



University of Hawai'i
Office of Research Services
PILI `Ohana Project
Evaluation Report
October 2014



EXECUTIVE SUMMARY

Contents

Executive Summary	2
Program history	4
Program goals	8
Program budget	9
Purpose of evaluation	10
Scope of evaluation	10
Methodology	10
Data collection and analysis	11
Results	11
Findings	14
Impact on beneficiaries	15
Recommendations	16
References	17
Appendices	18

Project summary

Partnerships to Improve Lifestyle Interventions (PILI) `Ohana is a coalition formed in 2005 to eliminate obesity disparities in Hawai`i. It was founded by the (1) Department of Native Hawaiian Health at the John A. Burns School of Medicine, (2) Ke Ola Mamo Native Hawaiian Healthcare Systems, (3) Kula no Na Po`e Hawai`i of the Papakolea, Kewalo, and Kalawahine Homesteads, (4) Hawai`i Maoli of the Association of Hawaiian Civic Clubs, and (5) Kokua Kalihi Valley Family Comprehensive Services. The following additional partners are included in being mentored to assist in the implementation of the Program: (1) Na Pu`uwai Native Hawaiian Healthcare System, (2) the Moloka`i Community Health center, (3) Wai`anae Valley Hawaiian Homestead Community Association, (4) Kuini Pi`olani Hawaiian Civic Club, and (5) North Hawai`i Medical Group Native Hawaiian Health Clinic.

The PILI `Ohana Project's purpose is to provide effective community-based interventions aimed at eliminating obesity in Native Hawaiians to reduce their risk for diabetes, hypertension, hyperlipidemia, sleep apnea, heart disease, and certain cancers. The Program targeted 400 overweight/obese ($BMI \geq 25$) Native Hawaiians in a nine-month culturally-relevant lifestyle intervention focusing on community and family. Program activities include face-to-face group sessions, community capacity building, and developing a sustainability and dissemination plan.

Purpose of the evaluation

The purpose of this summative evaluation is to (1) determine if the Program helped to address the OHA strategic result of reducing chronic disease rates by reducing obesity, (2) determine the cause for three budget revisions, and (3) identify findings and provide recommendations that may be useful in implementing future contracts of this Program or in other programs that target obesity. Furthermore, this evaluation will assist the Grants Division and the Grantee in making decisions regarding the continuation, development, and implementation of this Program.



Findings

Programmatically, the Provider reported that the goal of having 60% of participants achieve a weight loss of 3% or above was “an ambitious goal from the outset” due to more than half of the Program sites implementing this service for the first time. This was the only measure they did not achieve.

Administratively, the Program’s budget was amended three times, due to the changing of community partners and their respective budgets. Some of the community partners did not have the financial infrastructure in place to manage their share of the funds, and therefore became the responsibility of the University, to the mentoring organization, or to a separate organization designated as the fiscal manager. The extension of the Time of Performance was necessary to allow the Maui-based community partner time to establish itself and service enough participants.

Phase 1 of the Program shows the greatest progress with a decline in Phase 2. Ultimately, the results were positive and showed that outcomes based on the measures of BMI reduction, weight reduction, improved physical functioning, blood pressure control, increased physical activity levels, and improved eating habits were achieved. Based on the program model, it can be presumed that the decline is due to the reduced frequency in face-to-face group sessions held.

The Provider reported that one community partner is continuing to offer classes using other funding sources while another is pursuing the resources to continue offering classes. This shows that the participants and community partners have had a positive experience with the Program and that the partners have confidence in their facilitation and program management abilities.

Recommendations

1. Consider adding more face-to-face sessions to the activities of Phase 2 to help maintain the results seen at the end of Phase 1.
2. Consider placing more weight on the other quantitative output and outcome indicators (i.e. blood pressure, healthy eating, and BMI) versus focusing primarily on a 3% weight loss.
3. For future grants where the Grantee will use community partners to provide services sub-contractually, encourage the Grantee to ensure that each partner has a stable financial management plan in place to properly handle the funds.
4. In future obesity and/or weight management programs, define how individual performance measurement outcomes (i.e. improved physical functioning, improved eating habits) will be measured. This will provide a definitive quantitative measurement used to measure the qualitative outcome.



COUNCIL FOR NATIVE HAWAIIAN ADVANCEMENT PILI `OHANA PROGRAM EVALUATION

INTRODUCTION

Program history

Partnerships to Improve Lifestyle Interventions (PILI) `Ohana is a coalition formed in 2005 to eliminate obesity disparities in Hawai`i. It was founded by the following four community organizations and the Department of Native Hawaiian Health at the John A. Burns School of Medicine: (1) Ke Ola Mamo Native Hawaiian Healthcare Systems, (2) Kula no Na Po`e Hawai`i of the Papakolea, Kewalo, and Kalawahine Homesteads, (3) Hawai`i Maoli of the Association of Hawaiian Civic Clubs, and (4) Kokua Kalihi Valley Family Comprehensive Services. In the program proposal, the following additional partners are included as those assisting in the implementation of the Program: (1) Na Pu`uwai Native Hawaiian healthcare System (Moloka`i), (2) the Moloka`i Community Health center, (3) Wai`anae Valley Hawaiian Homestead Community Association (O`ahu), (4) Kui-ni Pi`olani Hawaiian Civic Club (Maui), and (5) North Hawai`i Medical Group Native Hawaiian Health Clinic (Waimea).

The PILI `Ohana Project's purpose is to provide effective community-based interventions aimed at eliminating obesity in Native Hawaiians to reduce their risk for diabetes, hypertension, hyperlipidemia, sleep apnea, heart disease, and certain cancers.

Program Partners. Of the nine partners, four of them- including the John A. Burns School of Medicine's Department of Native Hawaiian Health- were founding partners. Five additional partners were included to assist in the implementation of the Program.

Founding partners

- The Department of Native Hawaiian Health (DNHH) of the John A. Burns School of Medicine of the University of Hawai`i is the academic partner of the Program. In addition to being the fiscal sponsor, the role of DNHH is to (1) provide overall leadership and coordination to the partnering community organizations on all islands and their activities, and (2) provide needed technical/professional assistance in delivering and evaluating the intervention and other activities.



Founding partners (continued)

- Hawai'i Maoli – The Association of Hawaiian Civic Clubs (HM-AHCC) is a private non-profit organization made up of a confederation of 51 clubs with a collective membership of 2,400 people. This organization's role is to (1) mentor the new community partner, Kuini Pi'olani Hawaiian Civic Club on Maui by providing training and consultation in building capacity to deliver the intervention, and (2) to deliver the intervention to their Native Hawaiian membership.
- Kula no na Po'e Hawai'i (KNNPH) is a non-profit group formed by a group of concerned community women to help improve the educational skills of area children, but has since moved into the area of health. They serve members of the Hawaiian Homestead communities of Pāpakōlea, Kewalo, and Kalawahine. This organization's role is to (1) mentor the new community partner, Waianae Valley Hawaiian Homestead Community Association to include training and consultation in building capacity to deliver the intervention, and (2) to deliver to Native Hawaiians of their homestead and surrounding communities.
- Ke Ola Mamo (KOM) is a private, non-profit Native Hawaiian Health Care System for the Island of O'ahu. They provide services to primarily low income Native Hawaiians and among their services are community outreach, transportation assistance, health education and prevention/wellness programs. Ke Ola Mamo's role is to (1) mentor the new community partner, North Hawai'i Medical Group Native Hawaiian Health Clinic to include training and consultation in building capacity to deliver the intervention, and (2) to deliver the intervention to their Native Hawaiian clients.
- Kokua Kalihi Valley Comprehensive Family Services (KKV) is a community owned and operated non-profit corporation formed in 1972 by community and church leaders with social service representatives to address the lack of adequate and accessible health services in their community. Health services are provided to a primarily Pacific Islander and immigrant Asian population includes a wide range of services including dental, medical, women's health, mental health, nutrition education and community outreach and advocacy. The role of KKV will be to (1) mentor the new community partners, Na Pu'uwai Native Hawaiians Healthcare System and the Molokai'i Community Health Center and the Moloka'i Community Health Center to include training and consultation in building capacity to deliver the intervention, and (2) to deliver the intervention to their Native Hawaiian clients and to Native Hawaiians living in the Kalihi/Honolulu area.



New partners

- Waianae Valley Homestead Community Association, Inc. is comprised of 425 leased homesteads with an average of approximately six individuals per home for a total of over 2,500 potential beneficiaries of DHHL leased properties. Their role will be to (1) receive mentoring/training by KNNPH in building capacity to deliver the intervention, and (2) deliver the intervention to their homestead community.
- North Hawai'i Native Hawaiian Health Clinic was founded by the North Hawai'i Community Hospital to improve the health status of Native Hawaiians by (1) providing high quality and culturally appropriate medical and behavioral health services for all native Hawaiians, and (2) identifying Native Hawaiian health disparities particular to North Hawai'i and to clearly formulate a plan of action with the goal of addressing those health disparities. Their role will be to (1) receive mentoring/training from KOM in building capacity to deliver the intervention, and (2) to deliver the intervention to their Native Hawaiian patients and to other Native Hawaiians living in the North Hawai'i area.
- Na Pu'uwai is a community-based, non-profit Native Hawaiian Healthcare System on the island of Moloka'i (also serving Lāna'i) dedicated to the betterment of the health conditions of Native Hawaiians. It was founded as an advisory committee to the Moloka'i Heart Study in collaboration with the University of Hawai'i, the World Health Organization, and OHA. Their role will be to (1) receive mentoring/training by KKV in building capacity to deliver the intervention, and (2) to deliver the intervention to their Native Hawaiian clients and residents on Moloka'i in collaboration with Moloka'i Community Health Center.
- Moloka'i Community Health Center (MCHC) is the only federally-qualified health center on Moloka'i dedicated to providing and promoting accessible comprehensive individual and community health care to the people of Moloka'i. MCHC was created by community volunteers and concerned residents in response to the unmet needs for expanded primary health care services on the island. They deliver primary care, behavioral health, dental services, and enabling services that addresses acute and chronic disease conditions confronting Moloka'i communities, including obesity, diabetes, cardiovascular disease and asthma. Their role will be to (1) receive mentoring/training by KKV in building capacity to deliver the intervention, and (2) to deliver the intervention to their Native Hawaiian clients and residents on Moloka'i in collaboration with Moloka'i Community Health Center.



New partners (continued)

- Kuini Piʻolani Hawaiian Civic Club is a member of the Association of Hawaiian Civic Clubs, Maui Council. As part of their mission, they support the establishment and perpetuation of the Hawaiian language and cultural practices. Their role will be to (1) receive mentoring/training by HM-AHCC in building capacity to deliver the intervention, and (2) to deliver the intervention to their Native Hawaiian membership.

Program activities. The Program targeted 400 overweight/obese (BMI \geq 25) Native Hawaiians and their families served by the nine partnering organizations. Program participants received a nine-month culturally-relevant lifestyle intervention, which focused on community and family, and is delivered and evaluated by community peer educators. Effectiveness is measured and evaluated in reducing weight/BMI and blood pressure and improving physical functioning.

The Program was implemented in four overlapping activities over the two-year contract period:

- The first activity- the Obesity Intervention Delivery- is done in two phases. The first phase involves eight face-to-face group sessions delivered over three months. These sessions focus on behavioral strategies for healthy eating, physical activity, and the management of stress, negative emotion, and time. The second phase involved an additional six months of a weight loss maintenance intervention by expanding on the strategies from phase one by including family/friends and community resources into the participants' healthy lifestyle goals.
- The second activity runs concurrently with the first activity. In the first year, the four founding partners assisted the five new partners in building capacity to deliver the Program by providing training in the Program, facilitation, behavioral reinforcement, and evaluation. In the second year, the five new partners delivered and evaluate the interventions with the guidance and support of the original four partners.
- The third activity is a community assessment conducted by the five new partners in the first year, with assistance from the four original partners. The purpose of this activity is to prepare the five new partners for the first activity. Here, they will identify and evaluate their community resources to support the Program's activities.
- The fourth activity is to develop a sustainability and dissemination plan aimed to reduce obesity disparities in Native Hawaiians. Based on the lessons learned from the Program, the faculty of the Department of Native Hawaiian Health will conduct a series of meetings to identify the strengths and challenges of offering the Program after completion of the OHA funding period. A dissemination plan will also be derived that will identify the means by which the Program can be implemented to other Native Hawaiian communities.



Relevance to OHA's Strategic Plan. OHA's strategic priority of Maui Ola (Health)- to improve the quality and longevity of life, Native Hawaiians will enjoy healthy lifestyles and experience reduced onset of chronic diseases- is address in the course of this program. By the Program targeting obesity, the risk for diabetes, heart disease, diabetes, sleep apnea, and certain types of cancer in Native Hawaiians can be reduced. For those already afflicted, the loss of excessive weight may help to better manage their illness and reduce any possible complications.

Hamman et al. (2006) found that for every 5% reduction in percent fat, diabetes incidence was reduced by 25%. Therefore, the main outcome that will be evaluated by the Program is the number of overweight/obese Native Hawaiians who reduce their weight by 3% or more and who achieve improvements in their blood pressure and physical functioning.

Program goals

The ultimate goal of this Program is to provide an effective community-based intervention aimed at eliminating obesity in Native Hawaiians by building capacity among Native Hawaiian communities. The Program has been implemented with the following qualitative and quantitative goals as outlined in *Appendix A. MFR Model*:

- 60% of overweight/obese Native Hawaiians who lose 3% or greater of their baseline weight within 9-months of starting the PILI `Ohana program.
- 100% of community organizations within the PILI `Ohana network serving Native Hawaiians that has the capacity to deliver an effective culturally-relevant obesity intervention.
- Delivery of the PILI `Ohana Program to 75% of 400 Native Hawaiians across 9 community organizations on 4 islands.
- Building community capacity to deliver and sustain an effective culturally-informed and community-based intervention to address obesity in Native Hawaiians in 5 new community organizations.
- Conduct assessments of community assets/needs in addressing obesity in the communities served by the 5 new PILI `Ohana community partners.
- Develop a dissemination and sustainability plan to address obesity in Native Hawaiian communities.

After the contract had been executed, the MFR Model format was no longer used by OHA, therefore the Provider submitted a Performance Measures and Outcomes table that includes some of the goals from the original MFR Model. The table is attached to this evaluation as *Appendix B. Performance Measures and Outcomes*.



Program budget

The following contract budget information has been taken from the original contract. The total contract funding awarded by OHA was \$500,000 over a two year period. The budget was amended three times after the original contract was executed. Table 1 below reflects the total operating costs as outlined in the third and final budget amendment which was executed on October 29, 2013.

Table 1. Final total operating costs per fiscal year

	Fiscal Year	
	2012	2013
Operating costs		
Personnel Costs	\$145,264	\$101,999
Other Personnel Costs	\$6,526	\$6,447
Other Expenses	\$96,810	\$139,129
Equipment	\$2,400	\$2,425
Total	\$250,000	\$250,000

Table 2 below outlines the contract operating costs taken from the original budget, the first budget amendment, and the second budget amendment. The original budget was approved with the contract on February 21, 2012. The first budget amendment was approved on May 25, 2012. And the second budget amendment was approved on June 5, 2013. In each of these cases, the total contract budget over the two year period was \$500,000.

Table 2. Total original and amended operating costs

	Original Budget		1 st Amendment		2 nd Amendment	
	FY12	FY13	FY12	FY13	FY12	FY13
Personnel Costs	\$111,450	\$119,804	\$138,710	\$119,804	\$145,264	\$106,590
Other Personnel Costs	\$10,240	\$12,186	\$20,362	\$12,186	\$6,526	\$6,447
Other Expenses	\$125,010	\$118,010	\$87,328	\$118,010	\$96,810	\$134,138
Equipment	\$3,300	\$0	\$3,600	\$0	\$1,400	\$2,825
Total OHA Funds Awarded	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000



Purpose of the evaluation

The purpose of this evaluation is to (1) determine if the Program helped to address the OHA strategic result of reducing chronic disease rates by reducing obesity, (2) determine if three budget revisions to the contract were necessary, (3) determine if an extension to the contract's Time of Performance was necessary, and (4) identify findings and provide recommendations that may be useful in implementing future contracts of this Program or in other contracts that target obesity.

Scope of evaluation

This is a summative evaluation of the Pili `Ohana Project. This evaluation will assist the Grants Division and the Grantee in making decisions regarding the continuation, future development, and implementation of this Program. This evaluation concentrates on the program planning and implementation, and achievement of the quantitative measures in the time period between February 1, 2012 and June 30, 2014.

METHODOLOGY

The evaluation integrates both quantitative and qualitative information derived from documents such as the grant contract, progress reports, closeout report, and the contract budget. The program activities and goals were stipulated in various areas of the contract including the scope of services and in the grant proposal.

The information used in this evaluation was collected in a quantitative and qualitative form and the information was organized into sections in the grant folder. The documents that made up the contract packet included the original contract; program budget and amendments; proposal narrative; organization chart; funding award/commitment letters confirming matching support; commitment/support letters from partnering community organizations; resumes of key personnel and community partner leaders; Bylaws of the University of Hawai`i; list of the Board of Regents; consolidated financial statements; IRS Letter of Determination; project budget and funding information forms; quarterly progress reports; the final grant closeout report; and the Community Assessment Report submitted by the Provider.

Quarterly progress reports narratively identified key activities, issues or challenges impacting project implementation, budget expenditures, progress in achieving the goals of the program, and the accumulated successes of the program.



Data collection and analysis

A quantitative data analysis of the data submitted in both the *MFR Model* and the *Performance Measures and Outcomes* table was done by comparing the data submitted to the desired results as previously specified. Once the results were identified Phase 1 results were compared against Phase 2 results. A qualitative data analysis was done by reviewing the narrative responses from the Provider and the Grant Monitor in the progress reports and monitoring report and using that information to identify information relating to the implementation and management of the program that were not indicated in the quantitative results.

RESULTS

In general, program efforts resulted in a reduction of an average BMI of 1.11 points and an average weight loss of 4.45 lbs. Other program documentation suggests communities were successful by including other activities and events.

Program results were reported by the Provider and received by the Grant Monitor. Table 3 exhibits the program results as stated in MFR Model in the “results” and “services” sections of the Model. Table 4 exhibits the cumulative program results for Native Hawaiian participants through the contract period as outlined in the *Performance and Outcome Measurements Table*.

Table 3. MFR Model program results

Measure	Goal	Actual	Percent
Number of overweight/obese Native Hawaiians who lose 3% or greater of their baseline weight within 9-months of starting the PILI `Ohana Program.	240	119	49.5%
Number of community organizations within the PILI `Ohana network serving Native Hawaiians that have the capacity to deliver an effective culturally-relevant obesity intervention	10	10	100%
Delivery of the PILI `Ohana Program to 400 Native Hawaiians across 9 community organizations on 4 islands.	400	417	104.2%
Building community capacity to deliver and sustain an effective culturally-informed and community-based intervention to address obesity in Native Hawaiians in 5 new community organizations.	5	5	100%
Conduct assessments of community assets/needs in addressing obesity in the communities served by the 5 new PILI `Ohana community partners.	5	5	100%
Develop a dissemination and sustainability plan to address obesity in Native Hawaiian communities.	1	1	100%



Table 4. Performance and outcomes measurements

Performance Measures/Outcome Indicators	Total Metric and/or Participants
1. Program Intake	
Total number of Native Hawaiians enrolled in the program	417
Total number of participants who completed an Individualized Service Plan	417
Average weight at intake	105.41 kg / 232.39 lb
Average BMI at intake	38.17
Estimated dietary fat intake at >30% of total calories	2.82 / 331
2. Phase 1 (post treatment module completion)	
Number of participants who achieved reduction in BMI	237
Average BMI after Phase 1	37.13
Average weight loss after Phase 1	-1.77 kg / 3.9 lb
Number of participants who achieved improved physical functioning	242
Number of participants who achieved improved blood pressure control	263
Number of participants who reported increased physical activity levels	210
Number of participants who reported improved eating habits	259
Estimated dietary fat intake at >30% of total calories	2.62 / 226
Number of participants who completed Phase 1	358
3. Phase 2 (post support group completion)	
Number of participants who achieved reduction in BMI	202
Number of participants who maintained reduction in BMI	157
Average BMI	37.06
Number of participants who achieved reduction in weight	204
Number of participants who achieved reduction in weight by 3% or greater	119
Average weight loss after Phase 2	-2.02 kg / 4.45 lb
Number of participants who achieved improved physical functioning	217
Number of participants who maintained improved physical functioning	85
Number of participants who achieved improved blood pressure control	218
Number of participants who maintained blood pressure control	141
Number of participants who reported increased physical activity levels	161



Table 4. Performance and outcomes measurements (continued)

Performance Measures/Outcome Indicators	Total Metric and/or Participants
Number of participants who maintained increased physical activity levels	82
Number of participants who reported improved eating habits	198
Number of participants who maintained improved eating habits	96
Estimated dietary fat intake at >30% of total calories	2.65 / 179
Number of participants who completed Phase 2	307
Number of new community partners who delivered program intervention	5

A qualitative analysis of program documents suggest that over the course of the contract period, all of the community partners who make up this Program had achieved successes in their respective communities by incorporating other non-prescribed activities or enhancement methods. They have also conducted a community assessment, which will be discussed further. Examples of these additional activities or enhancement methods include the following:

- Community partners finding opportunities to join activities with other health promotion programs and organizations in their respective communities.
- Combine the PILI `Ohana Program with Ho`oikaika exercise programs.
- Taking groups of participants to farmers markets and planning workdays at a lo`i.
- Using Facebook to connect participants and share information about supporting healthy lifestyles.
- Abstract submission to the International Symposium on Minority Health and Health Disparities to take place in December 2014.

Community assessment. One of the first year activities conducted was a community assessment. The original intent for the assessment was to ask the new partners to conduct the assessments as a preparatory step for implementing the Program. The assessments examine two aspects of the community: (1) the availability, accessibility, safety and utility of resources in their community that promote healthy lifestyles, and (2) the community's readiness to address the problem of overweight and obesity. The questions asked in the community readiness survey focused on community concern or climate surrounding the issue of overweight/obesity, community knowledge of overweight/obesity, leadership support for addressing overweight/obesity, resources related to obesity prevention and the influence of stress on efforts to prevent overweight/obesity.



The Community Assessment questionnaire was adapted from the “Neighborhood Assessment” tool developed as part of the “Community Healthy Living Index”, a program of the YWCA’s Healthy Living Initiative. The questionnaire had five sections in addition to general questions regarding the parameters and population of the community. The sections were focused on: (1) community design, (2) physical environment related to physical activity, (3) physical environment related to food and nutrition, (4) safety, and (5) collaborative capacity/community engagement.

Results of the survey showed that Pana`ewa/Keaukaha Homestead communities differed significantly from other community types in terms of their overall readiness and specifically in the level of perceived community support for healthy eating, physical activity and resources to promote and support healthy lifestyles. This lower level of community resources was confirmed by the community assessment which showed low scores in the areas of physical environment related to nutrition and physical environment related to physical activity”.

FINDINGS

After reviewing the program results and the information reported in the quarterly reports and in the monitor’s report, the Provider reported some issues that presented challenges in the implementation and management of the Program and discussed the causes and what resulted from those issues.

Programmatically, the only area of concern identified by the Provider was that the goal of having 60% of participants achieving a weight loss of 3% or more of their initial weight- instead 41% of participants achieved this level of weight loss. The Provider stated that this goal was “an ambitious goal from the outset” due to more than half of the Program sites implementing this service for the first time.

Administratively, the program has amended the Program budget three times. The first budget amendment was due to a change in community partners on Hawai`i Island. The second and third amendments were due to the Program partners making changes to their budgets. The original four partners had planned to administer the program funds for the new community partners as part of the role of being mentors for the new partners. However, some of the partners did not have the necessary financial management infrastructure, if at all, and therefore were unable to directly accept the funds. Budget amendments were then made so that the management of funds became the responsibility of the University, to the mentoring organization, or to a separate organization which was designated the fiscal manager of the project. The contract extension of the Time of Performance was necessary because it allowed the Program enough time to ensure that the Maui-based partners had the time to establish itself and service enough program



participants.

While the overall results of the program show progress in achieving outcomes, Phase 1 shows the greatest progress with a decline in Phase 2. Ultimately, the results are still positive. By reviewing the program model, activities, and results, it can be presumed that the decrease in results at Phase 2 is due to having one face-to-face group session per month for six months compared to the eight sessions in Phase 1, which were once a week for the first month then every other week for the remaining two months.

IMPACT ON HAWAIIAN BENEFICIARIES

As stated in the above findings, the program succeeded in promoting healthy outcomes based on the measures of BMI reduction, weight reduction, improved physical functioning, blood pressure control, increased physical activity levels, and improved eating habits. Additional outcomes appeared in the Phase 2 section of the results focused on the achievement of the outcomes as well as the maintenance of those achievements. By including the maintenance measures, the results were able to show that a prolonged positive effect did exist for those participants who were accounted for in those individual results.

The Provider also reported that at least one of the five new community partners is continuing the Program and will be offering classes again using other funding sources while another partner is pursuing the resources to continue offering the classes. Both sites are Native Hawaiian Homestead communities. This development infers that the participants and community partners had a positive experience working with the Program and that the partners have confidence in their facilitation and program management skills that they've gained.



RECOMMENDATIONS

1. Consider adding more face-to-face sessions to the activities of Phase 2 to help maintain the results seen at the end of Phase 1.
2. Consider placing more weight on the other quantitative output and outcome indicators (i.e. blood pressure, healthy eating, and BMI) versus focusing primarily on a 3% weight loss.
3. For future grants where the Grantee will use community partners to provide services sub-contractually, encourage the Grantee to ensure that each partner has a stable financial management plan in place to properly handle the funds.
4. In future obesity and/or weight management programs, define how individual performance measurement outcomes (i.e. improved physical functioning, improved eating habits) will be measured. This will provide a definitive quantitative measurement used to measure the qualitative outcome.



REFERENCE

Hamman, R., Wing, R., Edelstein, S., Lachin, J., Bray, G., Delahanty, L., ... Wylie-Rosett, J. (2006).
Effect of Weight Loss With Lifestyle Intervention on Risk of Diabetes. *Diabetes Care*,
29(9), 2102-2107.



APPENDICES



APPENDIX A MFR Model

APPENDIX A. MFR MODEL

V. Evaluation

Exhibit C-1 - MFR Model for PILI 'Ohana OHA COMMUNITY PARTNERS PROGRAM FISCAL YEAR 2012

CUSTOMER: Who within the Native Hawaiian Community are we focused on helping?	
All overweight/obese (BMI > or = 25) adult Native Hawaiians and their family who are clients and/or residents served by the 9 community partners of the PILI 'Ohana partnership.	
RESULTS: What impact or result are we trying to create for this customer group?	
Result	Measure
Number of overweight/obese Native Hawaiians who lose 3% or greater of their baseline weight within 9-months of starting the PILI 'Ohana Program.	60%
Number of community organizations within in the PILI 'Ohana network serving Native Hawaiians that have the capacity to deliver an effective culturally-relevant obesity intervention.	100%
SERVICES: What type and level of services will it take to create this experience or result?	
Services	Measure
Delivery of the PILI 'Ohana Program (a 9-month lifestyle intervention) to 400 Native Hawaiians across 9 community organizations on 4 islands.	75%
Building community capacity to deliver and sustain an effective culturally-informed and community-based intervention (the PILI 'Ohana Program) to address obesity in Native Hawaiians in 5 new community organizations.	100%
Conduct assessments of community assets/needs in addressing obesity in the communities served by the 5 new PILI 'Ohana community partners.	100%
Develop a dissemination and sustainability plan to address obesity in Native Hawaiian communities.	1
DEMAND: What is the demand for this service?	
Demand	Measure
Overweight/obese Native Hawaiians wanting to control their weight to either avoid acquiring a chronic disease or to better manage a chronic disease.	400
Community organizations wanting to address the health of Native Hawaiian residents/clients in their community.	9
COST: What will these services at the service level desired cost to deliver the desired result?	
Total project cost is \$694,270 over 2 years (Year 1=\$352,045; Year \$342,225). Requesting \$447,180 over two years (Year 1=\$228,500; Year 2=\$218,680) from OHA.	



APPENDIX B

Performance Measures and Outcomes Table

APPENDIX B. PERFORMANCE MEASURES AND OUTCOMES
Priority Area: Health

OHA's Strategic Result: Decrease Chronic Disease Rates

Native Hawaiian chronic disease rates will be equal to or less than the general population of Hawai'i for each of the following: cardiovascular disease, obesity, diabetes, asthma, and cancer.

Grant Awardee: University of Hawaii – Partnerships to Improve Lifestyle Interventions (PILI)

Project Name: PILI Ohana Program

Performance Measures/Outcome Indicators	FY 2012	FY 2013
1) Program Intake		
Number of participants enrolled in program	300	300
Number of Native Hawaiians enrolled in program		
Number of participants who completed an individualized action plan	250	250
Average weight at intake		
Estimated dietary fat intake		
Average BMI		
2) Phase 1 (three month program completion)		
Number of participants who achieved reduction in BMI		
Number of participants who achieved reduction in BMI by ? or greater		
Average BMI		
Number of participants who achieved reduction in Weight		
Number of participants who achieved reduction in Weight by 3% or greater	210	210
Average weight after Phase 1		
Number of participants who achieved improved physical functioning		
Number of participants who achieved improved blood pressure control		
Number of participants who reported improved eating habits		
Estimated dietary fat intake		
Number of participants who reported increased physical activity levels		
Number of participants who completed Phase 1		
3) Phase 2 (nine month program completion)		
Number of participants who maintained reduced BMI reported in Phase 1		
Number of participants who achieved reduction in BMI		
Number of participants who achieved reduction in BMI by ? or greater		
Average BMI		
Number of participants who maintained reduced Weight reported in Phase 1		
Number of participants who achieved reduction in Weight		
Number of participants who achieved reduction in Weight by 3% or greater		
Average weight after Phase 2		
Number of participants who achieved improved physical functioning		
Number of participants who maintained improved physical functioning		
Number of participants who achieved improved blood pressure control		
Number of participants who maintained blood pressure control		
Number of participants who reported improved eating habits		
Number of participants who maintained improved eating habits		
Estimated dietary fat intake		
Number of participants who reported increased physical activity levels		
Number of participants who maintained increased physical activity levels		
Number of participants who completed Phase 2		
Number of new community partners who delivered program intervention	2	3