2012-2013
Minority Health Initiative
Annual Report

December 1, 2013

In accordance with Nebraska
State Statute 71-1628.07

Office of Health Disparities & Health Equity

Division of Public Health

Nebraska Department of Health & Human Services

Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Office of Health Disparities & Health Equity

Improving health outcomes for culturally diverse populations in Nebraska

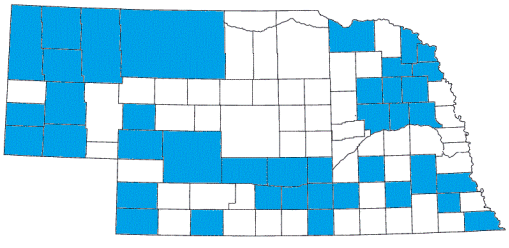
2012-2013
Minority Health Initiative Projects

10,613
Health improvements made by participants

13,409
Health/medical interpretation sessions provided

13,500+
Clients served

32,300+
Encounters provided



17
Projects funded

44
Counties covered

70+
Organizations involved

Prevalence/Death Rates Related to Priority Issues, 2001-2005 and 2006-2010

Health Issue	Race/Ethnicity	2001-2005	2006-2010
Cardiovascular Disease Death rate per 100,000 population	African American	246.4	214.2
	American Indian	280.1	131.7
	Asian	108.3	64.5
	Hispanic	114.6	89.7
	White	196.7	160.2
Stroke Death rate per 100,000 population	African American	84.2	40.8
	American Indian	62	66.6
	Asian	65.7	38.7
	Hispanic	29.2	28.4
	White	51.7	40.8
Diabetes Death rate per 100,000 population	African American	67.3	62.1
	American Indian	91	93.2
	Asian	13.9	18.7
	Hispanic	45.6	28.8
	White	20.3	21.1
Infant Mortality Death rate per 100,000 population	African American	15.1	13.8
	American Indian	15.2	7.7
	Asian	5.5	2.8
	Hispanic	6.8	5.7
	White	5.7	5.7
Obesity Prevalence among adults aged 18+	African American	33.9%	39%
	American Indian	29.6%	41.7%
	Asian	8.4%	10.3%
	Hispanic	25.5%	32%
	White	23.1%	26.7%
Asthma Prevalence among adults aged 18+	African American	12.3%	11.7%
	American Indian	15.5%	9.7%
	Asian	9.7%	7.3%
	Hispanic	3.8%	4.5%
	White	6.7%	7.7%

Sources: Nebraska DHHS Vital Statistics 2001-2010, Nebraska Behavioral Risk Factor Surveillance System (BRFSS) 2001-2010

Minority Health Initiative two-year projects (7/2011-6/2013) were awarded to the following organizations:			
Projects (Congressional Districts 1 & 3)	**Amount**	**County(ies)**	**Page**
Blue Valley Community Action	$90,765.71	Saline, York	12
Carl T. Curtis Health Center/Omaha Tribe	$88,204.20	Thurston	13
Central District Health Department	$654,382.42	Buffalo, Dawson, Hall, Kearney, Merrick, Phelps	14
Chadron Native American Center	$54,715.57	Cherry, Dawes, Sheridan	15
Community Action Partnership of Western Nebraska	$275,803.45	Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sioux	16
East Central District Health Department	$200,595.78	Colfax, Platte	17
Elkhorn Logan Valley Public Health Department	$148,693.67	Cuming, Madison, Stanton	18
Lincoln-Lancaster County Health Department	$938,626.18	Lancaster	19
Mary Lanning Memorial Hospital	$93,264.23	Adams, Clay, Webster	21
Norm Waitt YMCA	$197,572.36	Dakota	22
Northeast Nebraska Public Health Department	$29,583.36	Dixon, Wayne	23
One World Community Health Center	$146,288.34	Dodge, Sarpy	24
Ponca Tribe of Nebraska	$24,535.12	Knox, Sarpy	25
Sandhills District Health Department and Clinic (contract)	$13,962.34	Arthur, Keith	26
Southeast District Health Department (contract)	$55,345.46	Johnson, Otoe, Richardson	27
Southwest Nebraska Public Health Department (contract)	$28,155.64	Chase, Dundy, Red Willow	28
West Central District Health Department (contract)	$74,472.81	Lincoln	29
Total	$3,114,966.64		
Federally qualified health centers (Congressional District 2)			
Charles Drew Health Center	$714,050.50	CD 2	30
One World Community Health Center	$714,050.50	CD 2	32

Introduction

Minority Health Initiative funding is allocated by the Nebraska Legislature to counties in the first and third Congressional Districts with minority populations of five percent or greater, based on the most recent decennial census. Funding is directed to be distributed on a per capita basis and used to address priority issues of infant mortality, cardiovascular disease, obesity, diabetes, and asthma. Issues such as cancers, HIV/AIDS, sexually transmitted diseases, tobacco or alcohol use, mental health, translation/interpretation, injury prevention, and uninsuredness may be targeted in addition to at least one of the priorities. All projects should be responsive to the special cultural and linguistic needs of the populations they intend to serve.

To meet the directive, the Office of Health Disparities and Health Equity within the Nebraska Department of Health and Human Services uses a competitive request for applications process. Minority Health Initiative funds were awarded for two-year project periods, and 13 projects were awarded funding for the 2011-2013 project period. Four additional projects were implemented via contracts. This report covers the second year of the two-year project period.

The Minority Health Initiative grant program is designed to encourage the development or enhancement of innovative health services or programming to eliminate health disparities which disproportionately impact minority populations. The emphasis of this program is on service delivery through creative strategies by a single organization or by forming a network with at least two additional partners. Via collaborations among schools, faith-based organizations, emergency medical service providers, local universities, private practitioners, community-based organizations, and local health departments, communities have an opportunity to bring health parity for minorities. Populations to be addressed include racial ethnic minorities, Native Americans, refugees, and immigrants.

Also included in the appropriation is annual funding to be distributed equally among federally qualified health centers in the second Congressional District (One World Community Health Center and Charles Drew Health Center). Funding is to be used to implement a minority health initiative which may target, but is not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma.

For additional information on these projects, please contact Josie Rodriguez, Office of Health Disparities and Health Equity, at 402-471-0152 or minority.health@nebraska.gov.

Definitions

340B Medication Assistance program: a federal drug pricing program that limits the cost of covered outpatient medications to enable safety-net health care providers (e.g., federally qualified health centers, community health centers, tribal or urban Indian health organizations) to save significantly on the cost of prescriptions.[1]

Body mass index (BMI): measure of body fat based on height and weight.[2]

Case management: advocacy and guidance activities that help patients understand their current health status, what they can do about it, and why those treatments are important; and guide patients and provide cohesion to other health care professionals, enabling individuals to achieve health goals effectively and efficiently.[3]

Community health workers: people who assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Also know as lay health ambassadors, *promotoras*, and bilingual community health partners.[4]

Dental home: model of care characterized by provision and coordination of dental health care at a single location that takes responsibility for the patient's health care needs and arranging for appropriate care with other clinicians; includes a high level of accessibility, excellent communication, and full use of technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.[5]

Encounter: service provided to a client under this funding; may be duplicated numbers (i.e., multiple services may be provided to one person)

Health fair: event where organizations have an opportunity to disseminate health information to the public at booths and/or to provide health screenings.[6]

Interpretation: rendering of oral messages from one language to another.[7]

Medical home: model of care characterized by provision and coordination of health care at a single location that takes responsibility for the patient's health care needs and arranging for appropriate care with other clinicians; includes a high level of accessibility, excellent communication, and full use of technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.[5]

Translation: rendering of written information from one language to another.[7]

Encounters

This page summarizes the encounters experienced by the Minority Health Initiative projects in Congressional Districts 1 and 3 for the period July 1, 2012 through June 30, 2013. The projects are very different; some focus on health screenings and others on more complex services such as assisting people to find a medical home. Therefore, a simple listing of the number of clients served is not expressive of the depth of the work. We therefore added an Encounters page to the data report. This page is used to collect information on activities and services provided by the projects.

Assistance Provided	
Establish medical home	654
Establish dental home	967
Case management	557
Home visits	618
Apply for public assistance	504
Transportation	444
Referrals	941
Low-cost medications	4,018
Interpretation sessions	13,409
Health fair attendees	3,668
Other activities	2,648
Total	32,300

Interpretation Sessions—Languages	
Spanish	10,449
Arabic/Kurdish	1,485
Vietnamese	996
Karen/Burmese	361
French	12
Chinese	5
Other	101

Education and Screening Encounters

Health Education		Encounters
3,060	sessions providing	19,310

Health education is a key component of almost all of the Minority Health Initiative projects. During year two of the project period (July 1, 2012-June 30, 2013), the projects provided 3,060 health education sessions on topics including:

- Alcohol prevention
- Attention deficit hyperactivity disorder (ADHD)
- Breast cancer
- Cardiovascular disease
- Childhood depression
- Colon cancer prevention
- Communication/gaining support
- Community health workers
- Community emergency preparedness
- Diabetes
- Emotional coaching
- Family bonding
- Farmers markets
- Flu shots
- Goal setting
- Hand washing
- HbA1c labs
- Health risk assessment
- Healthy lifestyles/lifestyle changes
- HIV/AIDS awareness
- Importance of health screenings
- Infant/child car seat safety
- Keeping babies safe
- Mental health/depression
- Nutrition facts and labels
- Obesity
- Oral health
- Poison/safety
- Radon gas
- Skin care
- Sleep disorders
- Stress management
- Summer safety
- Tobacco cessation
- Tooth brushing
- Vaccines
- Women's health

Health screenings are another key component of the projects. During year two of the project period (July 1, 2012-June 30, 2013), the projects provided 15,984 health screenings.

Health Screenings	Encounters
Blood pressure	6,009
Glucose	2,041
Smoking cessation	994
BMI	3,033
Cholesterol	956
Dental	470
Breast cancer	76
Immunizations	915
Other	1,490
Total	15,984

Improved Health

Work by the Minority Health Initiative projects resulted in 10,613 improvements in health for participants.

Health Outcomes	Encounters
Improvements in BMI/weight loss	968
Improvements in blood glucose levels	76
Improvements in blood pressure	2,800
Improvements in cholesterol	119
Improvements in dental health	34
Increased physical activity	1,712
Improved nutrition	1,373
Improved medication management	1,532
Improved self-management of chronic disease	1,575
Received prenatal care in the first trimester	58
Stopped smoking	91
Other	275
Total	10,613

Clients Served

This page summarizes the clients served by the Minority Health Initiative projects for the period July 1, 2012 through June 30, 2013. These numbers represent the number of people provided services listed on the previous pages of this report. They also include the number of people who demonstrated changes in health indicators such as weight loss and lowering of cholesterol or blood pressure; and improvements in healthy behaviors such as increased physical activity, smoking cessation, or improved self-management of chronic diseases. "Other" includes refugee, immigrant, Arab, Middle Eastern, Russian, Irish, White Hispanic, and persons who chose not to identify their race and/or ethnicity—people served but for whom funding was not appropriated.

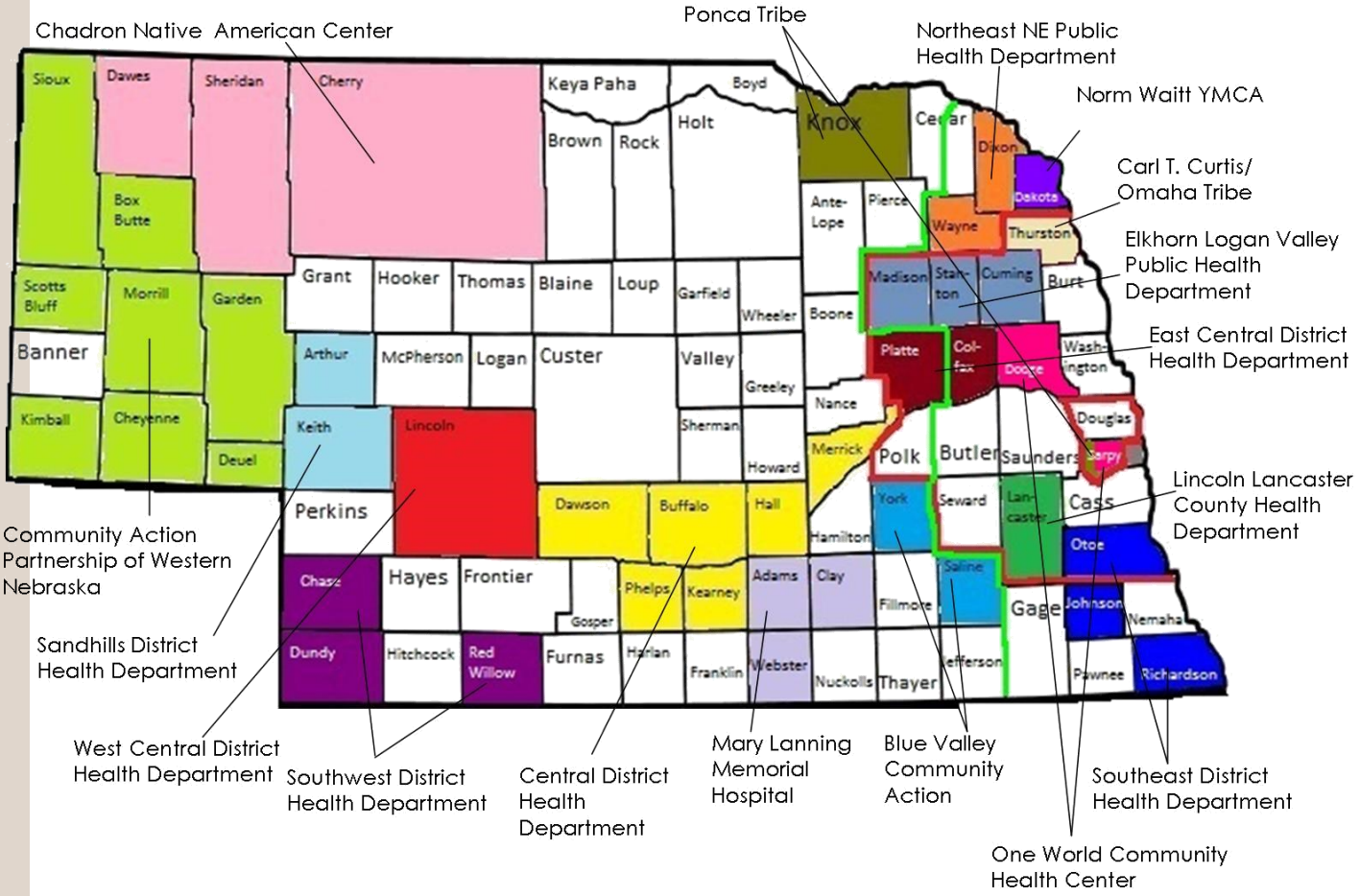
Female							
Age	Total	Non Hispanic					Hispanic
		Black	American Indian/ Alaska Native	Asian	Two or More Races	Other	
All Ages	8,456	426	671	301	326	2,184	4,548
0-19	2,317	40	117	23	68	905	1,164
20-39	2,940	162	141	133	197	486	1,821
40-59	2,317	163	284	73	51	522	1,224
60-79	742	37	116	60	7	426	296
80+	140	24	13	12	3	45	43

Male							
Age	Total	Non Hispanic					Hispanic
		Black	American Indian/ Alaska Native	Asian	Two or More Races	Other	
All Ages	5,144	401	636	265	114	1,275	2,453
0-19	1,996	40	158	45	44	733	976
20-39	1,338	136	186	99	29	165	723
40-59	1,274	180	218	63	31	243	539
60-79	423	30	63	39	5	116	170
80+	113	15	11	19	5	18	45

Individual Grantee Reports

The balance of this document includes summaries of the outcomes of the individual project grants in Congressional Districts 1 and 3 and funding allocated to the Federally Qualified Health Centers in Congressional District 2. The reports are arranged alphabetically by grantee name, and include the county(ies) covered by the project, the funding awarded for the second year of the project period, and the populations targeted by the project. They also include the funding priority(ies) and other areas targeted, the number of encounters and clients served during the first year of the project, and project partners.

A brief description of the project is followed by outcomes achieved July 1, 2012 through June 30, 2013.



Blue Valley Community Action Partnership

County(ies): Saline, York

Target Populations: Hispanic/Latino

Target Areas: Infant mortality, obesity, cardiovascular disease, diabetes

Other Areas: Mental health, translation/ interpretation, cancers, tobacco use, ununinsuredness, injury prevention

Dollars: $45,382.86 per year

Encounters 7/1/2012-6/30/2013: 2,402

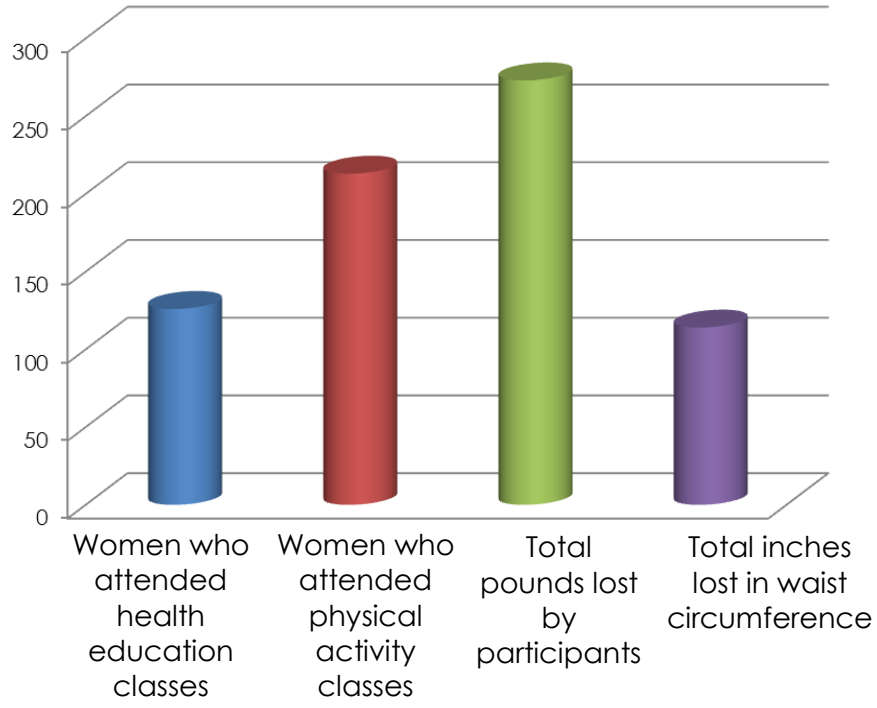
Clients Served 7/1/2012-6/30/2013: 768

Project Partners: Four Corners District Health Department, Blue Valley Behavioral Health, Crete Area Medical Center, University of Nebraska at Lincoln Nutrition Education Department

This project addressed outcomes to decrease targeted health disparities for pregnant Hispanic/Latina women and their families by addressing risk factors and access to care.

Outcomes July 1, 2012—June 30, 2013

- 159 pregnant Hispanic women enrolled in case management
- 161 women expressed increased knowledge of available services and signs and symptoms of pre/post-natal depression
- 126 women attended health education classes
- 126 women expressed increased knowledge about diabetes, cardiovascular disease, mental health, preconception health, immunizations
- 213 women completed an 8-week physical activity course
- 72% of participants increased daily physical activity
- 92% of participants expressed increased knowledge of preventive health concepts



Carl T. Curtis Health Center/Omaha Tribe

County(ies): Thurston

Target Populations: Native American

Target Areas: Cardiovascular disease, diabetes

Other Areas: Tobacco use

Dollars: $44,102.10 per year

Encounters 7/1/2012-6/30/2013: 904

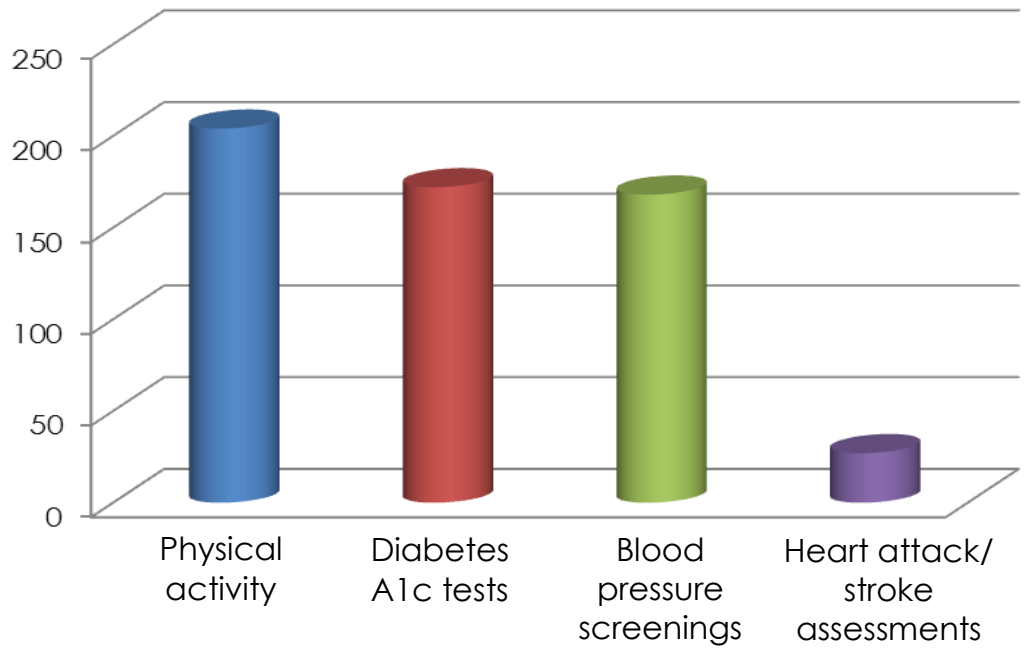
Clients Served 7/1/2012-6/30/2013: 620

Project Partners: Omaha Tribal Tobacco Coalition

The focus of this project was reduction of smoking and prevention of complications from Type 2 diabetes among members of the Omaha Tribe.

Outcomes July 1, 2012—June 30, 2013

- 172 participants completed A1C tests and received health education on diabetes
- 168 participants completed blood pressure checks and received information about their reading
- 27 participants completed risk assessment for heart attack and stroke
- 200+ individuals participated in physical activity on a consistent basis through martial arts such as Tai-Chi Chuan, which was introduced to the community as an alternative method of exercise to help diabetes patients and smokers with stress reduction while encouraging balance in their lives



Central District Health Department

County(ies): Buffalo, Dawson, Hall, Kearney, Merrick, Phelps

Target Populations: Native American, Hispanic/Latino, immigrant, refugee

Target Areas: Cardiovascular disease, diabetes, infant mortality, obesity

Other Areas: Tobacco or alcohol use, translation/interpretation, HIV/AIDS, cancers, sexually transmitted infections

Dollars: $327,191.21 per year

Encounters 7/1/2012-6/30/2013: 3,838

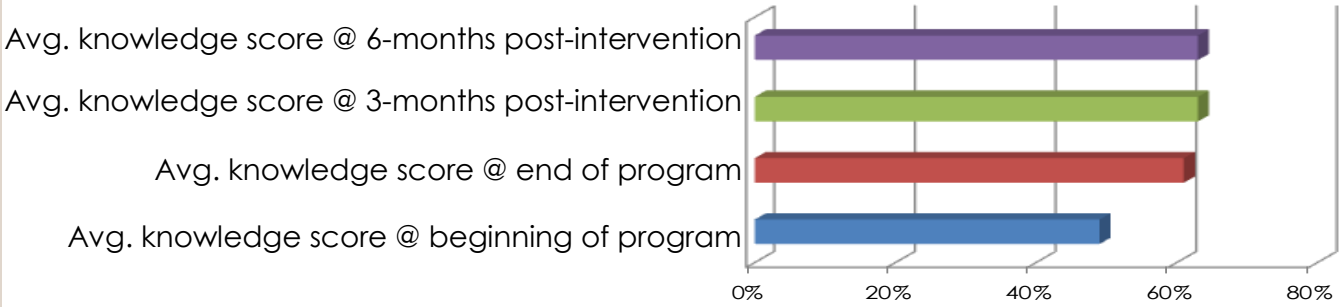
Clients Served 7/1/2012-6/30/2013: 727

Project Partners: Two Rivers Public Health Department, Central Health Center, Central Nebraska Council on Alcohol Addiction, Community Fitness Initiative, St. Ann's Church, St. Mary's Church, Somali Community Centers in Lexington and Grand Island, Tri County Hospital, Dawson County Interagency Team

The Choosing Health and Maximizing Prevention (CHAMP) program concentrated on expectant mothers, emphasizing healthy lifestyle choices and a continuum of care from pre-conception to the end of the reproductive years.

Outcomes July 1, 2012—June 30, 2013

- 484 participants received education on nutrition, physical activity, and preventive health care
- 19 series of CATCH Kids and Discovery Kids were provided, reaching out a combined total of 569 students
- 753 one-on-one counseling sessions were provided
- A nutritionist provided health education sessions on healthy lifestyle, nutrition, physical activity, preventive health care
- 610 participants (81%) reported significant improvement in positive behaviors
- 84% participants improved their knowledge of healthy eating and physical activity
- 389 interpretation encounters were provided, all in Spanish



Chadron Native American Center

County(ies): Cherry, Dawes, Sheridan

Target Populations: Native American, Hispanic/Latino

Target Areas: Cardiovascular disease, diabetes, infant mortality, obesity

Other Areas: Tobacco use, HIV/AIDS, mental health, uninsuredness

Dollars: $27,357.79 per year

Encounters 7/1/2012-6/30/2013: 388

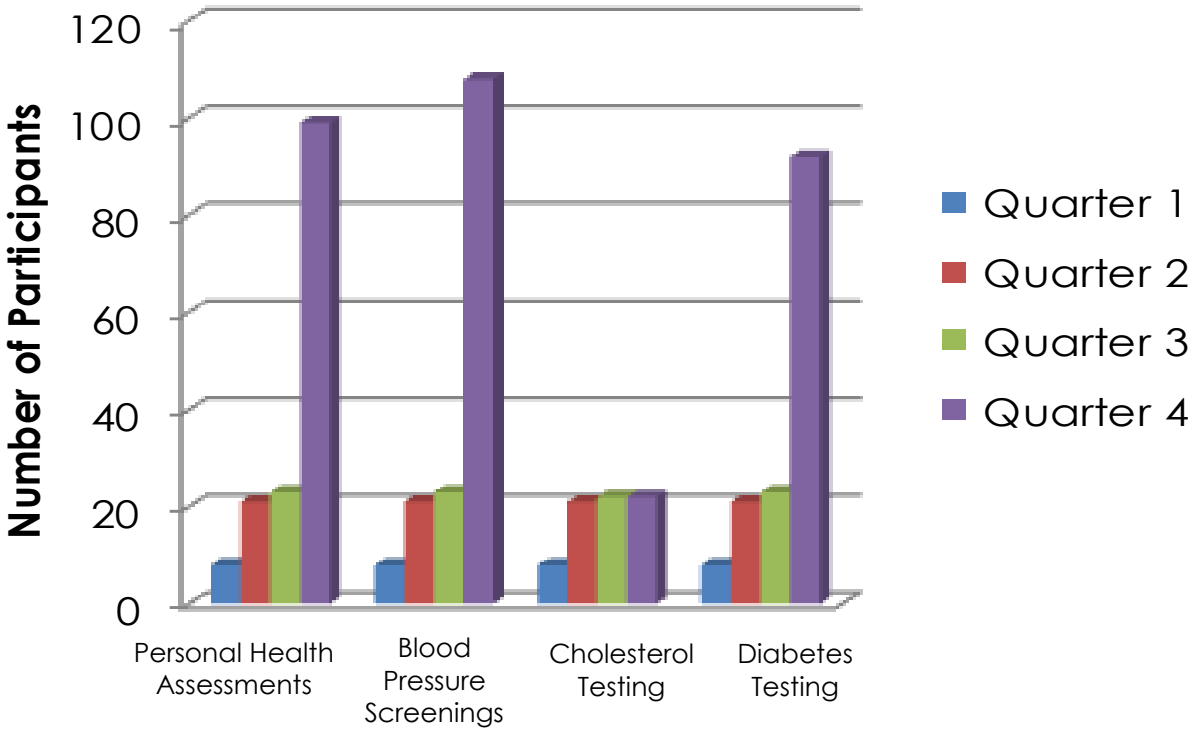
Clients Served 7/1/2012-6/30/2013: 99

Project Partners: Western Community Health Resources, Panhandle Public Health District

This project expanded community-based health promotion and disease prevention efforts in three counties. The focus was a model of personal health assessment to improve health behaviors.

Outcomes July 1, 2012—June 30, 2013

- 99 Personal Health Assessments (PHAs) were performed, followed by appointments with case managers to create care plans to address identified health risks
- 108 blood pressure screenings were performed
- 22 cholesterol tests were performed
- 92 diabetes tests were performed
- 20 one-to-one Assessment Survey Interviews were completed utilizing the Minority Health Interview Survey
- Native American community members aged 30 and older would like to address educational needs for their younger community members, particularly on topics such as substance abuse, teen pregnancy, and tobacco use



Community Action Partnership of Western Nebraska

County(ies): Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sioux

Target Populations: Native American, Hispanic/Latino

Target Areas: Cardiovascular disease, diabetes, obesity

Other Areas: Translation/interpretation, uninsuredness

Dollars: $137,901.73 per year

Encounters 7/1/2012-6/30/2013: 4,899

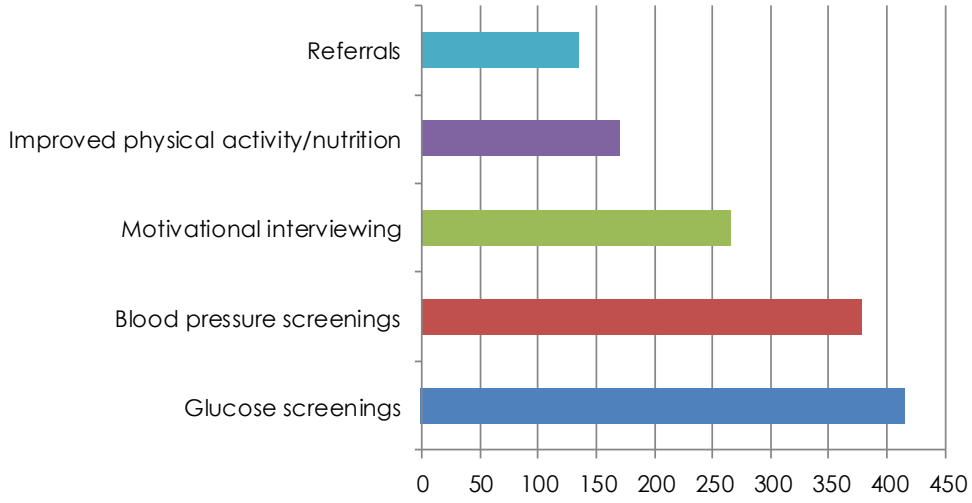
Clients Served 7/1/2012-6/30/2013: 497

Project Partners: University of Nebraska Medical Center West Nebraska Division College of Nursing, Western Community Health Services, Regional West Medical Center, Western Nebraska Community College, Lakota Lutheran Center, Memorial Health Center, Kimball Health Services, Panhandle Public Health District, Indian Center Inc.

This project addressed health risk factors through health screenings and addressed language barriers that impede access to health care.

Outcomes July 1, 2012—June 30, 2013

- 835 fliers advertising program activities were distributed
- 416 glucose and 379 blood pressure screenings were provided
- 265 people were found to have abnormal screening results and received health education via motivational interviewing
- 170 people demonstrated improvements in nutrition and physical activity
- 200 high risk diabetic patients received health education about self-management of their condition
- 134 referrals were made to the minority health *promotora*
- Over 275 Latina women attended the Red Shawl event to learn about breast cancer and cardiovascular disease
- Interpretation was provided in 2,976 encounters
- 8 people completed medical interpretation training



East Central District Health Department

County(ies): Colfax, Platte

Target Populations: Native American, Hispanic/Latino, refugee, immigrant

Target Areas: Cardiovascular disease, diabetes, obesity

Other Areas: Translation/interpretation, uninsuredness

Dollars: $100,297.89 per year

Encounters 7/1/2012-6/30/2013: 990

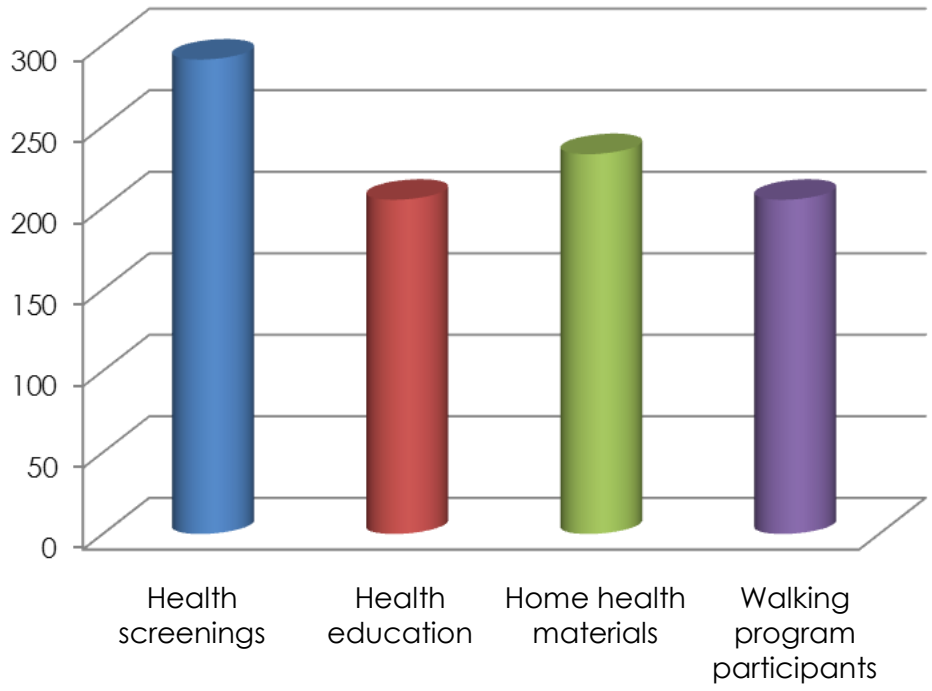
Clients Served 7/1/2012-6/30/2013: 603

Project Partners: Divine Mercy Church/ St. Augustine, Cargill-Schuyler, Good Neighbor Community Health Center, Schuyler Learning Center

This project targeted risk health factors through education, the application of knowledge, and increased physical activity.

Outcomes July 1, 2012—June 30, 2013

- 291 people were screened for cardiovascular disease, obesity, and/or diabetes
- 205 people received health education about nutrition and physical activity, participated in a walking program, and lost a combined total of 615 pounds
- Home health educational materials were provided to 233 people
- 89 people completed four-week diabetes classes
- *Promotoras* helped 129 people with health education and links to resources
- 80 people participated in aerobics classes
- 164 children received education on healthy eating and portions



Elkhorn Logan Valley Public Health Department

County(ies): Cuming, Madison, Stanton

Target Populations: Native American, African American, Hispanic/Latino, immigrant

Target Areas: Cardiovascular disease, diabetes, obesity

Dollars: $74,364.84 per year

Encounters 7/1/2012-6/30/2013: 6,479

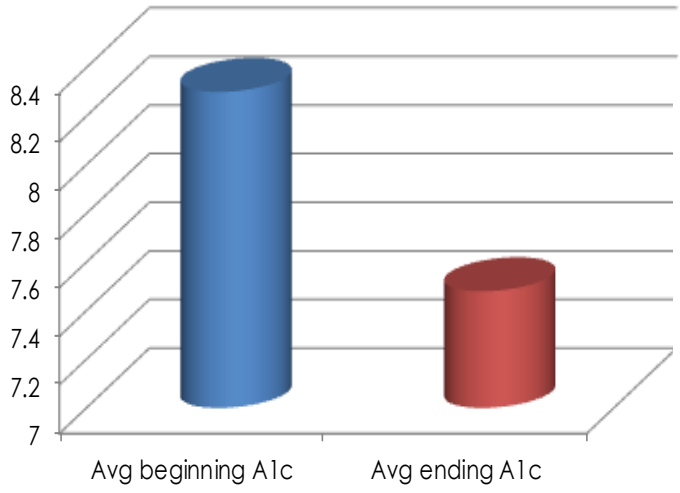
Clients Served 7/1/2012-6/30/2013: 1,084

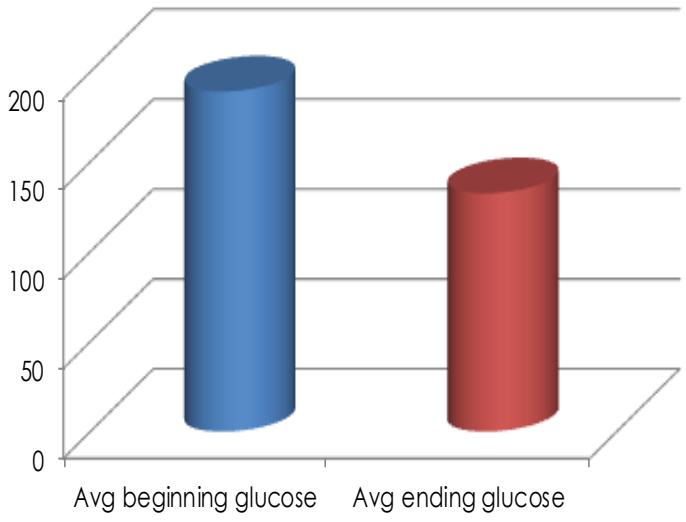
Project Partners: Norfolk Community Health Care Clinic, Madison Medical Clinic, Healthy Communities Initiative, Planned Approach to Community Health, Tyson Fresh Meats, schools, community and cultural centers

Minority Education for Greater Access to Health (Project MEGAHealth) was designed to help populations access assistive services, agencies, community partners, and programs; increasing access to health care in an effort to reduce health risk factors.

Outcomes July 1, 2012—June 30, 2013

- 81 people were educated on diabetes/chronic disease education.
- 126 people participated in physical activity classes, including 86 adults and 40 children – families took part in the classes together as a unit
- Monthly community education classes were very well attended and the word-of-mouth generated by participants helped to promote the program overall throughout the community, resulting in more and more attendance
- 75% of participants demonstrated mastery of skills
- 92% of participants adopted one or more healthy behaviors
- 603 people were provided referrals and information





Lincoln-Lancaster County Health Department

County(ies): Lancaster

Target Populations: Native American, Asian, African American, Hispanic/Latino, immigrant, refugee

Target Areas: Cardiovascular disease, diabetes, obesity

Other Areas: Interpretation/translation, tobacco use, uninsuredness

Dollars: $469,313.09 per year

Encounters 7/1/2012-6/30/2013: 24,768

Clients Served 7/1/2012-6/30/2013: 2,583

Project Partners: Asian Community & Cultural Center, El Centro de las Americas, Clyde Malone Community Center, Clinic with a Heart, The Health Hub, Lancaster County Medical Society, People's Health Center, University of Nebraska Medical Center College of Dentistry

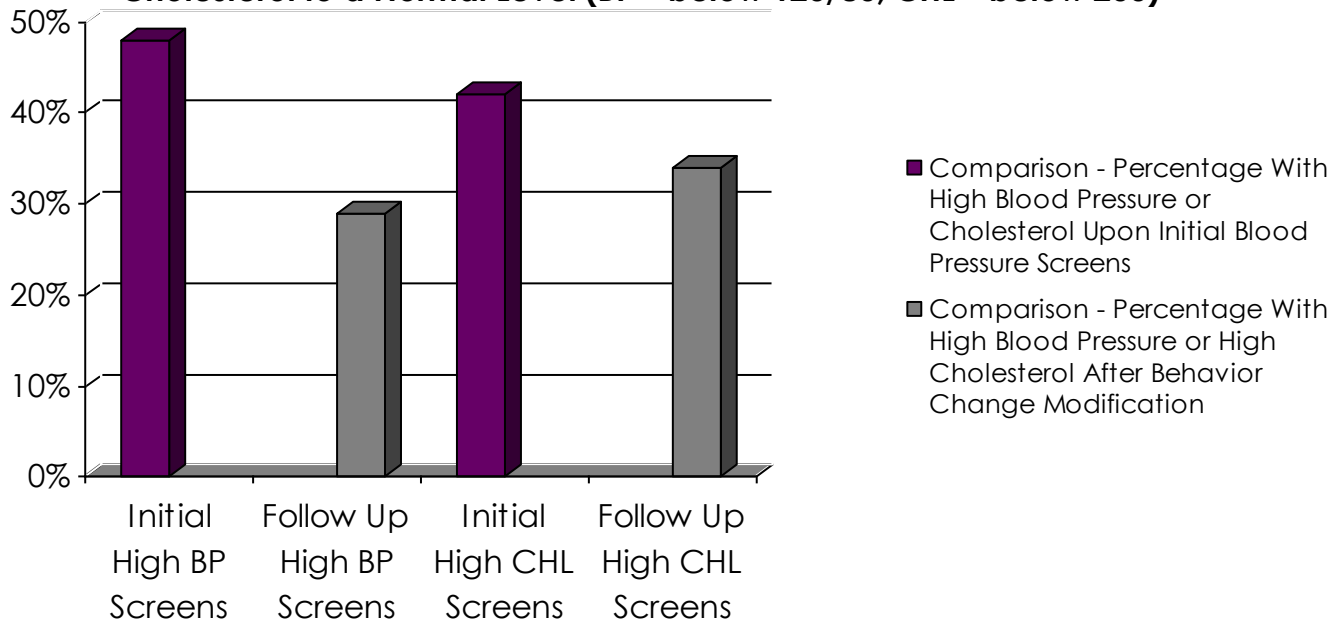
The goal of this project was to reduce health risk factors and associated health disparities.

Outcomes July 1, 2012—June 30, 2013

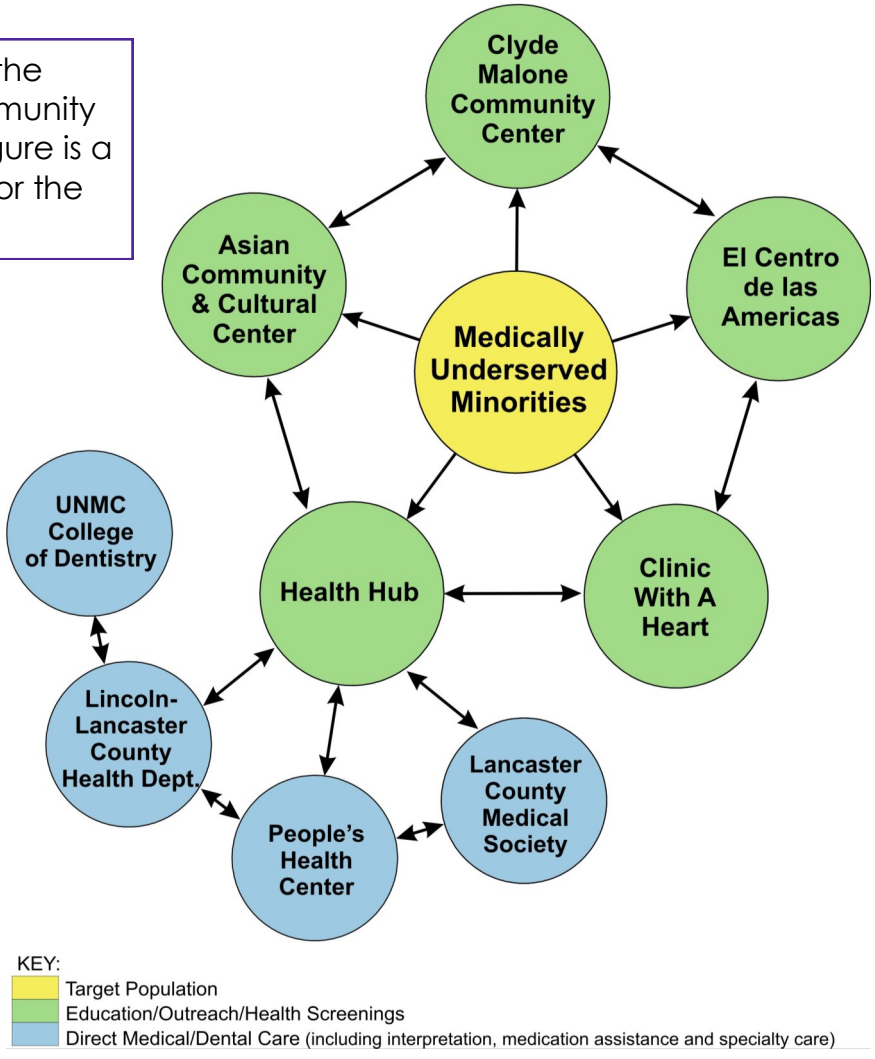
- 1,232 people were screened for cardiovascular risk and provided health education on preventive measures through Clinic with a Heart, the Asian Community and Cultural Center, the Clyde Malone Center, and El Centro de las Americas
- 1,232 people were provided referrals to project partners for additional medical and dental care
- 583 people established medical homes at People's Health Center
- 1,259 new and established patients at People's Health Center met with a diabetes health educator to develop individualized behavior modification plans
- 713 people were successful in changing at least one risk behavior for 3 months or longer—44 people lost weight, 322 improved their nutrition, 83 stopped smoking, and 235 made other healthy changes
- 950 people established dental homes at Lincoln-Lancaster County Health Department
- At least 8,987 interpretation encounters were provided in Spanish, Vietnamese, Arabic, Karen, and Kurdish
- 3,883 people received medication assistance
- 19% of clients with initial high blood pressure screenings improved their rates
- 38 health education sessions were provided to 751 people
- 84 people were referred to UNMC for specialty dental care

The project produced two promotional videos. They may be viewed at http://vimeo.com/57462423 and http://www.youtube.com/watch?v=XIkQFUmDxAM&feature=youtu.be

Decrease in Cardiovascular Risk Due to Decrease in Blood Pressure or Cholesterol to a Normal Level (BP – below 120/80; CHL – below 200)



This project relies on the Minority Health Community Collaborative. This figure is a simplified flowchart for the project.



Mary Lanning Memorial Hospital

County(ies): Adams, Clay, Webster

Target Populations: Hispanic/Latino

Target Areas: Cardiovascular disease, diabetes, obesity

Other Areas: Mental health, interpretation/ translation, uninsuredness

Dollars: $46,632.12 per year

Encounters 7/1/2012-6/30/2013: 2,460

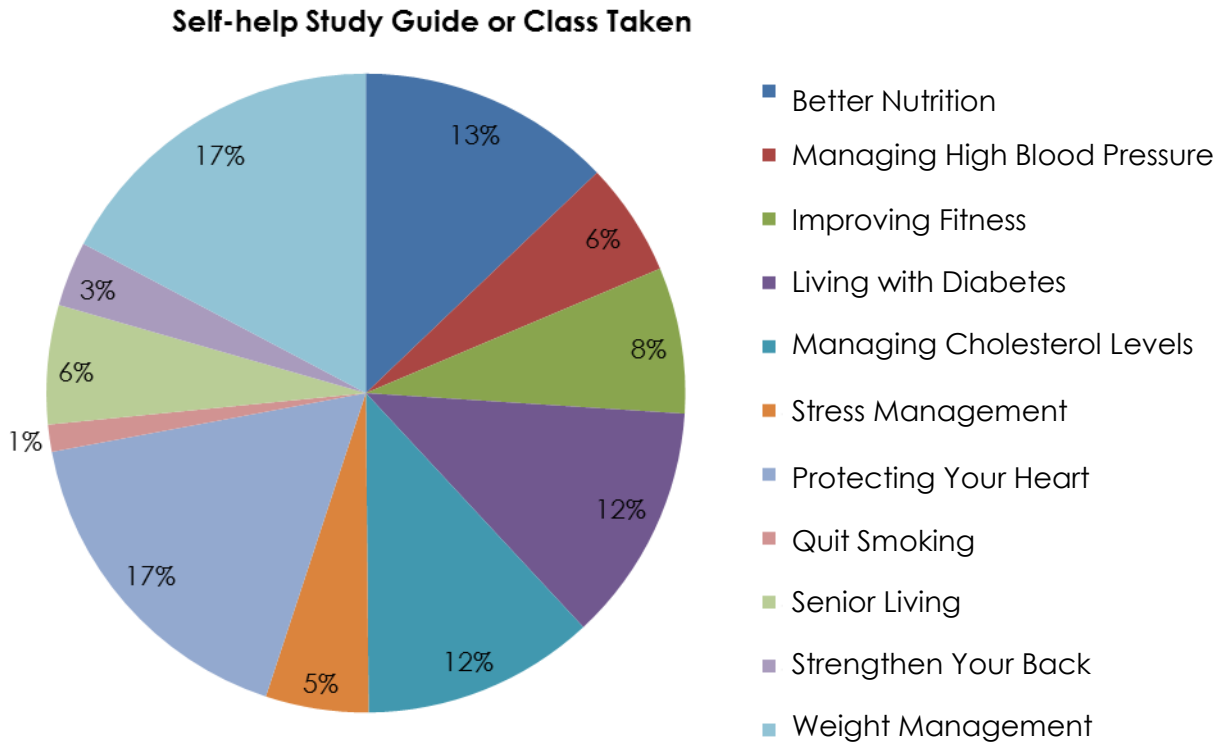
Clients Served 7/1/2012-6/30/2013: 653

Project Partners: YMCA, South Heartland District Health Department, Blue Hill Medical Clinic, Sutton Medical Clinic, Edgar Medical Clinic

This project improved access to comprehensive quality health care services, health education, and prevention methods for disease.

Outcomes July 1, 2012—June 30, 2013

- 86% of participants received at least one home visit or extensive phone call
- 12 fitness assessments were provided
- 3 physical activity educational sessions were provided, reaching 50 people
- 24 children in grades 1-3 participated in CATCH Kids
- 100% of adult participants in Adams County had a medical home
- By the end of the year, 68% of Clay County participants had a medical home
- All participants received services including connections to local pharmacies or medication assistance programs



Norm Waitt YMCA

County(ies): Dakota

Target Populations: Hispanic/Latino

Target Areas: Obesity

Dollars: $98,786.18 per year

Encounters 7/1/2012-6/30/2013: 12,772

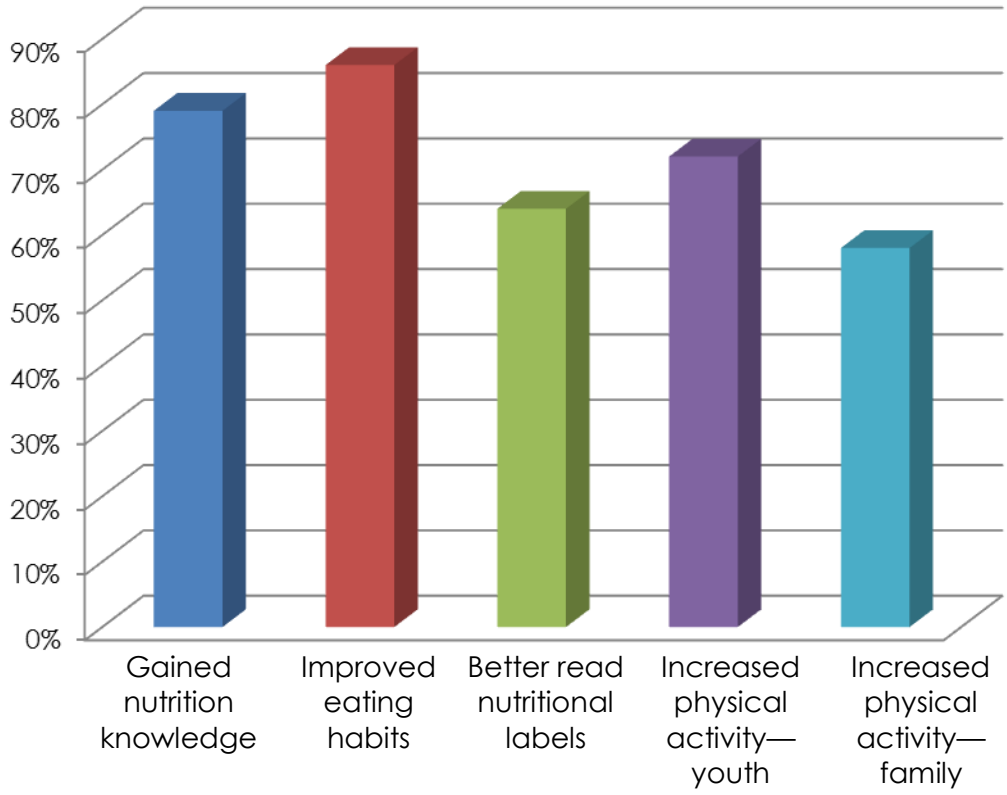
Clients Served 7/1/2012-6/30/2013: 917

Project Partners: Hy-Vee, St. Luke's Regional Medical Center

Goals of this program were centered on reducing the onset of obesity and diabetes among Hispanic children through health education.

Outcomes July 1, 2012—June 30, 2013

- 79% of participants demonstrated improved knowledge of nutrition
- 86% of participants reported improved eating habits for their families—drinking less soda, increased consumption of fruits, drinking more water
- 64% indicated increased awareness of nutritional labels
- 72% of participants reported increased activity among youth resulting from the program
- 58% of participants reported increased family physical activity
- 46% of participants reported an increase in physical activity at 6 months post-program



Northeast Nebraska Public Health Department

County(ies): Dixon, Wayne

Target Populations: Hispanic/Latino, immigrant

Target Areas: Diabetes, obesity

Other Areas: Translation/interpretation, uninsuredness

Dollars: $14,791.68 per year

Encounters 7/1/2012-6/30/2013: 637

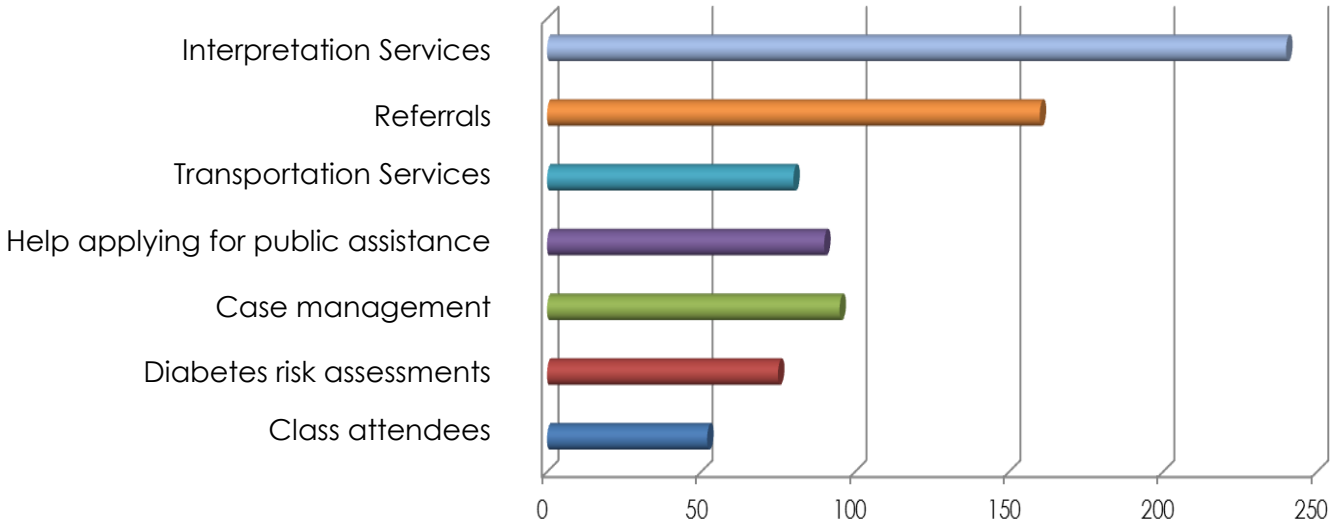
Clients Served 7/1/2012-6/30/2013: 116

Project Partners: Salem Evangelical Lutheran Church, Gardner Public Library, City of Wakefield, City of Wayne, Wakefield Public Schools

Targeting Type 2 Diabetes, this project provided health education, implemented preventive practices, and increased access to health care services.

Outcomes July 1, 2012—June 30, 2013

- 10 people completed the Community Health Worker training
- 46 people attended *Living with Diabetes* classes
- The project worked with Northeast Nebraska Community College to offer the first-ever college-credit Community Health Worker training in Nebraska
- 55 people were screened for diabetes
- The Mobilizing for Action through Planning and Partnership (MAPP) committee identified access to care, including language access services, as a priority area
- Incorporation of Community Health Workers into the local health care infrastructure was approved by the MAPP committee



One World Community Health Center

County(ies): Dodge, Sarpy

Target Populations: Hispanic/Latino, Asian, African American, Native American, immigrant, refugee

Target Areas: Diabetes

Dollars: $73,144.17 per year

Encounters 7/1/2012-6/30/2013: 1,660

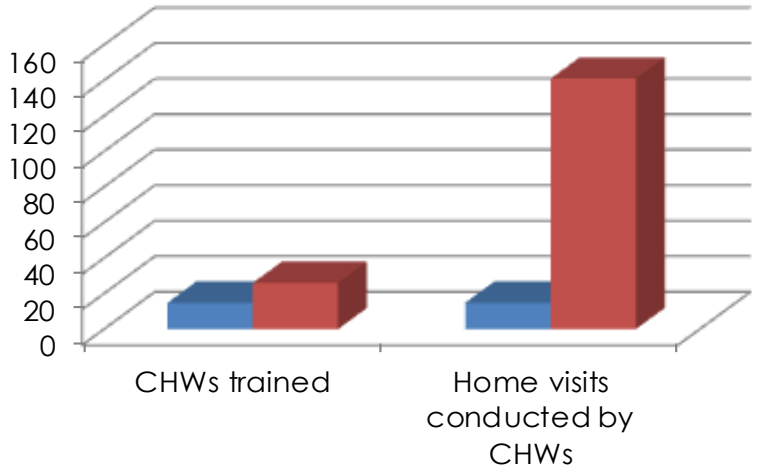
Clients Served 7/1/2012-6/30/2013: 478

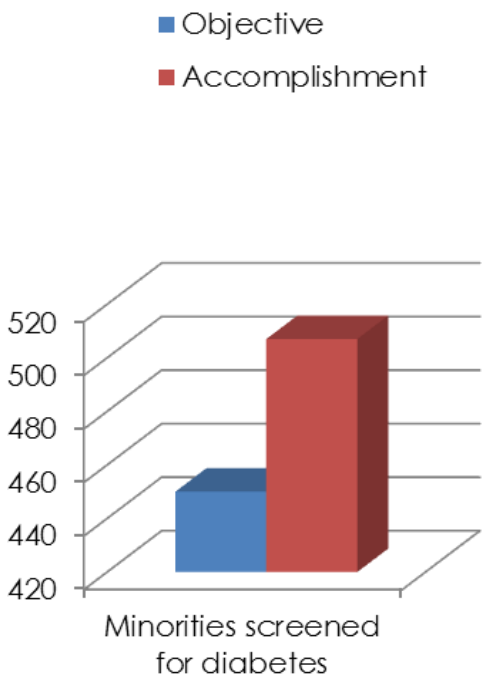
Project Partners: University of Nebraska at Omaha, Nebraska Methodist College

This project targeted increasing diabetes awareness, education, and testing among minority communities.

Outcomes July 1, 2012—June 30, 2013

- 624 people were screened for diabetes
- 29 people were identified as diabetic or pre-diabetic
- 44 community health workers were recruited and trained
- 162 home visits were performed, to include health education and screenings for family, friends, and neighbors of established project participants
- 29 people were referred for case management services
- 25 people were referred to One World for establishment of a medical home





Ponca Tribe of Nebraska

County(ies): Knox, Sarpy

Target Populations: Native American

Target Areas: Obesity, cardiovascular disease

Dollars: $12,267.56 per year

Encounters 7/1/2012-6/30/2013: 234

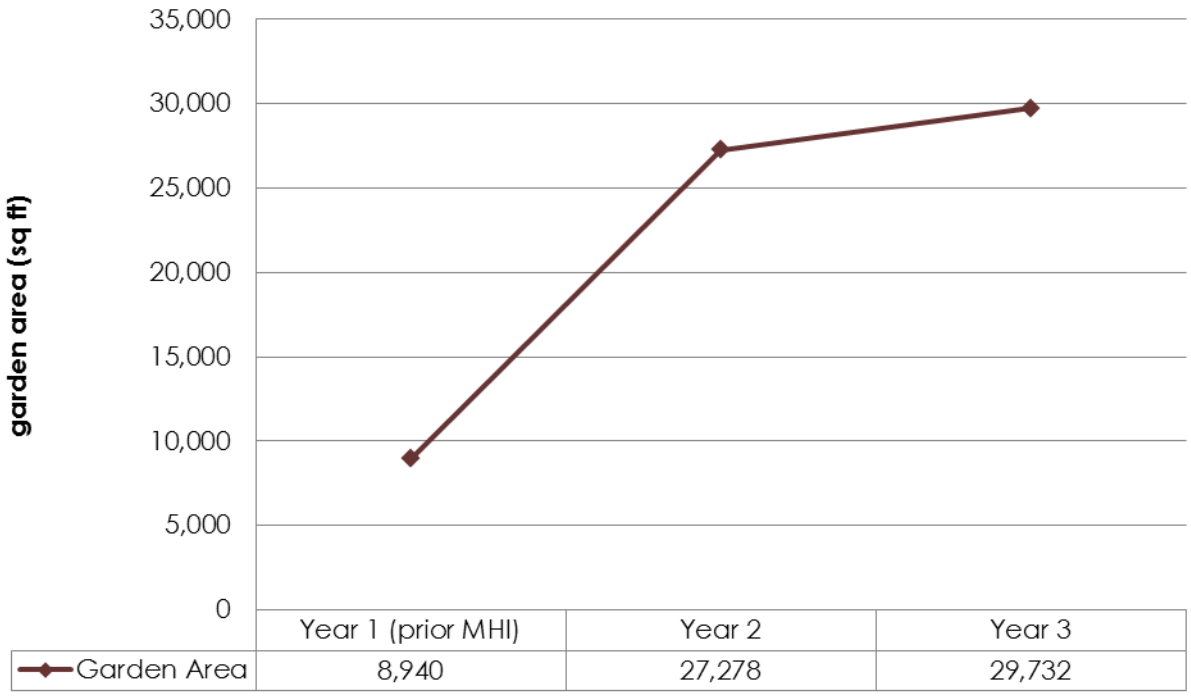
Clients Served 7/1/2012-6/30/2013: 183

Project Partners: Ponca Special Diabetes Program for Indians, Ponca Culture Department, Ponca Community Health Representative Program, Ponca Environmental Protection Department

This project emphasized healthy lifestyle choices, prevention, and health education in an effort to reduce and/or eliminate the onset of health risk factors and additional complications.

Outcomes July 1, 2012—June 30, 2013

- 25 family collaborative gardens were established
- 75% of participants demonstrated improvement in fruit and vegetable intake
- 75% of participants demonstrated improved weight
- The average weight loss was 13.6 pounds
- 17 additional people participated in the final year of the project
- 46% of participants decreased blood pressure
- The average decrease in blood pressure was 9.9 points (both systolic and diastolic)



Sandhills District Health Department and Clinic

County(ies): Arthur, Keith

Target Populations: Hispanic/Latino, Asian, African American, immigrant, refugee

Target Areas: Diabetes

Other Areas: Translation/interpretation, tobacco use, uninsuredness

Dollars: $6,981.17 per year

Encounters 7/1/2012-6/30/2013: 446

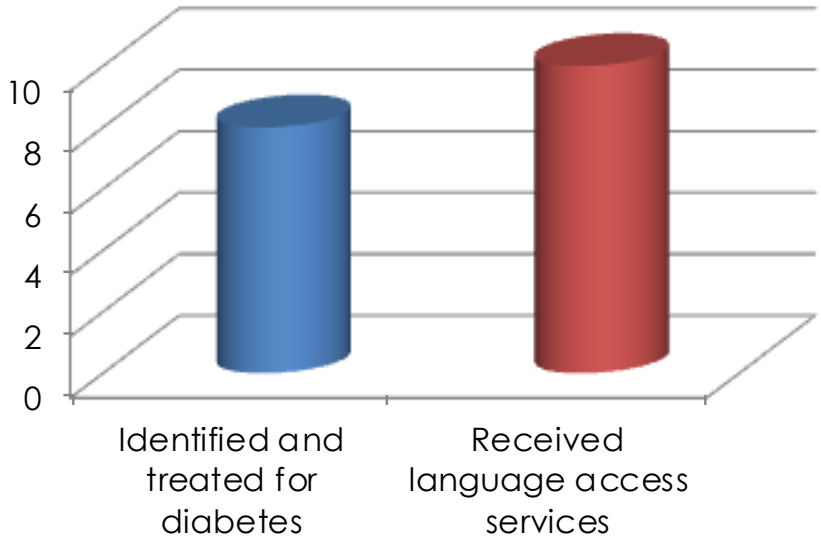
Clients Served 7/1/2012-6/30/2013: 164

Project Partners: Educational Service Unit 13, Keith County Commissioners, North Platte Pathology Services, Midland Medical

This project targeted development of partnerships and collaborations to improve the cultural and linguistic appropriateness of health care services.

Outcomes July 1, 2012—June 30, 2013

- 39 people were served at a health fair that included Spanish-language educational materials
- 8 people were identified and treated for diabetes
- 10 people received language access services
- The project interpreter received training in teaching of Tai Chi to facilitate provision of classes to community members
- Clinic hours expanded four evenings per week to improve access for clients unable to take time away from work



Southeast District Health Department

County(ies): Johnson, Otoe, Richardson

Target Populations: Hispanic/Latino, Native American, immigrant

Other Areas: Interpretation/translation

Dollars: $27,672.73 per year

Encounters 7/1/2012-6/30/2013: 586

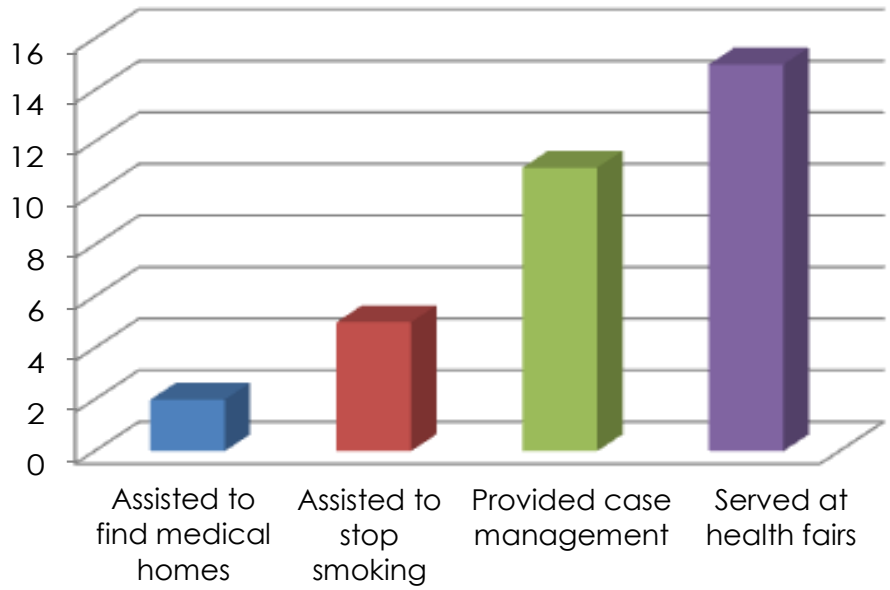
Clients Served 7/1/2012-6/30/2013: 586

Project Partners: Hospitals in Nebraska City, Syracuse, Tecumseh, Community Memorial Hospital

Year two of this project was devoted to ensuring access to interpreters, translation of documents, and development of a community resources guide.

Outcomes July 1, 2012—June 30, 2013

- Relationships developed with Native American populations
- Culturally appropriate presentations provided to Hispanic women
- Presentations provided to Native American women about prevention of breast and cervical cancer
- Efforts made to increase work with Tribal populations
- Interpreter services provided at immunization clinics
- 5 people were assisted to stop smoking
- 31 interpretation encounters were provided for Spanish-speaking clients
- 11 people were provided case management services
- 15 people were served at health fairs
- 2 people were assisted to find medical homes



Southwest Nebraska Public Health Department

County(ies): Chase, Dundy, Red Willow

Target Populations: Hispanic/Latino, immigrant

Target Areas: Obesity

Dollars: $14,077.82 per year

Encounters 7/1/2012-6/30/2013: 552

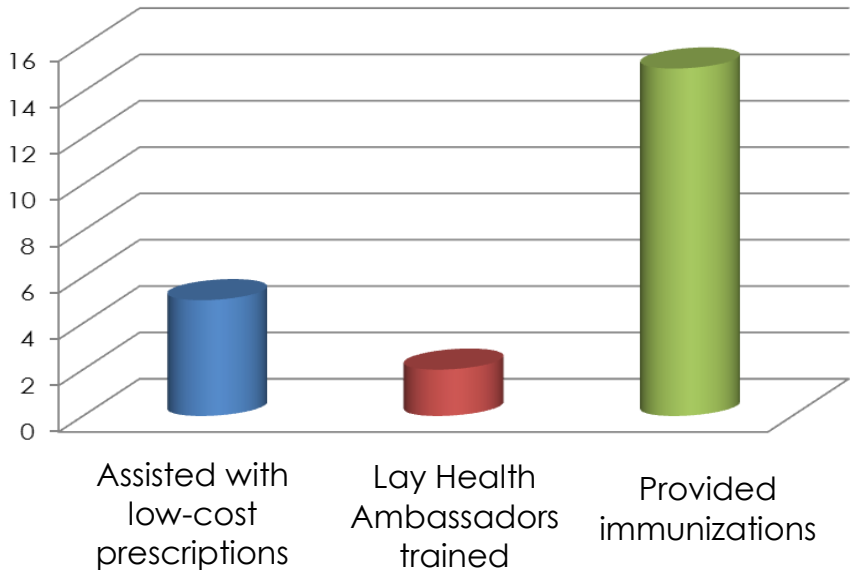
Clients Served 7/1/2012-6/30/2013: 272

Project Partners: Extension educators, clergy, English as a second language (ESL) instructors, hospital and clinic staff

This project targeted improvements in fitness and nutrition.

Outcomes July 1, 2012—June 30, 2013

- 5 people received Lay Health Ambassadors training
- Worked with local partners to perform needs assessment for minority community members
- Learned that access to care was the largest concern of minority populations in these counties
- Worked with local partners to ensure inclusion of Spanish-language public health materials
- Delivered Teaching our Youth Activities and Nutrition (TOUCAN) program to several groups of local children
- 34 people were screened for cholesterol
- 15 people were provided immunizations
- 232 people attended health education sessions
- 2 people were assisted to access low-cost prescriptions



West Central District Health Department

County(ies): Lincoln

Target Populations: Hispanic/Latino

Target Areas: Obesity, cardiovascular disease, diabetes

Other Areas: Translation/interpretation, cancers

Dollars: $37,236.41 per year

Encounters 7/1/2012-6/30/2013: 507

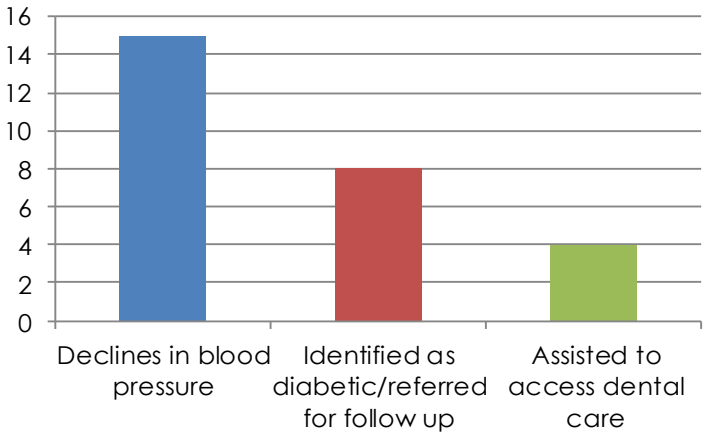
Clients Served 7/1/2012-6/30/2013: 126

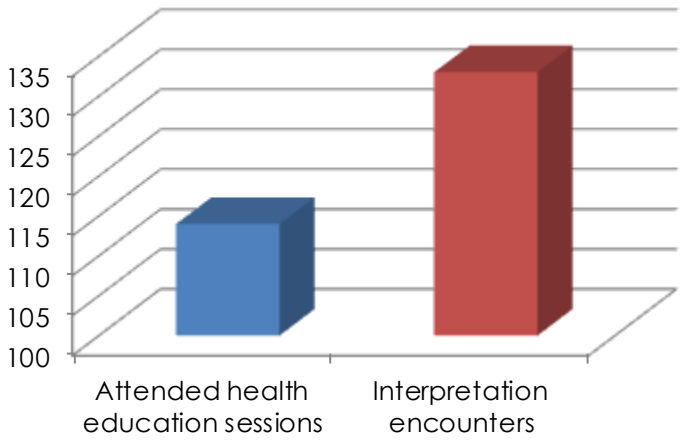
Project Partners: Great Plains Regional Medical Center, North Platte Public Library, community agencies

The goals of year two of this project were to reduce the incidence and impact of chronic diseases through increased knowledge and self-management skills resulting from participation in a culturally appropriate and linguistically competent program.

Outcomes July 1, 2012—June 30, 2013

- Needs assessment completed and used to determine topics for monthly health education classes
- Improved linkages and partnerships across the county
- 114 people attended one of five health education sessions
- 15 participants experienced declines in blood pressure
- 8 people were identified as high risk for diabetes and referred for follow up
- 4 people used discount vouchers to access dental care
- 133 interpretation encounters provided





Charles Drew Health Center

County(ies): Douglas

Dollars: $714,050.50

Target Areas: Cardiovascular disease, asthma, diabetes, obesity, infant mortality

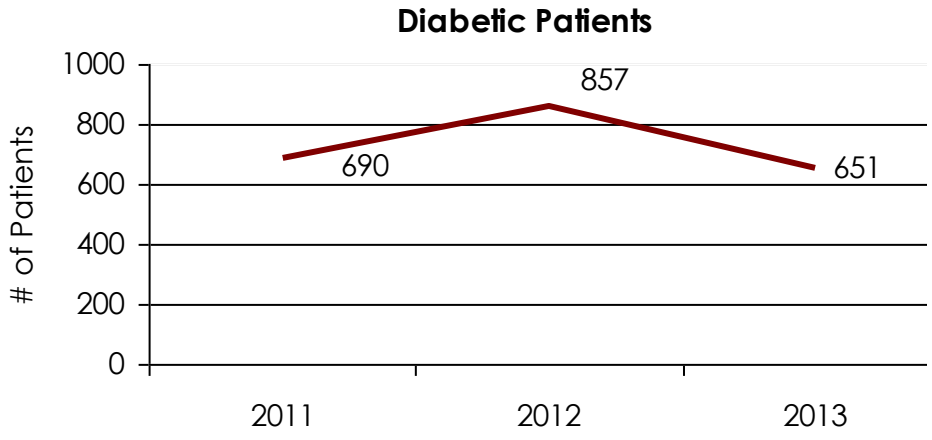
Target Populations: African American

Other Areas: Depression

* As noted earlier, included in the appropriation is annual funding to be distributed equally among federally qualified health centers in the second Congressional District. This is one of those projects.

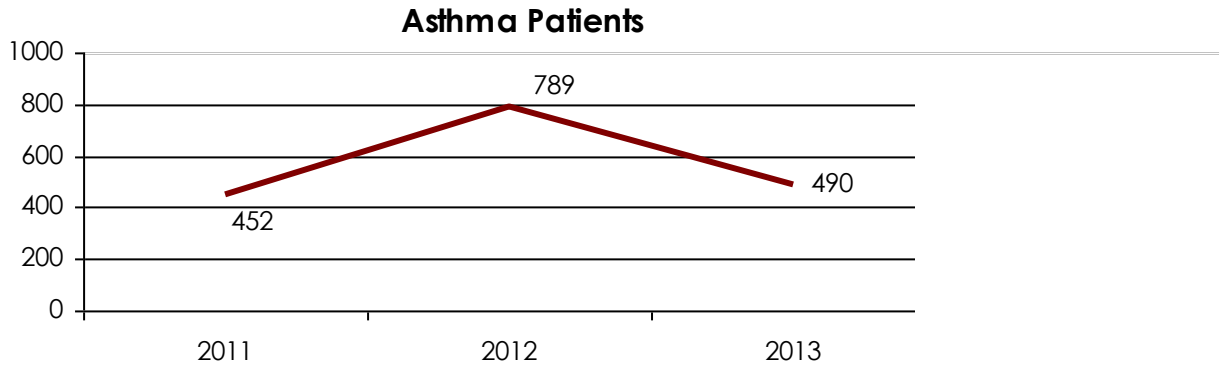
Outcomes July 1, 2012—June 30, 2013

- 75% of diabetic patients have an HbA1c of less than 9
- 90% of asthma patients are appropriately treated with an inhaled corticosteroid
- 62% of cardiovascular collaborative patients had controlled blood pressure
- 817 patients participate in the depression collaborative
- 76% of patients diagnosed with depression had documented self-management goals set during the past year

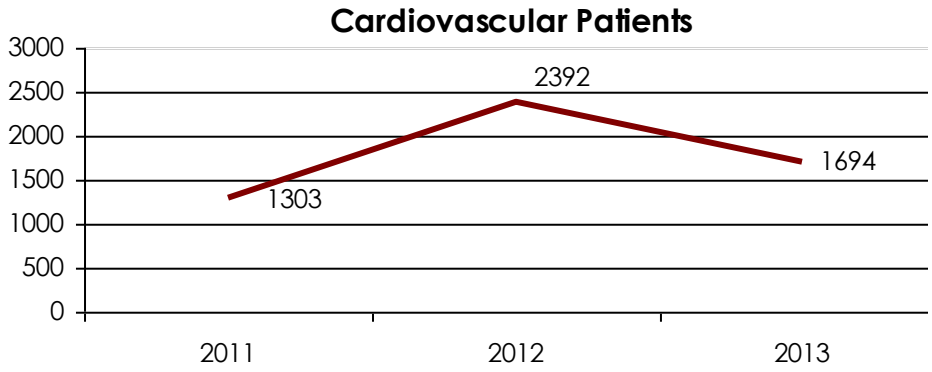


Diabetes Management	2012	Jan-June 2013
Diabetic Patients with an HbA1c less than 9	77%	75%

Charles Drew Health Center



Asthma	2012	Jan-June 2013
Persistent asthma patients, 5-40 years, with medications prescribed or dispensed	89%	95%



Cardiovascular Disease	2012	Jan-June 2013
Cardiovascular patients whose blood pressure was < 140/90	53%	61%
Patients with a diagnosis of CAD prescribed a lipid lowering therapy	74%	74%
Patients with a diagnosis of AMI, CABG, PTCA or IVD on ASA or other antithrombolitic	73%	79%
Adult patients queried for tobacco use	94%	98%
Tobacco users received cessation counseling	25%	18%
Adult weight assessment and required follow up	34%	38%

Childhood Immunizations	2012	Jan-June 2013
Up-To-Date Immunizations	22%	78%

Cancer Screening	2012	Jan-June 2013
Cervical Cancer Screening	24%	38%
Colorectal Screening	10%	14%

One World Community Health Center

County(ies): Douglas

Dollars: $714,050.50

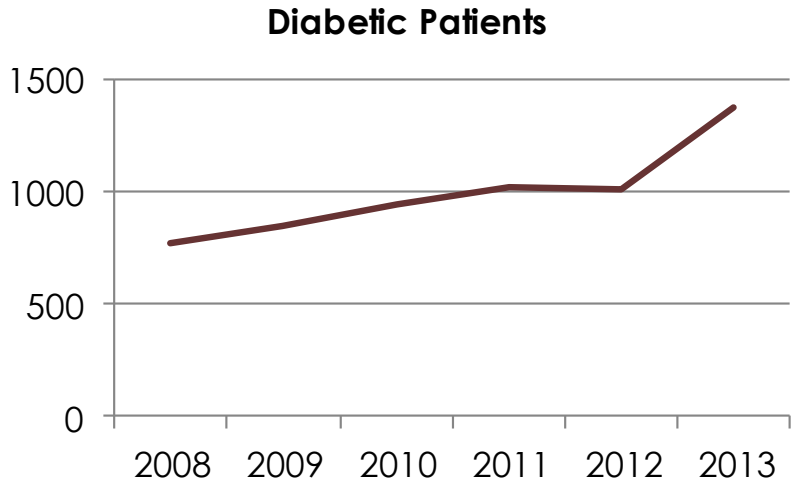
Target Areas: Cardiovascular disease, diabetes

Target Populations: South Omaha

Other Areas: Depression

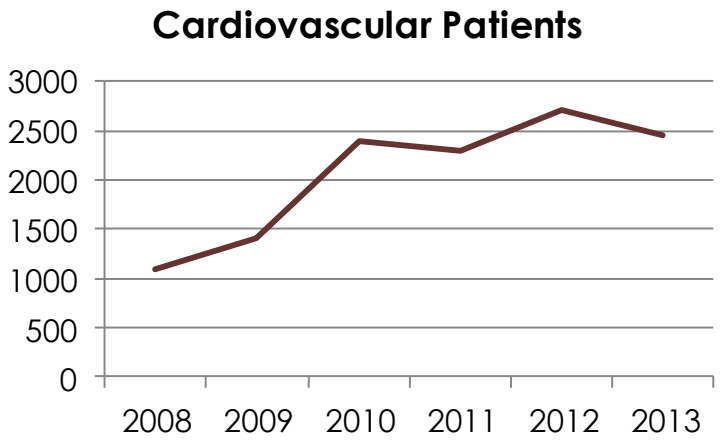
* As noted earlier, included in the appropriation is annual funding to be distributed equally among federally qualified health centers in the second Congressional District. This is one of those projects.

Tobacco	2012	Jan-Jun 2013
Adult patients queried for tobacco use	99.5%	99.8%
Tobacco users received cessation counseling	76.4%	74.1%

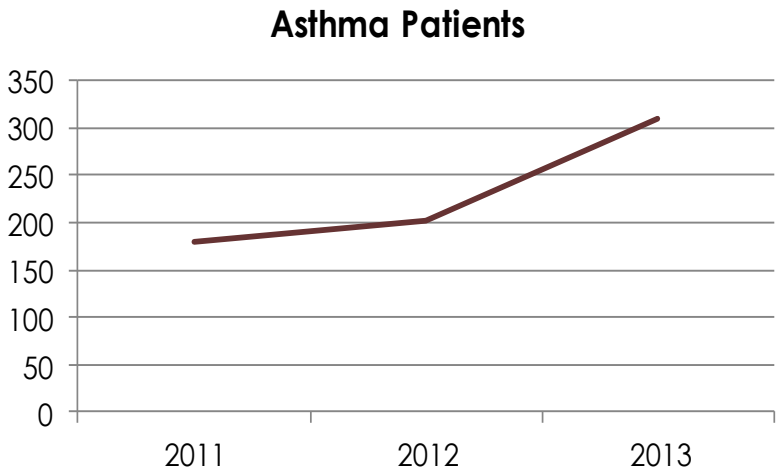


Diabetes Management	Jul 2012-Jun 2013
Diabetic patients with one or more HbA1c tests in last year	68.3%
Diabetic patients with blood pressure <130/80	55.8%
Diabetic patients who received annual foot exam	67.5%

One World Community Health Center



Cardiovascular Disease	Jul 2012-Jun 2013
Two or more blood pressure screenings in past year	80%
Patients with LDL cholesterol in control	68.7%



Asthma	2013	Jan-Jun 2013
Persistent asthma patients with medications prescribed or dispensed	86.1%	84%

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