators from the Native Hawaiian community during the first 2 years of the program. The article describes how we ended up in this vocation and a summary of what we have learned. We also describe walking with our patients through their journey of healing, a journey which begins at the bedside during hospitalization starting with the moment we say, "Aloha." (A companion article in this issue describes the KKN program history, design, and clinical outcomes in more detail.) We hope these stories are inspirational to others who fill the community health worker role and may walk in our shoes in other health care organizations and/or help support the planning and implementation of similar programs to meet other communities' health needs. We consider the implications for community-clinical linkages.*

Keywords

patient navigators, Native Hawaiian, health care system, hospital

Abbreviations

QMC = Queen's Medical Center
KKN = Ke Kuʻuna Naʻau
PCP = primary care provider

Highlights

- *We share the perspectives of our diverse, shared experiences as patient navigators.*
- *We describe the privilege to serve our community and our kūpuna (elders).*
- *We highlight the community-clinical linkages needed by our patients.*
- *We discuss the distinct ways we maintain self-care to be able to sustain our work.*
- *We provide guidance for similar programs starting in other settings.*

Introduction

The *Ke Kuʻuna Naʻau* (KKN) Native Hawaiian Behavioral Health Initiative was implemented in 2016 at The Queen's Medical Center (QMC) in Honolulu, Hawaiʻi with a focus on reducing hospital readmissions for socially and economically vulnerable Native Hawaiian adults. To our knowledge, QMC was the first acute care hospital in the state to implement the use of community health workers into the health care system in this way. (A companion article in this issue describes the program history, design, and clinical outcomes in more detail.) Inclusion criteria to participate in this program required that patients self-identified as Native Hawaiians, were admitted to the hospital on inpatient units, and identified psychosocial vulnerabilities. From January 2017 to January 2018, 338 patients were enrolled in the KKN program with an average of 37 patients meeting inclusion criteria per month. These patients often had a complex array of health needs or were estranged from friends, families, and any notable social supports. Many would have been considered "difficult to treat" by their providers or the health care system. Given the complex nature of each case, as well as the intense assistance given to each patient, our average intital case load per navigator was 16, which was reduced to 10 in the second year of the program to allow us to fully meet patient needs.

We are the 5 patient navigators from the Native Hawaiian community who have been the liaisons between the hospital and community to support a safe transition after discharge and assist our patients in obtaining the resources they need to support healing. We are members of the direct clinical care team and in this article, we each describe how we have arrived in this vocation through stories of our experiences and lessons learned over the last 2 years. We have been supported in our journey by our project coordinator/social worker, who has been our *hoʻokele* (steersman) and is also the lead author of this article. We describe our experiences of walking with our patients on their own health and healing journeys, starting with the moment we said *aloha* at the patients' bedsides during hospitalization. In our conclusions, we share implications for community-clinical linkages and designing effective programs to meet diverse community needs (cultural, practical, and clinical), particularly in vulnerable communities. Our team can be seen in Figure 1.

The overarching theme across all our individual stories that have brought us to this caregiving role and sustained us during these patient journeys is a Hawaiian worldview, a perspective that tells us we are all connected. Through this lens we understand that *lōkahi* (harmony) in the relationship between spirituality, mankind, and environment is important.[1,2,3] This worldview guides us in our work with patients, acknowledging the importance of the body, the mind, and the spirit.[1,2,3] A description of this concept is provided in this quote, which was gifted to one of us by a wise *kāne* (man) many years ago.

> *The community is like a reef. Everything in the reef is connected. The fish rely on the reef to survive. The fish, the water, the reef, and the land are interconnected. There is lōkahi when the ecosystem is healthy. In western culture we sometimes see a sick fish and we try to heal the fish without fixing the ecosystem. We remove the fish from the ocean and put it in a bowl (similar to the healing a patient in the hospital). Once the fish is healthy*

Figure 1. The Ke Ku‘una Na‘au care team at The Queens Medical Center, including (from left to right): Anthony Hereari‘i Negrillo (Patient Navigator); Damien Hanake‘awe (Patient Navigator); Lisa Garrett (Nurse Practitioner); Jonna "Minky" Ho‘opai (Patient Navigator); Laura Kau‘ionlani Nishizaki (Project Coordinator/Social Worker); Robert Naniole (Patient Navigator); Kehau Pu‘ou (Patient Navigator).

we put the fish back into the water. But then the fish gets sick again. We forget that the water is polluted. The reason the fish is sick is because the reef is sick. We don't address the root of the problem.

As Native Hawaiians and as navigators, we recognize the importance of building a strong community, or in this metaphor, the ecosystem, so our people can thrive. We understand that in order to heal the fish, we must *mālama* (care for) the reef, the water, and the land so that the ecosystem is healthy and the reef can heal the fish (*i‘a*). Even a fish in polluted water often finds a way to adapt and survive. In the same way, we are inspired by the resilience in our patients, despite obstacles and challenges.

When we look to the history of QMC, we learn that Queen Emma and King Kamehameha IV founded the hospital in 1859 in part, due to the sharp decline in the population of Native Hawaiians due to infectious disease. King Kamehameha IV stated we must, "…stay the wasting hand that is destroying the Hawaiian people…But let me remind you that so long as sickness shall exist, there will be a duty imposed upon us."[4] In this quote, he reminds us of our *kuleana* (responsibility) to our community which drives us in the work we do.

The QMC mission to improve the health of Native Hawaiians and people of Hawai‘i is still relevant today.[5] Recent statistics show that Native Hawaiians continue to experience high mortality and morbidity due to chronic disease.[6-8] As navigators, we often play the role of guardians or caretakers of our *i‘a* (the patients and our people). We strive to build the *kahua (*foundation) of our community and *mālama* (care for) our *kānaka* (people). In order to accomplish this, we look to the values and practices of our founders, *ali‘i* (ruler, monarch), and *kūpuna* (ancestors); values of *aloha* (love, affection, compassion, mercy, sympathy, kindness, grace, charity), *ha‘aha‘a* (humility) and *ho‘opono* (righteous, to behave correctly), which enabled the Hawaiian people to maintain health and harmony (*lōkahi*), individually and as a community.[1-3,8]

The importance of collaboration is clearly illustrated in the name of our program, *Ke Ku‘una Na‘au* which means to let down gently. This describes a traditional practice of healing. *Ku‘una* (to let down the fish net) describes the gentle laying of the net to catch fish. The *maka* (mesh of a net) are joined together by the knots. As navigators, we recognize we are simply one knot. The other knots represent the other community partners, as well as the patients' family or friends. Together we ease the patients' transition out of the hospital and into the community. If one part of the net is broken all are impacted.[1-3,9] We understand that we are not alone in carrying this *kuleana* to serve and *mālama* our people and our land. We need to work together with our patients and as a community and an ‘ohana (family) to see healing occur.

Our Stories

We now tell our individual stories from our journey in the KKN program, highlighting some important themes in addition to the overarching wordview that can be found from our experiences: providing aloha with open arms, *hilinaʻi* (trust), unconditional love and nurturing care; building on the foundation of our kupuna to mālama our people and to sustain health for future generation; *haʻahaʻa*; *hoʻomana* (empowerment); *kuleana* (as a priviledge as well as a responsibility); and *hoʻokahua* (building the foundation for our community).

Here's Story

My name is Anthony Hereariʻi Negrillo. I was a unit secretary at the Queen Emma Clinics for 14 years. I decided to apply for this program because I wanted to work more directly with patients. I love having the opportunity of working 1-on-1, having a connection and building a trusting relationship. I provide support and care with the intentions to create a healthier and enhanced quality of life for our patients. Simply providing the resources they need, like helping patients obtain food stamps is very rewarding for me. It makes me happy that I can make them happy.

My approach is simple: I am present with open arms, humble heart, open mind, caring thoughts and prayers, honesty, and consistency. When I meet a patient at the bedside, I explain the purpose of our program. If they agree to allow us to help them, then we provide resources and support without judgment.

About 98 percent of my patients have connected with me and have accepted my services. Many come from broken families, have families that are not able to help them, or are not able to be there to give them the love, support, and encouragement they need. I make sure that they know I am here for them and will always provide support as long as they need it. Although our program is intended to be for 30 days, I never look at that 30-day window. When you build a relationship with these patients, they become like family. You don't just throw away your family away after 30 days.

Once the 30 days are up, I explain to my patient what they have accomplished, what we've done together, and how they have succeeded. I am clear and open with them. I say "your service plan is complete. But, if you need me at any time, whatever you need, call." I leave it open, and they do call, sometimes just to say hello or for help. For instance, one of my patients recently received a letter from the State Department requesting information. He didn't understand the letter. I patiently explained it to him and we went to obtain the document he needed. He was able to fulfill his requirement on time and obtain his benefits. This was a monumental success for us.

Success Story

Another success story is a male in his 30s who was admitted to Queen's for nearly 6 months, undergoing many procedures with multiple diagnoses including paranoid schizophrenia. Prior to admission, he had been homeless and had lost all of his social, financial, and healthcare benefits, along with his family and his home.

This was a challenging case, as his mental illness delayed his healing process. Teamwork between case managers and social workers on the floor helped put the pieces of the puzzle back together. Despite months of healing in the hospital and preparation for successful discharge, he was discharged to the street with nothing, in part because of system barriers and delays. There was much to follow-up on after discharge in order to help him access care.

After only days at a respite home, he left and never returned. A family member finally found him wandering at a bus stop and took him home. This reunion offered him a safe space to heal. The day after discharge, I went with him to obtain financial help. I went to his medical appointments once his health insurance kicked in. I sat with him for 8 hours in the state office to help him get identification. During this process we attended numerous medical and psychiatric evaluations to support approval of long-term social security benefits. I'm so grateful that soon he will also be receiving retroactive pay for close to a year's worth of disability benefits. I know this will help the family.

Trust

We have a very trusting relationship which started when I first met him at bedside. He knows who I am. He always has a big smile when he sees me. Our relationship is very good. When you show him consistency, the trust gets even better. When you show him love and nurturing care, it helps the healing and growing of trust. I constantly remind him that I will always be there for him.

Hawaiian Focus

For me, Hawaiian or not, we're all human and we should be treated equally with respect. This is how we *mālama* our people. It is not only important to care for the physical body, but also for the entire being, body, mind, and spirit.[2] I am Hawaiian. This is a priority for me. The connection comes from our *piko (*the navel, where life begins, connection to ancestors), to perpetuate our culture and our lifestyle, our language and our wellbeing.[3] To teach one another, to help however we can to sustain our health and for our future generations to come, and to be humble!

Advice for New Navigators

I truly believe we must approach each patient with an open mind and an open heart to have that compassion to do this work, and to be strong enough to separate work, your feelings, and self. Patient navigators need a passion and compassion to serve the underserved. Our patients can be difficult. It can be tough to see the circumstances in which they live. Navigators must prioritize self-care because it can be easy to burnout.. Our patients can see if you genuinely care. They know if the compassion is real and if you truly care about their community.

Robert's Story

My name is Robert Naniole. In 1996, I started working at a local social service agency which helped low-income individuals and families become economically self-sufficient. That is how I started as a helping professional. This work experience allowed me to work with the local community, including collaborating with social service providers to better provide services to the homeless. I have also helped my own family members navigate the health system (my mom, my paternal grandmother, my mother-in-law, and father-in-law). Due to my community services background and my own personal experience, I thought I could contribute to implementing community health navigation services for patients, individuals, and families.

One major challenge in this role is getting patients to their community clinics or private physician appointments. Transportation is a barrier for many of the people we serve. Working with transportation services on coordinating pick-ups from homes, shelters, and at times, the street, can be a difficult. The amount of time a navigator may put into a patient's appointment can vary, and can sometimes be 3 or 4 hours. Patients are often burned-out from the experience of dealing with transportation services (being put on hold for phone reservations, waiting during multiple stops to pick-up other patients, transportation delays, breakdowns, and human error). Nevertheless, many patients are still appreciative of receiving free transportation through Medicaid.

To soften the burden for my patients, I often make the transportation reservations at discharge. Eventually I teach and encourage the patient to call on their own, in order to empower the patient. We try to encourage the patient to do as much as they can on their own, support them to do so, and, eventually, they are successful.

Rewards of the Work

One of our goals is to keep patients out of the hospital by making sure they're connected to: (1) transportation, (2) their health providers, and (3) social services.[10] We help people find financial resources through state and federal aid programs (such as state financial assistance, food stamps, and social security benefits). It is often surprising to see how disconnected our patients are from resources. Therefore, it is very rewarding to see them finally recieve the resources available to them. In particular, it is rewarding to see a homeless patient receive housing. We spend much of our time working with local non-profit housing programs. Having a roof over their head goes a long way to improving their health and healing in the community.[10] Our patients get better right in front of our eyes—it is remarkable and gratifying.

Success Story

One of my patients who was very difficult for others to deal with because of his non-compliant behavior. This patient was homeless for many years, living at a bus stop. Recently, I helped him move into a new apartment with a supportive housing program. It was a long journey of nearly 12 months. Initially, he was non-compliant with taking his medications. I helped him re-connect with his primary care provider (PCP) who was able to help him understand his medication and the side effects of not taking his medication. Now, he takes his medicine because he understands it better. I have had to encourage him a lot. I go to his doctor's appointments and coach him on questions to ask, which allows him to be more comfortable in communicating with his doctor.

Another patient was a male in his 60s who was homeless for many years. He would stay with family and friends intermittently. He has a long history of chronic health problems. One major barrier to housing was he did not have the appropriate legal documents. I helped him obtain and prepare more than 6 different types documents, including his housing application. I worked with another agency to get one additional document. This patient uses a walker, and it would have been very difficult for him to get these documents on his own. He often expressed frustration with the long lines of people waiting to get documents. I accompanied him to various agencies and waited in line with him. Often, I was able to expedite the process on his behalf. It took about 8 months to obtain all of his documents. These documents allowed the patient to enroll in a subsidized housing program. Now, he has his own home and pays only a portion of his income for rent.

At first, I didn't anticipate spending so much time helping patients get documents for their housing applications. However, it became apparent that housing was very important to support our patients' healing process and help them stay out of the hospital.[10]

Advice for New Navigators and Building a Program Like This

It helps if the program is appropriately funded. Additionally, it helps to have a supportive team like we do, members who are community-oriented and are sincerely concerned about people. It is useful to spend time doing some community development work to build a repertoire of community resources. This is needed as a resource net to ensure results in meeting the goals of our patients. It is important to be tolerant of other providers who have different approaches, mainly because our community is made up of diverse groups of people with different perspectives about helping others.

Kehau's Story

Aloha, my name is Kehau Pu'ou. My background is in the medical field and social services. Prior to becoming a navigator, I was an EMT in the hospital setting. It was then that I knew I wanted to be closer to the Native Hawaiian population. I transitioned to the social service field where I worked closely with at risk *keiki* (youth) on the West side of O'ahu. I truly enjoyed working in both medical and social services. They complimented each other. I later returned to school. When it was time to be part of the work force again, a navigator position at QMC crossed my path. At first, I wasn't sure it was for me, but I liked that it was something new at QMC which involved working in the hospital and in the community.

Being chosen to carry this *kuleana* is truly a privilege. It is an honor to represent my *kūpuna* and the mission and vision they set forth. That alone is truly something our team holds at the forefront. We, as navigators, are mission-driven and grounded in our *kūpuna*. This *kuleana* allows us to *aloha* our patients at the bedside. It is the first contact we have with them to form a relationship. From there, the journey begins. For the most part, by the time they are discharged, our patients are familiar with us and our program, which makes the transition into the community a comfortable start.

Relationships in the Community

Being with our patients in the community allows us to meet service providers, spend time at community health centers, and learn the services out there for our patients. We also see the barriers that prevent our patients from staying connected, or getting connected to the services they need. Establishing *pono* (good, upright, righteous) relationships and working through barriers that occur during our journey are essential for our patients' well-being.

Self-Care

I am grateful to be part of a team that prioritizes cultural *huaka'i* (excursion), which is something we participate in and gather as at team for once a month. A *huaka'i* is an opportunity for us individually and as a team to focus on cultural grounding. We immerse ourselves in Native Hawaiian history and culture by engaging in a culturally-rich activity together. During this time we spend time with one another in reflection and connect to our ancestors and founders. This practice really focuses us, and allows us to nourish our *na'au* (of the heart or mind), which involves spending time with our *'āina* (land), *kai* (ocean), our founders, our *kūpuna*, and with each other. Although we each find our own way to self-care individually, it is when we are together and reflect on our *kuleana* that I am most certain that I am in the place I am supposed to be.

Advice for New Navigators

Our team is diverse in our personalities and life experiences. When we are working together, it is evident that we always have a common goal to serve our people and our community. For someone new, the first thing that comes to mind is to be humble. To be sure that you present yourself with genuine *aloha* and to listen. Our team is well aware of our purpose and our *kuleana*. Regardless of the attention we receive because of the positive outcomes we are achieving for our patients, we are humble. This purpose and *kuleana* is bigger than us. It's about our *kūpuna* and the foundation they built to *mālama* our people and the people of Hawai'i. It is our *kuleana* to continue this and to carry it forward.

Damien's Story

Aloha my name is Damien Hanakeawe. My background is in Hawaiian Studies and Hawaiian Language. Before becoming a navigator, I worked at the Family Treatment Center, which is the child and adolescent behavioral health unit here at QMC. I was recruited from my role there to help start the Native Hawaiian health navigation team. When the navigator role was proposed to me, I asked for an explanation of a day in the life of a navigator, and was told "we're not really sure." I was offered the opportunity to help build the program from scratch, which was very appealing to me.

One of the more meaningful aspects of my job is applying my cultural knowledge to helping patients heal. There is a very specific way Hawaiians communicate with each other when we first meet. Before even mentioning our name, we talk about our '*ohana*, where we were born, and what part of the island we come from. This is done to see what familial connection we share. Once that has been established, we can continue with pleasantries of stating our name and what we do. Even if we are not related, we have learned so much about each other and feel like family. If our patients feel that we share the same values and beliefs, it is the first step in opening the door to allow us to assist them.[12] Once that connection is made in the hospital, it is very easy for the navigator to reconnect with the patient once they have been discharged to the community.

Because of the cultural trauma that has happened to Hawaiians, a lot of the *kūpuna* (elders) have a difficult time trusting Western institutions, especially when it involves health and healing.[1] For Hawaiians, hospitals are often viewed as places devoid of culture and life, where people come to die, sterile institutions filled with people that don't look like them, or talk like them. All they see are medical staff with an agenda, whether it is taking vitals or checking a pain scale. For us as navigators, in the beginning, it is very important that we skip all that. It is more beneficial that we create a connection that is rooted in our Hawaiian-ness.

For example, recently I was called to assist an elderly Hawaiian woman on one of our units. She was refusing to eat, and requested to speak with someone who was fluent in Hawaiian. Upon arrival, a doctor introduced us, and I immediately began speaking Hawaiian to her. Her eyes glossed over, and I quickly realized that she did not understand anything I was saying. She said, "Baby, my Hawaiian isn't that good, can we talk story in English?" "Of course!" I said. "What were you saying?" she asked. I began telling her of my family from Moloka'i. Then she told me about her family and where they were from. Before we knew it, 45 minutes had gone by. We realized we were not related, but in that short time we knew everything about each other. I looked like her. I spoke like her. I thought like her. We shared an understanding that is very unique and special to this place. She realized that although her hospitalization was very difficult, she could depend on me to treat her like I would treat my own *Tūtu* (grandmother). Once that connection happens, the rest is easy.

Also, in the beginning it is very important that our patients know that we are here to serve them-- not the doctors, or nurses, but them. We want to understand their needs and hopes, and what it means to be healthy in their eyes. Our job is to support them and help that vision come to fruition.

Challenges

During the genesis of our program, we spent a lot time meeting with other organizations in the community in hopes of building alliances to better serve our patients. Unfortunately, we have learned which organizations were good at their work, and which were unreliable. Often we see organizations shut down, or change in the way they function to serve the community. It is important as a team that we stay agile, able to change as the community changes. I'm grateful for my fellow navigators because we can learn from each others' experiences.

Another challenge is trying to assist our patients in a more holistic way. Often our patients suffer from psycho-social detriments that exacerbate their health. For example, one of my patients was constantly being hospitalized for respiratory issues. However, this patient primarily suffered from bouts of depression and often faced conflict within his family. When conflict arose, it would affect his breathing and often lead to hospitalization. I talked with him about the triggers that led to his respiratory failure, and the coping mechanisms he could establish to address those situations.

One of the struggles we face is defining the scope of our practice. If another navigator were to say: "Oh, I went to this homeless encampment and couldn't find my patient, then I walked a mile up the beach hoping to find her," it would not surprise me. That is how we function. Much of what we do goes unseen. Our patients know the dedication we have to them. They know they can call us. To me that is very honorable. It can be hard to know where to draw the line. What are the boundaries for what we do, and how do these boundaries impact the health and well-being of each navigator? These are questions we have not fully answered yet.

Advice for New Navigators

To be a great navigator, you must have a passion to serve the weak and destitute, and to stand and fight for those who cannot fight for themselves. Compassion fatigue is a real thing that affects all of us. However, the greatest lesson I have learned about how to remain compassionate is to constantly root myself in humility. It is not a duty to serve this population; it is a privilege. A bad day in my life is nothing compared to the challenges my patients face daily. That, coupled with the *kuleana* I was taught to serve my *kūpuna*, enables me to serve unconditionally. Patients know the difference between people who help them because it is their job and people who serve them because theys care.

For example, I have one patient who becomes tearful and is constantly apologetic because he vents all his frustrations to me. But I remind the patient that it is okay. That is why I am here and I am not going anywhere. I am willing to carry the burden so his family or doctor does not have to. I tell him "You're stuck with me!" It is much better that I take the brunt of his frustration, verses a caregiver refusing to see him because then they would see him as having a bad attitude.

Minky's Story

My name is Jonna "Minky" Ho'opai. I was working for The Queen's Health Systems for some time, both at Punchbowl and on Moloka'i, but I was looking for my purpose in the organization. I had not found my niche. I knew I wanted to be a servant, but I just did not know in what area. So one day I was looking in human resources and I saw a position as a patient navigator, and the term kind of struck me. Everyone is a navigator in their own way, but we need to identify how we can apply our abilities and skills to serve others. I thought "this is a great program," especially when it stated that we would be serving our Native Hawaiian population.

Most people think navigation is simply about showing others where to go, because the definition of navigation is "wayfinding." In Polynesian navigation or wayfinding, you know your destination, you know your route, and you know how to navigate using the elements around you.[11] In patient navigation, we take the time to listen to our patients and to their *'ohana*. The majority of my patients become my family. When I go to appointments, my patient tells the physician, "This is my niece." It is heart-warming.

When I look at the modern Western medical practice, I realize that healthcare has changed dramatically from when I was a little child. The doctor rarely takes time to ask, "How's life? What can we do to help you?" Visits are often about typing on a computer in the electronic medical record instead of engaging. There is a disconnect between the physician and the patient which causes detriment.[13] As a navigator, I can be the buffer and interpret what the physician is saying to my patient in their language so they understand. I say, "Uncle you have cellulitis." But uncle doesn't know what cellulitis is. So I say, "Uncle you have a *puka* (hole, opening, issue) on your leg. Take this antibiotic to help you. Take care of it by wrapping it and keep it elevated." Then he understands. I reinforce this understanding through weekly engagement, "Uncle, how you doing? How's the leg swelling? Did you elevate it?"

For example, I attended an appointment with a patient and he graduated from his treatment at the wound clinic. He was elated when he got his certificate of care completion. He was even more proud that I pushed him and said, "You can do this. You can care for yourself." As navigators, we don't take the role of a parent, sibling, or family member to do the tasks for our patients. Instead, we give them the tools and encourage their ability to do it for themselves. It is their responsibility to care for themselves. I am here as a support system to advocate when needed. I truly feel that this is my purpose. I was put on earth to be a navigator.

Connecting with Patients

When I meet my patients at the physician's office, I ask the patient to meet me 10 to 15 minutes early so we can connect prior to going in. I want to know: How did they get there? Are they feeling all right? Often, we walk into a physician's office and the patient gets their vitals done and their blood pressure is sky rocketing because they are nervous about the visit. They are wondering: "What am I going to hear today? Is it bad or good news?" So, before the visit, I take time with the patient. We joke around and talk story. I usually start with: "How's the weather today? Did you eat?" It is vital to take the time to put the person at ease, to reassure them it is okay and focus on the human connection. Then I sit with them when they talk to the doctor. The doctor is speaking directly to the patient. As navigators, we try not to interrupt. It is the physician's time. We listen. It is funny because often my patients will continuously look up at me, looking for that reassurance, with a question on their face of: "Is that right or is that okay?"

How to Empower Patients

One of the things that I do when I am meeting with my patients at bedside is bring an intake form and a goal sheet, with short term goals for their hospital stay as well as goals post-discharge. It is important to identify attainable goals. I want patients to feel they have accomplished meaningful goals within the 30 days. This could be a goal like obtaining a birth certificate or an ID. We also agree on a long-term goal, such as housing or reconnecting with family. The long-term is goal needs to be something important to them because I want them to keep striving and pushing to achieve it.

One example is a gentleman who was admitted for sepsis and had a history of leg amputations. He had been homeless, living on the street in his wheelchair for many years. His inpatient goal was to complete taking his antibiotics as prescribed and to work with providers to get stronger and be discharged. His short term goal was to reapply for food stamp benefits which he previously lost. We filled out the necessary applications and submitted it so by the time he was discharged he could get his benefits reinstated. His long term goal was to obtain housing because living in a wheelchair for so many years was difficult. Planning carefully for his housing goal was important in order to ensure that if he obtained housing, he could keep it. It is expensive to live here in Hawai'i, and a new responsibility can be terrifying. I advocated for him to receive prioritization due to his medical conditions and he was awarded a housing voucher. He was able to move into a unit with extremely affordable rent.

Later, I provided budget counseling so he could see his own income versus expenses. We worked together and he learned to manage household tasks. I taught him how to address an envelope in order to mail his rent. We practiced together, including where to put the stamp. He had not done any type of paperwork in over 5 years and prior to that his spouse (now deceased) would typically do it. By the second month, he was able to do it on his own. He called me late one evening to tell me, "I can do it by myself, pay my rent on time by myself." Sharing moments like these with our patients, witnessing their success, is a major reward for us as navigators, like winning the lottery.

Advice for New Navigators

When I was a child, I remember strong community support. When a neighbor fell ill, other neighbors would come over with meals. They would offer rides and say, "Auntie, you gotta go doctors. I'll take you." How do we build our communities back up again? It is important to let people know that they are not alone in this journey and others are here to help. When people feel alone, it's harder for them to heal. Sometimes we have to sit back and really look at the bigger problem. Often, we're so consumed with finding an answer that we really don't look at all the options first. Part of this job is to take a step back and try to see the whole person and the complexity of their situation. A physician can walk into a patient's room, and say, "This patient has congestive heart failure. Let's refer them to a specialist. Let's order his medication. Let's treat it this way." But it is important to ask: What's causing it? Is it substance abuse? Is it a poor diet? Is it stress from work? Is it family strain? All of these things may contribute to illness. Often physicians or clinical staff are in a rush and do not make the time to talk story, or understand the bigger picture. We don't have enough of the human connection. If we did we would see the benefit from that holistic care and we would see patients doing well and not coming back to the doctor so often.

Discussion

Our KKN program offers relevant, culturally-sensitive care meeting a complex, personalized array of needs for 338 patients in just over one year. During this time, we have been there to support many of our patients on their personal journey. We have ridden the bus side-by-side. We have waited all day in line for documents with our patients. We have attended countless appointments and spent hours on the phone obtaining medications, supplies, or scheduling transportation. We partner with the community to support our patients' journeys and meet service providers to advocate for second chances. We have mowed lawns and helped with personal care when no one else was there. We have driven miles to pick up medications and visit our patients regularly at homeless encampments. We have been a shoulder to cry on and carried their burdens so our patients can focus on healing. The reward is seeing our patients transform in self-confidence, circumstances, and health. We have seen lives touched and families reconnected. We have been there to help our patients move into homes with a warm bed after having spent years of living on street without safety or security. It has been our privilege to share these experiences with you in order to illustrate our dedication to our *kuleana* to *mālama* our people and to build a strong foundation of health and wellness for our community.

Practical Implications

From our collective experiences as navigators we share insights and recommendations that we feel are important to serve this population with respect and compassion.

1. We are ʻOhana, connected. Therefore, we must empower each other.
2. "Aloha with open arms." This is imperative in gaining trust and nurturing those (regardless of race) who need unconditional support in their healing journey.
3. See the whole person and the complexity of their situation in order to build a foundation (*hoʻokahua*) for our community.

4. Remember to incorporate the value of “*kōkua*” and “*mālama* community,” values we grew up with.
5. Have a passion and compassion for the weak and destitute. Fight for those who cannot fight for themselves —it is the way of Queen Emma.
6. Be humble (*ha‘aha‘a*). A great lesson is to root the self in humility and remember this service is not a duty, it is a privilege, which enables us to serve unconditionally.
7. Support and *mālama* each other in the work we do.
8. Be genuine with patients. Listen.
9. Our Hawaiian values—*aloha*, *kuleana*, *mālama*, *ha‘aha‘a*, and *pono* shape and support how we serve our people.
10. The *kuleana* we have is a privilege, the driving force, given to us by our *kūpuna*, based on the foundation they build to *mālama* our people. It is not about us. It is about our patients.

Our belief system tells us that in order to improve the health and wellbeing of Native Hawaiians and promote healing in our community we must *mālama* the body, the mind, and the spirit.[1-2] Often we find that medical care is siloed and system barriers create obstacles for patients’ healing. It is crucial that holistic and culturally-sensitive models are developed to support patients.[8] At QMC, we have a saying “Living the Queen Emma Way.” It means to live with *aloha* and to apply this loving kindness in an genuine, humble, non-judgmental, and supportive way with each other and with patients. Our Queen illustrated *aloha* when she stated, “We, on our parts, must not forget to show…loving kindness, in all ways.”[4] We follow her footsteps and visit each patient at the bedside with the intention of forming a genuine and meaningful relationship, in the way Queen Emma visited patients in the hospital when she was alive. It is with *aloha* that we are effective in assisting vulnerable, disenfranchised patients with tasks that seem insurmountable like obtaining financial assistance, legal documents, or housing.[10,13] These services address the underlying social determinants of health that create barriers to healing. In this way we heal our ecosystem.

The culturally-based and patient-centered approaches we have discussed allow us to help our patients navigate through a complex health care system to achieve our mission to support Native Hawaiians in a safe transition from hospital to home, to address basic needs, to connect with supports, to increase long-term sustainability, and to improve patient quality of life. This approach also contributes to achieving positive outcomes that are particularly important to health care systems, such as reduced 30 day readmissions.

Conflict of Interest

None of the authors identify a conflict of interest.

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