2014-2015 MINORITY HEALTH INITIATIVE Annual Report

December 1, 2015

In accordance with Nebraska State Statute 71-1628.07

Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services

From the Administrator…

The Nebraska Department of Health and Human Services is pleased to provide this report, created by the Office of Health Disparities and Health Equity, for the Nebraska Legislature to highlight the activities and outcomes of the Minority Health Initiative funding for the 2014 – 2015 year.

The Minority Health Initiative (MHI) 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, but not be limited to, priority issues of infant mortality, cardiovascular disease, obesity, diabetes, and asthma. Appropriations also include 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 for the federally qualified health centers is also used to implement a minority health initiative which may target, but is not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma.

To meet the directive in Congressional Districts One and Three, the Office of Health Disparities and Health Equity (OHDHE) uses a competitive request for applications process. This report covers the second year (2014 - 2015) of the two-year Minority Health Initiative project period 2013-2015. Sixteen projects were awarded funding for the this period. Arthur and Keith Counties did not receive an allocation as applications were not received for these counties. The Minority Health Initiative grant projects support the direct delivery of health care services by expanding existing services or enhancing health service delivery through health education, promotion, and prevention. 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 via collaborations among schools, faith-based organizations, local universities, private practitioners, community-based organizations, local health departments, and other key stakeholders to bring health parity for minorities. Populations to be addressed include racial and ethnic minorities, American Indians, refugees, and immigrants.

During the 2013-2015 project period, several new components were incorporated into the MHI grant process to improve the program achievements and outcomes. Among these were integration of community health workers, linking projects to the work plan of a federal grant, and having external evaluators for each project. The Office of Health Disparities and Health Equity recognizes the important role community health workers play in improving health of communities. Research has demonstrated integrating CHW's into community-based interventions is an effective strategy for prevention of chronic diseases by providing outreach and cultural linkages between communities and delivery systems. As chronic diseases are a focus of the MHI funding and are leading causes of death for minorities, the OHDHE encouraged the use of CHW's as a strategy.

The work conducted by the Minority Health Initiative projects is vital in improving minority public health services in Nebraska. As you will see in this report, the projects are fostering positive change and improving the health among minority populations in Nebraska. The Office of Health Disparities and Health Equity continues efforts to improve outcomes of the Minority Health Initiative funding by working with grantees to identify effective strategies, measuring the effectiveness of the interventions, and providing technical assistance.

On behalf of the Office of Health Disparities and Health Equity, the projects funded during this past year, and Nebraska's minority population, we thank the Nebraska Legislature for providing the Minority Health Initiative funding to improve health outcomes for Nebraska's racial and ethnic populations.

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

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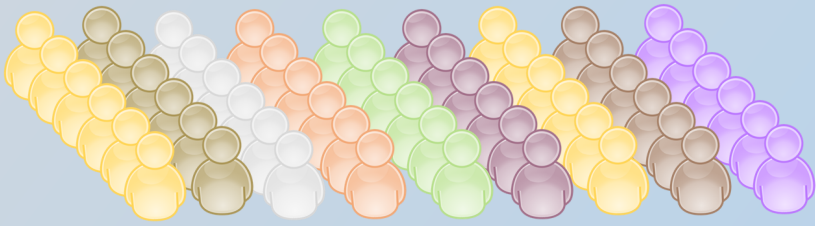
2014-2015 Minority Health Initiative Projects

16 projects served **23,520 people**



1,044 people assisted to find a medical home

718 people assisted to find a dental home

18,069 interpretation sessions provided

Spanish
Arabic
Vietnamese
Karen/Burmese
French
Other

80.3% of those found to be at-risk were referred for additional services

14,432 health screenings provided

9,112 blood pressure checks

1,273 cholesterol checks

3,057 diabetes checks

6,800 screened for obesity

2014-2015 Minority Health Initiative Projects

212 Community Health Workers

helped

5,585 people

With

Health education
Case management
Create/maintain links to community services/resources
Ensured cultural and linguistic appropriateness of messaging
Informal counseling/social support
Peer counseling
Assess needs of clients
Assist with accessing public assistance
Assist with enrolling in medication assistance programs
Advocate for clients and communities
Empowering clients
Recruited peers into training programs
Provide supportive services
Lead physical activity sessions
Interpretation
Health navigation
Health screenings
Health referrals

519 people assisted with transportation to medical appointments

7,997 health education sessions provided to 15,453 participants

85% ↑ knowledge/awareness

91.7% + changes in attitudes/perceptions

90.4% changed behavior

90% ↑ satisfaction

Topics

Cardiovascular disease
Childhood depression and anxiety
Diabetes
Emergency preparedness
Hand washing/hygiene
Health insurance
Healthy nutrition/food portions
Healthy relationships and self esteem
Hypertension
Medical homes
Obesity
Physical fitness/activity
Poverty
Pre- and Post-natal care

Clients Served

This page summarizes the clients served by the Minority Health Initiative projects for the period July 1, 2014 through June 30, 2015. This represents the number of people provided services by the projects as a group. They also include the number of people who demonstrated changes in health indicators such as weight loss and lowered 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 Arab, Middle Eastern, Russian, Karen, Portuguese, Eastern Indian, White Hispanic, persons who chose not to identify their race and/or ethnicity and others.

		Female						
		Hispanic	Non Hispanic					
Age	Total		Black alone	American Indian/Alaska Native alone	Asian alone	Two or More Races, non-Hispanic	White/Other, non-Hispanic/ alone
All Ages	14,564	8,792	1,898	957	1,400	240	1,277
0-17	3,441	1,908	500	117	392	143	381
18-24	1,059	669	107	49	103	28	103
25-64	9,249	5,831	1,157	692	761	66	742
65+	815	384	134	99	144	3	51

		Male					
		Hispanic	Non Hispanic				
Age	Total		Black alone	American Indian/Alaska Native alone	Asian alone	Two or More Races, non-Hispanic	White/Other non-Hispanic alone
All Ages	8,956	5,063	1,369	527	1,010	94	893
0-17	3,102	1,734	527	35	463	49	294
18-24	444	270	51	18	46	6	53
25-64	4,782	2,732	750	420	363	31	486
65+	628	327	41	54	138	8	60

Death Rates Related to Priority Issues, 2004-2008 and 2009-2013

Health Issue	Race/Ethnicity	2004-2008	2009-2013	Change
Heart Disease	African American	221.8	199.4	↓
	American Indian	185.8	135.5	↓
Death rate per 100,000 population	Asian	86.1	70.7	↓
	Hispanic	100.0	70.8	↓
	White	171.4	148.7	↓
Stroke	African American	72.2	56.3	↓
	American Indian	55.4	35.8	↓
Death rate per 100,000 population	Asian	41.1	28.9	↓
	Hispanic	22.7	28.1	↑
	White	43.8	37.1	↓
Diabetes	African American	76.2	49.0	↓
	American Indian	107.3	73.7	↓
Death rate per 100,000 population	Asian	22.8	15.4	↓
	Hispanic	35.2	29.5	↓
	White	21.1	20.5	↓
Infant Mortality	African American	14.3	10.8	↓
	American Indian	11.2	8.2	↓
Rate per 1,000 live births	Asian	5.8	2.2	↓
	Hispanic	6.4	5.6	↓
	White	5.8	5.3	↓

The above is a summary of the mortality rate changes we have seen throughout Nebraska between 2004 and 2013. There were decreases during this period for infant mortality, heart disease, diabetes, and stroke mortality for all racial and ethnic groups, except for the Hispanic population, for which the stroke mortality rate increased. The heart disease mortality rate for American Indians decreased from 185.8 deaths per 100,000 population in 2004-2008 to 135.5 deaths per 100,000 population in 2009-2013. Stroke mortality rates for American Indians decreased from 55.4 to 35.8 deaths per 100,000 population. Diabetes mortality in American Indians decreased from 107.3 to 73.7 death per 100,000 population. Finally, the infant mortality rate for American Indians decreased from 11.2 to 8.2 per 1,000 live births.

Despite this progress, these issues are still challenging to minority populations, especially African Americans and American Indians.

Data Source: Nebraska DHHS Vital Statistics 2004-2013

Risk Factors Related to Priority Issues, 2001-2005 and 2006-2010

Health Issue	Race/Ethnicity	2001-2005	2006-2010	Change
Obesity Prevalence among adults aged 18+	African American	33.9	39.0	↑
	American Indian	29.6	41.7	↑
	Asian	8.4	10.3	↑
	Hispanic	25.5	32.0	↑
	White	23.1	26.7	↑
High Blood Pressure Prevalence among adults aged 18+	African American	35.8	33.9	↓
	American Indian	36.2	28.2	↓
	Asian	15.7	25.1	↑
	Hispanic	17.1	21.8	↑
	White	22.6	25.3	↑
5+ Daily Servings of Fruits & Vegetables Prevalence among adults aged 18+	African American	15.4	25.5	↑
	American Indian	23.8	19.1	↓
	Asian	18.0	49.6	↑
	Hispanic	19.7	22.4	↑
	White	18.2	22.0	↑
Perceived Health Status: Fair or Poor Prevalence among adults aged 18+	African American	19.7	19.0	↓
	American Indian	24.7	22.9	↓
	Asian	17.0	9.1	↓
	Hispanic	25.2	25.2	↔
	White	11.4	10.9	↓

The table above summarizes the changes in the prevalence of certain health indicators in Nebraska between 2001 and 2010. Compared to 2001-2005, the percentage of people reporting fair or poor health in 2006-2010 declined among all racial and ethnic groups except Hispanic. Asians saw a large decrease in fair or poor health reporting, declining from 17% to 9%.

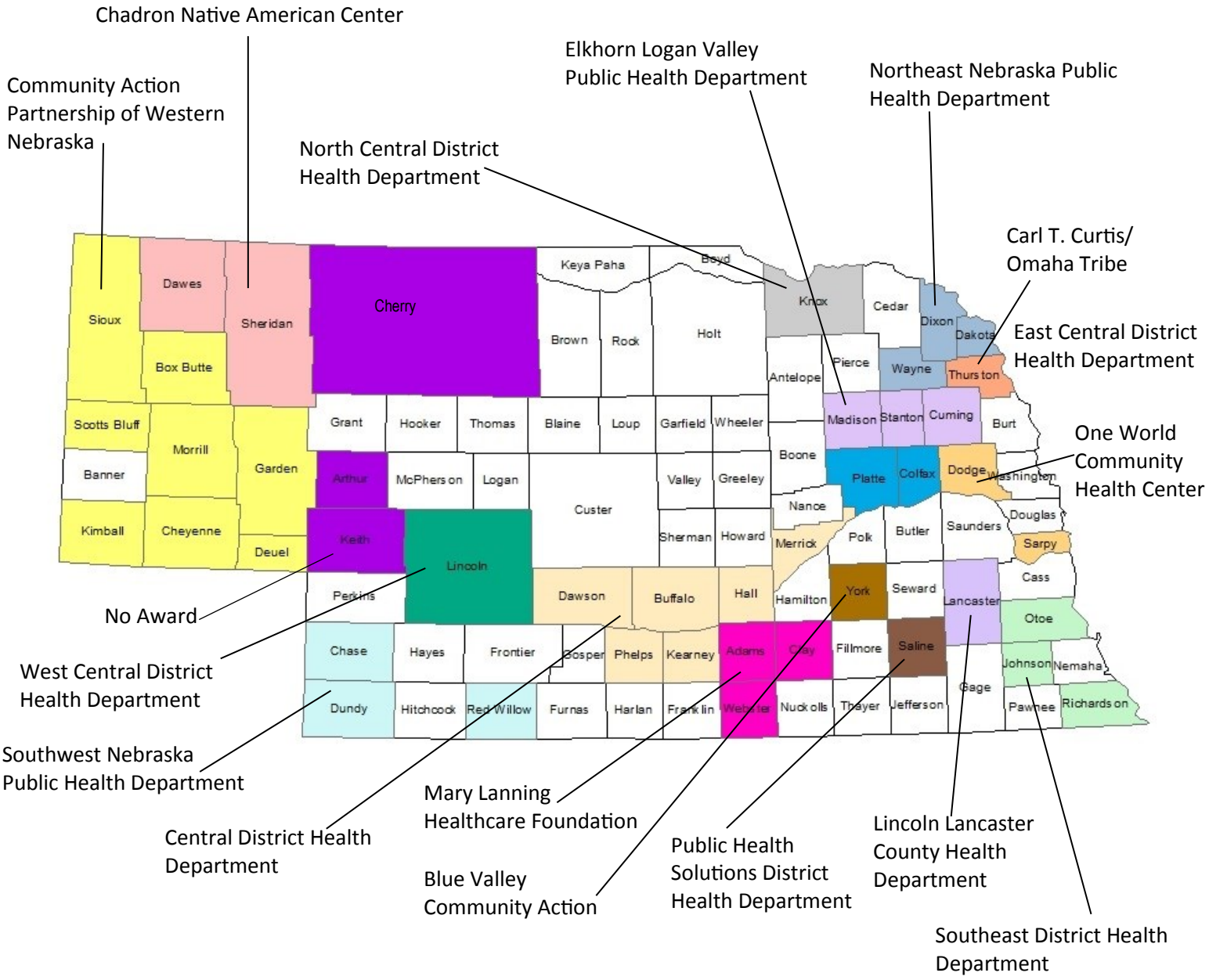
Diets high in fruits and vegetables can reduce the risk for cancer and chronic disease. All racial and ethnic groups, except American Indian, increased the percentage of individuals who consumed five or more servings of fruits and vegetables a day between 2001-2005 and 2006-2010. There were also some negative changes. The percentage of people with obesity (a BMI of 30 or over) increased across all racial and ethnic groups. In addition, almost 42% of American Indians were obese in 2006-2010.

BRFSS data collection, structure, and weighting methodology changed in 2011 and are not directly comparable to previous years of BRFSS data.

Data Source: Nebraska Behavioral Risk Surveillance System (BRFSS) 2001-2010

Grantee Map and Reports

A map of the Minority Health Initiative projects funded for 2014—2015 is shown below. Summaries for the outcomes of each project in Congressional Districts 1 and 3 begin on page 11 of this report. The reports are arranged alphabetically by grantee name, and include the county(ies) covered by the project, funding awarded, funding priority(ies) and other areas targeted, number of clients served during the second year of the project, and project partners. A brief description of each project is followed by activities implemented and outcomes achieved from July 1, 2014 through June 30, 2015. Pages 27 and 28 of this report include the outcomes for the federally qualified health centers in Congressional District 2.



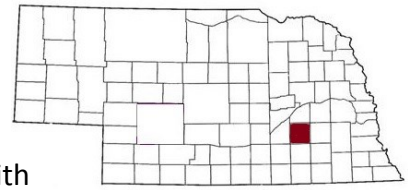
Minority Health Initiative two-year projects (7/2013—6/2015) were awarded to the following organizations:

Projects (Congressional Districts 1 & 3)	2-Year Award	County(ies)
Blue Valley Community Action	$18,126.96	York
Carl T. Curtis Health Center/Omaha Tribe	$81,012.07	Thurston
Central District Health Department	$601,024.31	Buffalo, Dawson, Hall, Kearney, Merrick, Phelps
Chadron Native American Center	$39,223.70	Dawes, Sheridan
Community Action Partnership of Western Nebraska	$253,314.57	Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sioux
East Central District Health Department	$184,239.30	Colfax, Platte
Elkhorn Logan Valley Public Health Department	$136,569.26	Cuming, Madison, Stanton
Lincoln-Lancaster County Health Department	$862,091.05	Lancaster
Mary Lanning Memorial Hospital	$85,659.51	Adams, Clay, Webster
North Central District Health Department	$19,534.69	Knox
Northeast Nebraska Public Health Department	$208,633.56	Dakota, Dixon, Wayne
One World Community Health Center	$391,812.24	Dodge, Sarpy
Public Health Solutions District Health Department	$65,237.76	Saline
Southeast District Health Department	$50,832.61	Johnson, Otoe, Richardson
Southwest Nebraska Public Health Department (contract)	$25,859.88	Chase, Dundy, Red Willow
West Central District Health Department	$68,400.33	Lincoln
No Award	$23,854.25	Arthur, Keith, Cherry
TOTAL	$3,115,426.00	

Federally qualified health centers (Congressional District 2) For a one-year period:

Charles Drew Health Center	$688,550.50	CD 2
One World Community Health Center	$688,550.50	CD 2

York County



Blue Valley Community Action

Through education, guidance and support, this project provided participants with the skills and knowledge to promote chronic disease prevention, maternal and child health promotion, reduce obesity, and improve physical activity among all minority populations in York County. In addition, it raised awareness of post-partum depression and other mental health issues related to challenges facing new immigrants.

Target health issues
Obesity, infant mortality, cancer, cardiovascular disease, diabetes

Other health issues
Mental health

Dollars
$9,063.48 per year

Clients served
94

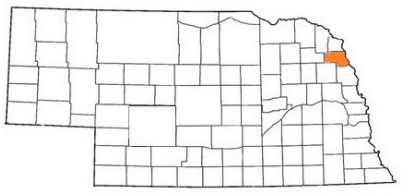
Project partners
Blue Valley Behavioral Health, Four Corners Health Department

Activities & Outcomes July 1, 2014—June 30, 2015

- 23 women were screened, and all were referred to other services
- 19 participants attended the mental health education session, and 100% demonstrated increased knowledge
- 90% increased knowledge of preventive health measures
- 11 people participated in language focus groups
- 14 people participated in the nutrition sessions
- 14 people participated in a childhood depression education session
- External evaluator attended partnership meeting to expand knowledge of project
- Partners worked to provide a more holistic approach to meet the various needs of participants that are not addressed by grant funding

Thurston County

Carl T. Curtis Health Education Center



This project provided education and services to Tribal and minority populations residing in Thurston County. It promoted awareness of *Healthy People 2020* leading health indicators of cardiovascular disease prevention and control.

Target health issues
Cardiovascular disease, diabetes

Dollars
$40,506.04 per year

Clients served
166

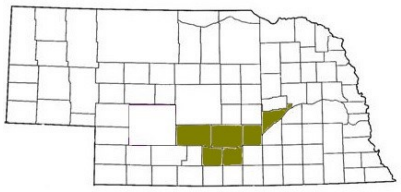
Project partners
Local programs, education providers, healthcare organizations

Activities & Outcomes July 1, 2014—June 30, 2015

- Over 200 Native American adults participated in health risk assessment based on established protocols from St. Luke's Occupational Health
- 52 participants achieved improved health status based on positive changes in their wellness score
- 114 minority adults successfully completed the CPR training and received their certifications, which will tremendously help the community with more access to CPR services and reduce fatality rates associated with heart disease
- The preliminary data collected from the comprehensive Health Risk Assessment, especially the longitudinal nature of the wellness score, has provided a solid foundation for the future development of the project
- This project has helped the Carl T. Curtis Health Education Center to further develop its outreach capacity by working with Community Health Representatives and other community organizations

Buffalo, Dawson, Hall, Kearney, Merrick, Phelps Counties

Central District Health Department



Through a continuum of education and referral care, Choosing Health and Maximizing Prevention (CHAMP) targeted obesity, diabetes, cardiovascular disease, and infant mortality in at-risk minority populations. CHAMP used a life-course educational approach and peer health educators to instill healthy lifestyle behaviors that will improve health status and impact long term health outcomes.

Target health issues
Obesity, diabetes, infant mortality, cardiovascular disease

Other health issues
Sexually transmitted diseases, tobacco or alcohol use, HIV/AIDS

Dollars
$300,512.16 per year

Clients served
1,577

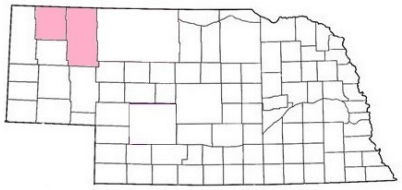
Project partners
Two Rivers Public Health Department, Central Health Center, Central Nebraska Council on Alcoholism and Addictions, Community Fitness Initiative, Multicultural Coalition of Grand Island, community and cultural centers, employers, faith-based organizations, Lexington Regional Health Center

Activities & Outcomes July 1, 2014—June 30, 2015

- 258 students participated in a CATCH Kids Club series, and all improved their assessment scores on at least seven of the assessment items
- Discovery Kids served 148 students, and the majority improved on no fewer than eight of the assessment items
- 181 people participated in interviews at 3 months and 6 months, and 3/4 of follow-up participants indicated their diets were healthier
- Health education class participants improved their scores by no fewer than nine items included in pre- and post-assessments
- Focus group data indicated that participants in the classes made lifestyle improvements related to healthy eating
- Over 602 adults participated in health fairs and screening events
- 311 adults participated in an eight-week series of nutrition classes
- Participants of eight-week nutrition classes (mostly women) indicated that while their husbands and other male supports were not involved with the CHAMP Program directly, they had the most influence on healthy food choices and preparation and the amount of physical activity in the household
- 70% of participants demonstrated a positive change in behavior around nutrition and/or physical activity

Dawes, Sheridan Counties

Chadron Native American Center



This project continued a wellness program in Dawes and Sheridan counties to include wellness checks and the evidence-based National Diabetes Prevention Program (NDPP).

Target health issues
Obesity, diabetes, cardiovascular disease

Dollars
$19,611.80 in year two

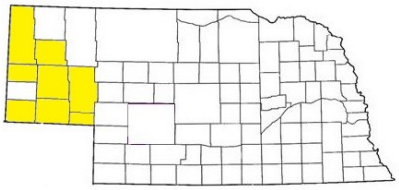
Clients served
1,138

Project partners
Panhandle Public Health District, Western Community Health Resources

Activities & Outcomes July 1, 2014—June 30, 2015

- 100% of those who attended events received basic screening
- 85% of those screened and at-risk were referred to other services
- 80% of health education participants increased knowledge of healthy eating habits
- 50% increased consumption of fresh fruits and vegetables
- 50% increased physical activity
- Among patients receiving case management, 30% adhered to their medication regime
- Among patients receiving case management,8% achieved control of their blood pressure and/or diabetes
- For clients enrolled in the Diabetes Prevention Program (DPP), 66% cut down on their fat intake and 36% lost 5-7% body weight or more

Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Sioux, Scotts Bluff Counties



Community Action Partnership of Western Nebraska

This project reduced health disparities by using community health workers to provide intensive case management to racial ethnic minorities, Native American, refugee, and immigrant populations with chronic diseases (diabetes, cardiovascular, and obesity); and used lay health ambassadors to identify and connect minorities who have diabetes, cardiovascular, and obesity issues with a medical provider.

Target health issues
Obesity, diabetes, cardiovascular disease

Dollars
$126,657.29 per year

Clients served
595

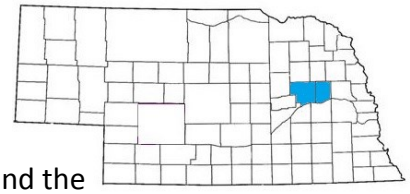
Project partners
UNMC Western Nebraska Division of College of Nursing, Regional West Medical Center, Lakota Lutheran Center, CAPWN providers, Indian Center Inc., ESU 13, Scotts Bluff County Health Department, Panhandle Public Health District, Nebraska AIDS Project

Activities & Outcomes July 1, 2014—June 30, 2015

- 10 health screenings were held with 139 minority patients who received basic health screening and educational lessons
- 89 % increase knowledge rate for hypertension education
- 99% increase knowledge rate for diabetes education
- 100% of participants screened and found to be at-risk were referred to additional services
- Significant activities of the project included outreach to minorities with chronic diseases, and culturally and linguistically appropriate case management for each patient through community health workers (CHWs)
- 100% of recruited patients participated in intensive case management
- 100% of participants received education on health care
- 100% of people with abnormal screenings received motivational interviewing
- 57% of people who received motivational interviewing were referred for additional follow up
- 36 diabetes patients and 70 hypertension patients received case management (910 total encounters) with 100% and 99% customer satisfaction rate respectively
- All participants in the chronic disease self-management program (CDSMP) demonstrated increased knowledge
- 90% of CDSMP attendees were referred for further educational sessions
- CHWs facilitated bridging the gap in communication among providers and clients, improving timely responses and trust, which will improve health outcomes in the long term through 2,668 encounters
- 257 Native American and 95 Hispanics received transportation services to receive medication

Colfax, Platte Counties

East Central District Health Department



Through prevention programs, this project reduced the incidence of diabetes and the economic burden of diabetes, and improves the quality of life for all racial ethnic minority, Native American, refugee, and immigrant populations who had or were at-risk for diabetes.

Target health issues
Cancers, diabetes, cardiovascular disease

Dollars
$92,119.65 per year

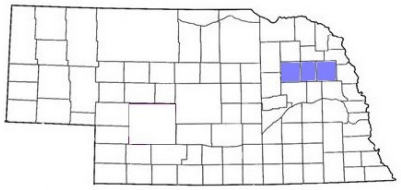
Clients served
249

Project partners
Alegent Creighton Health Clinic, Divine Mercy Church, Good Neighbor Community Health Center, Schuyler Community Resource Center, St. Bonaventure Church

Activities & Outcomes July 1, 2014—June 30, 2015

- 22 new clients improved glycemic control and received a follow up consultation
- ECDHD screened 202 minorities for undiagnosed diabetes
- 5 *promotoras* assisted 25 individuals each quarter during the second year in an effort to increase their daily level of physical activity, for a total of 100 clients served
- The average number of steps per day for 50 program participants increased on average 19.8% by the end of the project year
- Survey results indicated that participants reported high levels of satisfaction with the program
- 202 individuals received blood glucose screenings to determine the presence of undiagnosed diabetes, 100% at risk referral rate
- 51% of diabetes case management patients improved their A1c levels
- 50% of the hypertension case management patients achieved control of their blood pressure levels

Cuming, Madison, Stanton Counties



Elkhorn Logan Valley Public Health Department

With prevention as the primary priority, this project continued the work of reducing obesity and the subsequent chronic disease impact that obesity triggers among all minority populations. Program staff, with assistance from community health workers, implemented evidence-based strategies that aligned with *Healthy People 2020*, the DHHS OHDHE strategic plan, as well as the *National Partnership for Action* to reach program goals, objectives, and outcomes.

Target health issues
Obesity, diabetes, cardiovascular disease

Other health issues
As indicated are necessary by the people served

Dollars
$68,284.63 per year

Clients served
1,063

Project partners
Norfolk Community Health Care Clinic, Madison Medical Clinic, other local medical providers, Tyson Foods, local schools

Activities & Outcomes July 1, 2014—June 30, 2015

Cardiovascular Group Education:

- 94% of respondents gained a better understanding of weight, BMI, and blood pressure measurements

Individual Diabetes Self-Management Sessions:

- 79% reported changes in their nutritional habits
- Biometric measures: 70% lost weight; 70% lowered their BMI; 94% reported changes in exercise/activity, exceeding the 75% goal, and 88% reported improvements in their nutrition; about one in seven (14%) reduced their waist by at least one inch, and overall 65% reduced their waist measurement; of those with repeated A1c measures (19% of all), half (50%) showed a reduction in their A1c measure; 84% reduced their glucose levels

Physical Activity Classes:

- Of those maintaining participation in exercise classes, 39% lost at least 5+ pounds in weight

Topic of the Month Sessions:

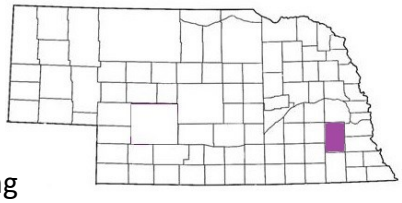
- 100% of 180 individuals improved knowledge according to pre-/post-test measures

Referrals:

- 100% of persons who were reached in the follow-up reported having followed through with the referral

Lancaster County

Lincoln-Lancaster County Health Department



This project focused on decreasing health risk from chronic disease and reducing the associated health disparities often experienced by minority populations. Partners of the Minority Health Community Collaborative continued to play a significant role with the health safety net in the community. Partners provided services such as outreach, education, help in applying for assistance programs, health screening and health risk assessments, health care navigation, breastfeeding consultation, help to establish a medical and dental home, specialty health care referral, medication assistance, and interpretation services for minority populations in Lancaster County.

Target health issues
Obesity, diabetes, cardiovascular disease, cancers

Other health issues
Oral health, tobacco or alcohol use

Dollars
$431,045.53 per year

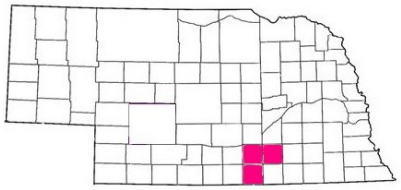
Clients served
16,129

Project partners
Asian Community & Cultural Center, Clinic with a Heart, Clyde Malone Community Center, El Centro de las Americas, Lancaster County Medical Society, MilkWorks, People's Health Center, UNMC College of Dentistry, Health Hub at Center for People in Need

Activities & Outcomes July 1, 2014—June 30, 2015

- 420 screenings were conducted and 919 clients received education through cultural centers
- Participated in 24 health fairs and cultural center staff interacting with 1,370 clients
- 97% of at-risk clients referred for additional services by cultural centers (221)
- 627 provided help with basic assistance programs
- 1,066 clients at Clinic With A Heart (CWAH) received clinic services (including medical, dental, physical therapy, chiropractic, mental health, vision, hearing, medication assistance, interpretation, and spiritual health) and 874 were referred on for additional services in the community
- 648 patients established a medical home at People's Health Center and 54 through Lancaster County Medical Society
- 712 patients established a dental home
- 63 patients were referred and received services with a 50/50 match at the University of Nebraska Medical Center College of Dentistry
- 186 Native American patients received screening and education through Nebraska Urban Indian Health Coalition, and 131 established a dental home
- 10,417 interpretation services were provided by MHI partners for the following languages: Spanish, Arabic, Karen, Vietnamese, French, Kurdish, Chinese and Burmese
- 136 minority mother-baby pairs were served with 343 MilkWorks breastfeeding consultations
- 263 minority patients met with a diabetes educator (186 completed a personal behavior modification plan, 68%)

Adams, Clay, Webster Counties



Mary Lanning Healthcare Foundation

El Paquete Total (EPT) served the Hispanic population, offering health, wellness, education, nutrition, and exercise components to address diabetes. The program focused on individuals experiencing diabetes using a "total family" program. EPT offered individual disease management using the American Association of Diabetes Educators' (AADE) seven self-care behaviors as well as offering educational and support programs to family members, including YMCA memberships, family garden plots, volunteer activities, home visits, and advocacy.

Target health issues
Obesity, diabetes, cardiovascular disease

Other health issues
Mental health

Dollars
$42,829.76 per year

Clients served
700

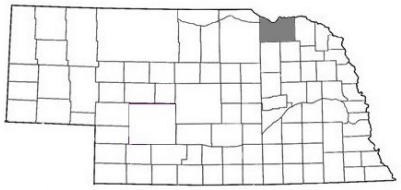
Project partners
Mary Lanning Diabetes Department, Mary Lanning Healthcare Foundation, YMCA, South Heartland District Health Department

Activities & Outcomes July 1, 2014—June 30, 2015

- 116 minority participants in Adams County and 20 minority participants in Clay County received case management and were connected to primary care provider/Medicaid/Medicare assistance program
- 79 minority participants in Adams County and 20 minority participants in Clay County received diabetes or health risk screenings
- 3 health education sessions on nutrition and weight management were provided to 150 participants
- 79 adults in Adams County and 20 adults in Clay County had their BMI monitored, and 8 participants received nutritional consultations
- 20 case management participants in Adams County increased and/or maintained their exercise program
- 120 participants received physical activity education
- 47 minorities participated in 2 outdoor activities sessions in Adams County and 20 participated in 1 outdoor activity session in Clay County
- 10 minority children participated in CATCH Kids Club activities in Clay County
- 79 health risk assessments were conducted in Adams County and another 20 in Clay County
- 54 healthcare providers completed health literacy training

Knox County

North Central District Health Department



This project focused efforts to improve the quality of life for all racial ethnic minorities, Native American, refugee, and immigrant populations in Knox County who had diabetes, by increasing education, prevention efforts, and community capacity. Sexually transmitted diseases were also addressed through increasing access to quality health services through education and prevention efforts.

Target health issues
Diabetes

Other health issues
Sexually transmitted diseases

Dollars
$9,767.35 per year

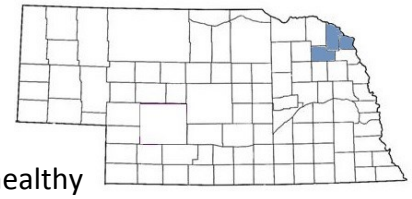
Clients served
815

Project partners
Santee Sioux Nation (Santee Health Center)

Activities & Outcomes July 1, 2014—June 30, 2015

- 46% of males and females achieved a reduction in blood pressure measures
- 46.3% of female participants lost some weight; there was an overall loss of 494 pounds for those participating in the program
- 48.8% of male participants lost some weight, with a group total of 171 pounds
- On average, male participants lost 2.3 pounds from the first to second measure, and female participants lost 7.3 pounds from the first to second measure
- For females, 33% decreased or maintained the same A1c from first to second measure
- For males, 33% decreased A1c levels from the first to the second measure
- Among male participants, 40% had a foot exam within the past year; of those, 64% were classified as abnormal
- Of females, 60% had a foot exam within the past year; of those, 44% were classified as abnormal

Dakota, Dixon, Wayne Counties



Northeast Nebraska Public Health Department

This program focused on the prevention of chronic disease and promotion of healthy lifestyles. Community health workers were integral to the success of this project. The focus on health literacy and collaboration with community health workers provided the evidence-based approach necessary to ensure accomplishing the goals of the project.

Target health issues
Cardiovascular disease, diabetes

Other health issues
Access to care

Dollars
$104,316.78 per year

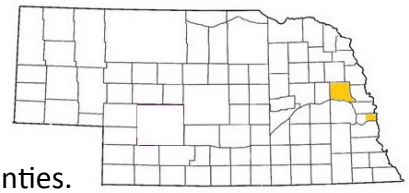
Clients served
1,226

Project partners
Northeast Nebraska Community Action Partnership, Salem Evangelical Church, Gardner Public Library, local hospitals, medical clinics, city and county governments

Activities & Outcomes July 1, 2014—June 30, 2015

- Outreach to minority populations to 4 distinct population groups including: Hispanic, African-American, Asian, and Native American in Dakota County
- Interpreter services were provided in twelve (12) languages: Spanish, Mayan Dialects of K'iche and Kaqchikel, Vietnamese, Laotian, Cambodian, Tagalog, Somali, Arabic, Amharic, Tigrigna, and Oromo
- 49 family health assessments were completed
- 12 screening events were offered to more than 300 participants
- 83% of people found to be at-risk through screenings were referred for additional services
- 84% of participants receiving a referral report completed their follow-up
- More than 300 people received education on their chronic conditions
- Of those participating in the educational offerings, 62% demonstrated improvement in their understanding of the health topic covered
- Provided outreach to professional partners in Dakota and surrounding counties to increase knowledge of CLAS standards among healthcare professionals

Dodge, Sarpy Counties



One World Community Health Center

Funds were used to continue the *promotora* programs in Sarpy and Dodge Counties. The goal of the project was to train 150 additional *promotoras*, provide additional training to *promotoras* already trained through the previous grant cycle, and screen at least 1,800 individuals for diabetes, hypertension, and obesity in Sarpy and Dodge Counties. Individuals who had high test results were connected to the One World outreach lead and individually connected to One World as a medical home to manage and improve their health condition.

Target health issues
Obesity, diabetes, cardiovascular disease

Dollars
$104,316.78 per year

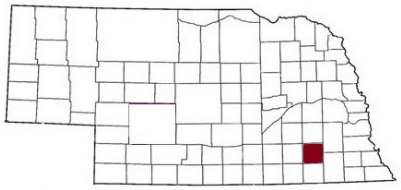
Clients served
2,443

Project partners
Nebraska Methodist College, Hope Medical Outreach Coalition, Midland University

Activities & Outcomes July 1, 2014—June 30, 2015

- 198 *promotoras* were recruited and trained
- The work plan goal set at reaching 1,800 minorities for screenings was exceeded, reaching 2,443 (135%) of targeted goal
- 1,133 of those screened were found to be at-risk
- 59% of people screened (everyone found to be at-risk) were referred for additional services
- 80% indicated satisfaction with the health screening process
- 85% demonstrated increased awareness and knowledge regarding health topics addressed
- 100% of those receiving services were assisted to establish a medical home
- 86% of participants reached by *promotoras* indicated satisfaction with the *promotora* support

Saline County



Public Health Solutions District Health Department

The primary goal of the My Life, My Health (*Mi Vida, Mi Salud*) Program was to minimize the detrimental impact of diabetes on the racial ethnic minorities, American Indian, refugee, and immigrant populations through educating community members about ways to prevent and/or manage diabetes through healthy eating and physical activity.

Target health issues
Obesity, diabetes, cardiovascular disease

Dollars
$32,618.88 per year

Clients served
130

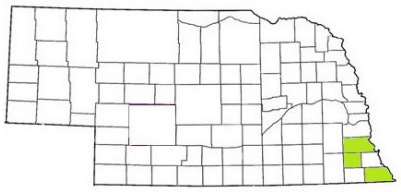
Project partners
Saline Medical Specialties, Crete Area Medical Center, Gage County and Saline County Extension, Saline Eldercare, El Paraiso, Crete Community Gardens, Bruce Kennedy, DDS

Activities & Outcomes July 1, 2014—June 30, 2015

- 27 screening events were conducted
- 138 unduplicated minority participants received screenings for diabetes
- 49 racial ethnic minorities who were at-risk for type 2 diabetes participated in nine *Road to Health* Programs; of these, 48% demonstrated an increase in knowledge, and 91% indicated adoption of a healthier diet
- 59% of minorities identified as diagnosed diabetics participated in *Journey for Control* Programs; of these, 79% demonstrated an increase in knowledge and awareness, and 100% indicated choosing healthier foods and plans to exercise more
- 25% of participating diagnosed diabetics received a foot screening, and 22% reduced their A1c's within three months
- 79% of the participants found to be at-risk for diabetes, obesity, or cardiovascular disease were referred for additional services
- 64% of participants with matching pre/post assessments demonstrated an increased knowledge of their personal health risks

Johnson, Otoe, Richardson Counties

Southeast District Health Department



This project improved access for all racial/ethnic minorities, Native American, refugee, and immigrant populations to three existing programs: *Growing Great Kids*, *Every Woman Matters*, and the *Nebraska Colon Cancer Program* (NCP). Community-based lay health ambassadors served as liaisons between the public health system and minority communities and provide health education and outreach. Community-wide cultural competency training workshops also increased awareness of health disparities and advanced cultural intelligence.

Target health issues
Infant mortality, cancers

Dollars
$25,416.31 per year

Clients served
672

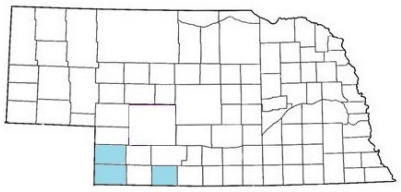
Partners
Catholic Health Initiative/St. Mary's, Educational Service Unit #4's Early Development Network, Nebraska City Medical Clinic

Activities & Outcomes July 1, 2014—June 30, 2015

- 162 referrals were made to the *Growing Great Kids* program
- 75% of the referrals screened as at-risk, received an in-home survey visit to assess for family stressors, substance use, and to measure healthy parenting factors
- 56% of families receiving the in-home survey visits who qualified for further services were enrolled into program services
- All families requiring the use of interpretation services were accommodated
- Results indicated 100% satisfaction with services, which exceeded the project goal which was set at 75%
- Successful working relationships were furthered with Educational Service Unit #4's Early Development Network, Catholic Health Initiative/St. Mary's and Nebraska City Medical Clinic

Chase, Dundy, Red Willow Counties

Southwest Nebraska Public Health Department



This project aimed to increase access to preventive healthcare services offered through Southwest Nebraska Public Health Department.

Target health issues
Obesity, cancer, cardiovascular disease

Other health issues
Tobacco or alcohol use, access to preventive healthcare services

Dollars
$12,929.94 per year

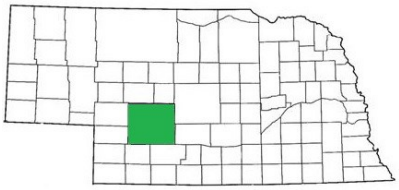
Clients served
179

Activities & Outcomes April 1, 2014—June 30, 2015

- A Spanish-speaking program assistant was hired
- Registration forms, service flyers, brochures, and other forms developed were translated into Spanish
- Outlying clinics have been established
- Diabetes was identified with one client whom has now successfully brought her diabetes under control with diet and regular physician visits
- Pockets of underserved residents were identified and 179 were reached for services

Lincoln County

West Central District Health Department



By utilizing community health workers, educated minority populations on health-related topics, which included obesity, cancer, cardiovascular disease, diabetes, and mental health issues. Additionally, the community health worker served as a member of the care delivery team by serving as an advocate for the clients. The community health worker collaborated with a team comprised of a physician, nurse or allied health worker, and assistant to deliver health education or basic screening services while the providers conduct medical exams and will also serve as an interpreter when needed.

Target health issues
Obesity, cancer, cardiovascular disease, diabetes

Other health issues
Mental health

Dollars
$34,200.94 per year

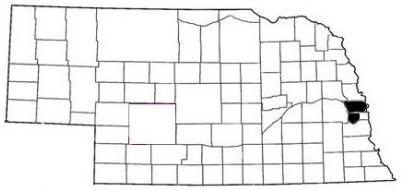
Clients served
1,057

Project partners
Great Plains Regional Medical Center

Activities & Outcomes July 1, 2014—June 30, 2015

- Educational sessions on diabetes, cholesterol, heart health, healthy families, immunizations, emergency preparedness, infant nutrition, mental health, physical fitness, tobacco cessation, nutrition, and stress were provided to 196 participants
- 93% of those who completed an evaluation for the health fair event indicated satisfaction with the program
- 137 minorities enrolled in the diabetes management program
- 14 education/screening sessions were provided, 54 screenings were provided
- 37% of participants improved their blood pressure levels; 33% improved their blood glucose levels; and 40% experienced intentional weight loss
- 670 interpretation sessions were provided

Charles Drew Health Center



Also included in the appropriation is annual funding to Charles Drew Health Center in the second Congressional District. 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. The information below is for all clients served by the organization.

Target health issues
Cardiovascular disease, asthma, diabetes, obesity, infant mortality

Other health issues
Depression, oral health, substance and alcohol use

Dollars
$688,550.50

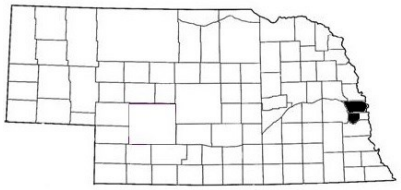
Clients served
5,590

Minority clients
69.8% or 7,295

Activities & Outcomes July 1, 2014—June 30, 2015

- 16% of Charles Drew Health Centers (CDHC) patients speak English as a second language
- 88% of patients 12 years and over were screened for depression and had a follow-up plan documented if patient was considered depressed
- CDHC had a total of 346 adult patients, 18 years and over, with a diagnosis of Type I or Type II diabetes. From July, 2014—June, 2015, 75% of our diabetic patients had a HbA1c less than 9%
- Asthma: The current number of asthma patients aged 5—40 years with a diagnosis of mild, moderate or severe persistent asthma is 97; 82% of those patients are being treated with an accepted inhaled Corticosteroid or an accepted alternative medicine. Our goal is to reach 90%
- Cardiovascular: CDHC has 1,024 adult patients (age 18—85 years), with a diagnosis of hypertension. The percentage of cardiovascular patients with controlled hypertension (blood pressure less than 140/90) has increased from 56% to 58%; the goal is to reach 61%. The percent of adult patients with a diagnosis of Coronary Artery Disease (CAD) who were prescribed a lipid-lowering therapy increased from 80% to 92% (goal is 70%). The percent of adult patients with an active diagnosis of Ischemic Vascular Disease (IVD) or been discharged after Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG) or Percutaneous Transluminal Coronary Angioplasty (PTCA) with documentation of ASA use or another antithrombotic is 80%; goal is 70%
- Prenatal: There was a total of 987 obstetrician appointments and 56 postpartum appointments from July, 2014—June, 2015. The percentage of women initiating their prenatal care during the first trimester is 68%; goal is 78%. The percentage of births <2,500 gram is 10%; goal is <7.8%
- Obesity: The percentage of patients aged 2—17 years with weight assessment and counseling for nutrition and physical activity increased from 47% in 2014 2.5% in 2015; goal is 55%. The percentage of adult patients with weight screening and follow-up increased from 37% in 2014 to 50.5%; the goal is 54%
- Tobacco use: The percentage of adult patients who have been screened for smoking status and if diagnosed with tobacco use, have had a cessation medication prescribed in 24 months of reporting date is 82%
- Immunizations: The percentage of children who were fully immunized by their 3rd birthday is 77%

One World Community Health Center



Also included in the appropriation is annual funding to One World Community Health Center in the second Congressional District. 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. The information below is for all clients served by the organization.

Target health issues
Diabetes, infant mortality, cardiovascular disease

Other health issues
Tobacco or alcohol use, depression, asthma, pediatric oral health

Dollars
$688,550.50

Clients served
29,995 in calendar year 2014

Activities & Outcomes July 2014—December 2014

- 95.6% of adult patients were screened for tobacco use, compared to the *Healthy People 2020* goal of 30%, the national average of 59%, and Nebraska average of 60%
- In 2014, 1,112 patients had their hypertension in control, 59% of those were minority patients
- 82.6% of diabetic patients had HbA1c results less than 9 mg/dl

1,447 expectant mothers received prenatal care at OneWorld in 2014

- Over 77% of prenatal patients began their care in the first trimester, which is higher than the national community health center average and the *Healthy People 2020* benchmark
- Only 5.78% of babies born to OneWorld patients were of low birth weight
- In 2014, OneWorld cared for 2,647 patients diagnosed with depression and other mood disorders
- 92% of patients aged 12 and over who were screened for depression received treatment and follow-up
- In 2014, over 95% of all OneWorld patients were screened for tobacco use and for those found to be a tobacco user, received cessation counseling intervention or medication
- In 2014, OneWorld cared for 5,541 pediatric dental patients at all locations, including their pediatric mobile dental unit
- 231 patients aged 5 through 40 diagnosed with persistent asthma had an acceptable pharmacological treatment plan in 2014
- 6,913 children and adolescents aged 3 to 17 had a documented Body Mass Index (BMI) percentile and received counseling on nutrition and physical activity

Success Stories

Blue Valley Community Action Partnership

In January of 2015 a non-English speaking pregnant Hispanic woman contacted the Healthcare Case Manager, having received the case manager's phone number from another family member who had been provided case management services. The case manager made an appointment for the caller to come to the WIC (Women, Infant and Children) clinic the following week. The family (Father and Mother), were both non-English speaking and new to the community, so the Hispanic Healthcare Case Manager completed an assessment to determine if they had any additional needs. The case manager made referrals and appointments due to additional identified needs. The family had not applied for Medicaid to help with the medical expenses of the unborn due to lack of knowledge of how the process worked. The case manager assisted them with the application and followed up to be sure all the paperwork was completed and that the client was in an approved status for service. The client was approximately four months pregnant and had not received medical care, so she was assisted in securing a medical home. Because the family was living with relatives, an appointment was made with BVCA local housing assistance program. In addition, the case manager assisted in getting two other children enrolled in Head Start. They were referred to and received assistance with additional food and clothing from BVCA Family Community Service program.

The case manager did a monthly follow-up with the family, and learned that the father had found employment and they were approved for low-income housing. The pregnant woman continued to be seen monthly at the WIC clinic and was provided support for her nutritional risk, late pre-natal care, and education on breastfeeding. In early June she delivered a healthy baby boy. She did have some problems with breastfeeding and received support from the case manager who also serves as a WIC PEER Counselor. The family expressed how thankful they were for all the support services that the Case Manager and the project provided.

Central District Health Department

A participant who needed help from the community health worker for information about gestational diabetes. She attended each of the program sessions on prevention and delay of diabetes, with the result being that she made changes in her eating and physical activity. She, along with her family, benefited by learning and applying the knowledge into their lifestyle.

Another participant stated, *"Thanks for your help, I wish more people would benefit from such good information to be made aware and make changes. We need more programs like this to make changes." "My family and I are very happy with the changes we've made, we feel more active and energetic. Thanks for helping us."*

Chadron Native American Center

A 67-year-old Native American male client who has been accessing services since 2011 came to us with a history of Type 2 Diabetes, high cholesterol, and smoking. He was asked to fill out a risk assessment and prepare a life plan. His cholesterol numbers have always been good; his numbers for glucose have always been in the pre-diabetes range and he reports taking his medication as directed. We scheduled him to come in monthly for one-on-one education using the national diabetes prevention program curriculum. We check his blood pressure and weight and ask how much exercise he is getting per week. We also conduct a post-evaluation to determine if what we are providing is helping him. We have concluded that he is benefitting from our program. He continues to be diligent about coming to the office monthly and is always positive about wanting to try and be healthy. He has tried to reach others about what he has learned in class. He is a veteran and tries to walk in the parades and participates in pow wows. Overall, post evaluations are consistently positive showing he has learned from the participating in our program.

Community Action Partnership of Western Nebraska

On February 27, 2014 a 41-year-old female participated in a health screening at CAPWN. Measuring 4'7'' and weighing 128.5 lbs., her blood pressure reading of 155/98 was unexpected. Subsequently, she was immediately scheduled for an appointment with one of the CAPWN providers and was added to the Case Management Patient List.

March 13th, 2014 she had her first appointment at CAPWN with a blood pressure reading of 158/105. She had been following up with her appointments at CAPWN which were scheduled every one to three months; she was also contacted by a community health worker on a monthly basis. Consequently, her blood pressure reading was within normal range at 129/85, 118.2 lbs. With the combination of two different blood pressure medications, exercise, and a healthy diet, the patient's blood pressure is under control.

East Central District Health Department

Celina has been diabetic for the last 20 years. She has been seen by the same doctor in her hometown for the last 10 years with no concerns and no conflicts at all. Celina was provided with community health worker (CHW) services on two occasions during her doctor's visits before this incident happened: One day Celina contacted the CHW with a concern and broken down voice stating, "I received a letter from the insurance company telling me that Blue Cross/Blue Shield is not going to cover my medical bills anymore, I don't know what will happen." The CHW asked Celina to bring the letter to her office. The following day, Celina brought the letter to the CHW and learned it was true - Celina had been removed from her husband's insurance due to some documentation not completed on time; consequently, she would not qualify until December. The CHW- referred Celina to Columbus - Good Neighbor Clinic where she received financial assistance, medical care and transportation for her medical appointments. Now that Celina is back on her insurance and she can go back to her local provider she said, "I will continue to go to the Good Neighbor Clinic because I don't know what changes this insurance will make in the future and I don't want to go back and forth. Here I got all the services in one location. Gracias!"

Elkhorn Logan Valley Public Health Department

Algo's father and his entire family have diabetes, so he knew to watch for symptoms as he aged. He did not, however, know to what extent that diabetes can affect his general health. He was diagnosed with diabetes and hypertension and his wife also has diabetes; their 6 children are at risk of diabetes. When Algo started diabetes self-management classes his A1c level was 9.2 (estimated AVG glucose 217). As a result of receiving services from ELVPHD, Algo's most recent lab test (July), showed a significant decrease on A1c to 6.7 (estimated AVG glucose 152). Now Algo and one of his sons who lives with him are always looking for and studying up on as much information as they can on "their" disease. The family makes a good team and the children encourage their father to avoid unhealthy food, especially his favorite snack "flour tortillas and bread."

Lincoln –Lancaster County Health Department

A 55-year-old Vietnamese male who worked full time in janitorial services was having more difficulty at work due to a large hernia he had for years. The program helped him to establish a medical home at the Peoples' Health Clinic (PHC); the provider worked diligently to encourage him to contact our office about surgery. He was pleasantly surprised we were able to get the surgery completed at a discounted rate, and he missed only four days of work.

A 68-year-old Spanish speaking client from Mexico had been diagnosed with breast cancer in her home country. Since she was not a permanent resident, she did not qualify for any governmental assistance. However, we were able to work with the family, the oncologist and a local hospital to obtain cancer treatment at discounted rates, and she is now in remission.

A 47-year-old Arabic mother of seven needed a diagnostic colonoscopy. As a patient of PHC, they were able to schedule her for the procedure that was performed by one of the PHC providers at a local clinic. There were several cancer polyps removed and she was referred to an oncologist for follow up. All services were provided at discounted rates in a timely fashion.

A woman who participates in the El Centro Zumba class program has seen great success. Prior to the class, she suffered from elevated cholesterol and thyroid dysfunction, and was overweight. She never seemed to have sufficient energy in her daily activities. Since starting the Zumba program she reports feeling better physically, mentally, and emotionally. In addition, her primary care physician has informed her that her cholesterol has decreased and her thyroid is returning to a normal functioning state. She reports more energy and a positive attitude. She has been making better diet and nutrition choices in her daily life and looks forward to continuing on a healthy path.

An elderly client was living on $400 a month and did not have health insurance coverage. He did not speak English and could not apply for benefits due to the language barrier, even though he qualified for many benefits. He was sick and wanted to seek health care, but was afraid of the cost. The Asian Center helped him obtain services such as Medicaid, supplemental retirement income, food stamps, housing and utilities assistance.

Mary Lanning HealthCare Foundation

Mr. A.C. is one of our participants and a senior member of our community; he has been in our Program for about 3 years to address his hypertension and risks associated with a family history of cardiovascular disease. He consistently attends our exercise group, the *Stretch for Life* program, and very seldom misses our regular monthly meetings as well as our annual health fairs. Everything happened very quickly, it was a regular work day during lunch time; A.C. started feeling not well, having dizziness, but the most striking symptom was the pain in his left arm accompanied by a cold sensation and numbness in his left hand and fingers which turned bluish and pale. He knew something was wrong, he knew, because we have, in more than one occasion, discussed in our group meetings about red flags that should be considered as an emergency and to seek immediate assistance. However, Mr. A.C. was unsure where to go, because he is not proficient in English and his family was at work. He knew he could reach one of the leaders of the program and ask for advice and help. We immediately advised him to come to the hospital, where we met him, assessed the situation and immediately took him to the Emergency Department. Mr. A.C. was diagnosed with a blood clot lodged in his left brachial artery as a consequence of an atrial fibrillation (AFib) that he was not aware of. He was treated at the hospital and then transported by ambulance to Lincoln where he underwent surgery to remove the blood clot. Once Mr. A.C. came back from his surgery he approached us as he wanted to let us know how much he appreciate our help and quick response during that day, but most of all about everything he has learned in our support group meetings, which was crucial for him in identifying the problem and getting assistance. Currently Mr. A.C. is doing fairly well. He continues attending our support group meetings and we have been able to keep helping him in his continuing healthcare.

OneWorld Community Health Center

Flor H. and her family have made several positive changes in their lifestyle. At first, Flor's son did not want to attend MHI training, but is now currently very interested in volunteering and it has influenced him to study medicine/health. Because Flor H. is now buying less soda, her husband is drinking more water. She offers her visitors natural juices and explains to her visitors the importance of a healthy lifestyle. As a result of all the positive changes she is making, Flor's husband has lost some weight; she provides more vegetables to her family, and shares the healthy lifestyle tips with her neighbors.

Laura H., who is the first graduate of the Minority Health Initiative program, remembers the first day she learned about the health promoters. She had just won her battle against cancer, when she attended a health fair that "impacted her life." She states that becoming a health promoter has made her very happy because

she considers her role to be exciting as it requires her to continue educating herself so that she can educate the Latinos of South Omaha. Currently, Laura H. works for One World Community Health Center where she provides her experiences as a community health worker. Because Laura H. knows that she can educate others, she is improving her English skills so that she can reach other minorities. She has become a leader and inspires to serve and promote the wellness of her Latino community.

Public Health Solutions

"Edgar," a 62-year-old Hispanic male walked into our office requesting assistance in applying for Medicaid on behalf of his children. The application counselor began to speak with Edgar and quickly grew concerned that he appeared ill. His speech was somewhat slurred, he appeared very thin and his gait was unsteady. The application counselor called Maria, a bilingual community health worker and Kim, a public health nurse, to take a look at the client. Upon assessment, it was determined that Edgar had been diagnosed with diabetes for many years but was currently not taking any medication or seeing a healthcare provider for the condition. Edgar explained through Maria's interpretation that he was unemployed due to his illness and his family simply could not afford his medication. Edgar had seen a local physician within the last year but was required to pay privately for the appointment and could not make the payments, so he no longer had access to that clinic. Kim performed a capillary blood glucose and A1c. Both results were so high that the meters could not give an accurate reading. His blood pressure was extremely high as well. After assessing Edgar, it was determined that he needed to be seen in the emergency room (ER).

Because Edgar had no transportation and had walked to the PHS office, he was transported to the ER via an agency vehicle. Hours after his admission to a local ER, Kim received a call that Edgar's blood glucose and A1c levels were extremely high. He was stabilized and released with instructions to follow up with a primary care physician. Because Edgar had no access to a primary care physician, Maria began working with him to make an appointment at People's Health Center, a local Federally Qualified Health Center (FQHC) in Lincoln. After another ER admission days later and calling directly to ask for a quick appointment at the FQHC, Edgar began receiving medical care at People's Health Center.

Maria continued to work with Edgar every day and taught him how to manage his nutrition, take his blood glucose daily and make changes to improve his health. Kim continued to monitor Edgar's health and assessed his medical progress each week. Edgar participated in Maria's *My Life, My Health* classes and slowly began to make changes. Through People's Health Center, he began to receive his insulin and started administering it correctly. Two months later, Edgar stopped in for a blood pressure check. His blood glucose and blood pressure were within the normal range. Edgar has started to gain weight and his gait was much steadier. Edgar stated that he was using all the tools Maria had given him. When asked if he feels better now, Edgar smiled big and yelled, "Si!"

Edgar continues to improve and maintain his health. He has now brought his wife to Public Health Solutions for screening and she was found to be diabetic as well. Edgar and his wife are working together to eat healthier, monitor their blood glucose daily, see a physician at People's Health Center on a regular basis, and take better care of themselves.

West Central District Health Department

Client #219 joined the MHI program in 2014 having been referred by one of our clients. We met client #219 in one of our educational classes given in the North Platte Public Library. She and her husband had recently moved to our community from Colorado and they did not have any knowledge about local resources. Client #219 was in the first stage of pregnancy at the time. Once she joined the MHI program she was connected with the OB/GYN clinic and eventually with WIC.

On the first visit to OB/GYN she and her husband were informed that the ultrasound showed a spot in the fetus' brain. The couple was extremely worried because she had been suffering from migraines, they had found out that their blood type was not compatible, and the doctor had told them that theirs was a high

-risk pregnancy. Aggravating factors were that they had limited knowledge of English and she had experienced some bleeding. MHI provided an interpreter for the following doctor visits. Through the interpreter, the couple learned that this spot is commonly seen and might disappear in the course of the pregnancy. They were told that if it did not disappear, the expectant mother would be referred to a specialist from Lincoln who traveled to North Platte when needed. They did see the specialist twice in two different months and in the last visit they were told that the spot had disappeared and they did not have to worry any more.

Once the baby was born, the mother decided to breastfeed her but had some difficulties with the baby being able to nurse. Hospital nurses encouraged the mother to keep trying, but it did not work, and the mother had to pump her milk to feed the baby. MHI referred the mother to breastfeeding specialists in WIC and Great Plains Pediatrics. They were able to recommend a devise that eased the difficulty of the baby nursing, and the mother was able to breastfeed successfully. MHI connected the client to DHHS and her Medicare application is in process. The client is very grateful for all the help she's received from the MHI program.

Definitions of Key Terms

A1c: a test of blood sugar levels, which reflects a person's average level of blood sugar in the previous two to three months; also referred to as HbA1c[1]

Body mass index (BMI): measure of body fat based on height and weight.[1]

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.[2]

Community health workers: an umbrella term used to define other professional titles; an individual who serves as a liaison/link between public health, health care, behavioral health services, social services, and the community to assist individuals and communities in adopting healthy behaviors; conducts outreach that promotes and improves individual and community health; facilitates access to services, decreases health disparities, and improves the quality and cultural competence of service delivery in Nebraska; a trusted member of, or has a good understanding of, the community they serve; able to build trusting relationships and link individuals with the systems of care in the communities they serve; builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

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.[3]

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

Interpretation: rendering of oral messages from one language to another.[4]

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.[3]

Outcome: the statement of an intended result.

Translation: rendering of written information from one language to another.[4]

References

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