NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

December 1, 2016

Patrick O'Donnell, Clerk of the Legislature
State Capitol, Room 2018
P.O. Box 94604
Lincoln, NE 68509

RE: 2015-2016 Minority Health Initiative Annual Report

Dear Mr. O'Donnell,

In accordance with Nebraska State Statute 71-1628.07, please find attached a copy of the 2015-2016 Minority Health Initiative (MHI) annual report. This report covers the first year of a two-year MHI project period for 2015-2017 and demonstrates that the work accomplished by the 2015-2016 MHI projects one producing positive change and improving the health among minority populations in Nebraska.

Sincerely,

Thomas L. Williams

Thomas L. Williams, MD
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

2015-2016 MINORITY HEALTH INITIATIVE Annual Report

December 1, 2016

In accordance with Nebraska State Statute 71-1628.07

NEBRASKA

Good Life. Great Mission.

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

From the Administrator…

This report was created by the Nebraska Department of Health and Human Services, Office of Health Disparities and Health Equity for the Nebraska Legislature to highlight the activities and outcomes of the Minority Health Initiative (MHI) funding for the 2015-2016 year. The 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, but not be limited to, priority issues of infant mortality, cardiovascular disease, obesity, diabetes, and asthma.

To meet the directive, the Office of Health Disparities and Health Equity uses a competitive request for applications process. This report covers the first year of a two-year Minority Health Initiative project period for 2015-2017. Eighteen projects were awarded funding for the 2015-2017 period. Also included in the appropriation is annual funding to be distributed equally among the federally qualified health centers in the second Congressional District, which is also 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 Minority Health Initiative grant projects should 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 various partners to advance health equity for minorities in Nebraska. Populations to be addressed include racial and ethnic minorities, American Indians, refugees, and immigrants.

During the 2015-2016 project period, the Office of Health Disparities and Health Equity incorporated various new components to the grant to improve program outcomes. These components included the use of evidence based programming, performance measures, alignment of strategies with those of the NDHHS Chronic Disease Program, and the use of community health workers to provide case management services. The Office of Health Disparities and Health Equity recognizes that community and clinical linkages are an important component in the reduction of chronic diseases and that community health workers can provide the cultural linkage 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 continued to encourage the use of community health workers as a strategy for projects during this project period.

This report demonstrates that the work accomplished by the 2015-2016 Minority Health Initiative projects is producing positive change and improving the health among minority populations in Nebraska. New evaluation methods were employed in 2015-16, which allowed the evaluators to track individual participants across the various strategies implemented. Thousands of minority citizens across Nebraska were served through the projects, resulting in behavioral changes leading to healthier lives by increasing healthy eating and physical activity, connecting individuals to medical homes, and providing case management. Including the use of evidence based strategies in the projects, resulted in achievements of blood pressure control, lowered diabetes hemoglobin A1C rates, and at least 5% of weight loss, for many individuals during the first year of MHI funding.

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

Table of Contents

2015-2016

MINORITY HEALTH INITIATIVE

ACTIVITIES AND OUTCOMES

SELF MANAGEMENT

533

people were assisted with setting up a self-management plan.

> "I am very thankful that there are programs like this offered and that there are people willing to help us with this along the way."

HEALTH IMPACT

- Case management for diabetes is effective in improving both glycemic control and provider monitoring of glycemic control[1].
- Use of community health workers in supporting care for diabetics has been demonstrated to improve appropriate healthcare utilization[2].

CASE MANAGEMENT

931

people received case management services.

HEALTH IMPACT

- Interventions designed to improve physical activity behaviors demonstrated cost effectiveness, with cost effectiveness ratios ranging from $14k-$69k per quality-adjusted life year (QALY) gained[3].
- In an analysis of 10 different types of nutrition related interventions, all 10 were cost effective[4].

HEALTH EDUCATION

1,404

minorities participated in formal health education.

755

minorities participated in informal health education.

> "I weighed 240 pounds when I started the program with a high blood glucose. I have been using what I learned in class and joined the Wellness Center. I lost 16 pounds in 3 months and my glucose is lower."

2015-2016

MINORITY HEALTH INITIATIVE

ACTIVITIES AND OUTCOMES

DENTAL HOME

423

people were assisted to find a dentist.

> When we went to the pediatric dentist, I could understand better what was going on. I wouldn't go to appointments if the Community Health Workers (CHW) didn't go with me. I went by myself one time and had a hard time understanding.

MEDICATION

584

people were assisted with adhering to their medication regimen.

> The program was very good! Everything I learned was what one never hears, and now I can support others with what I have learned.

HEALTH IMPACT

- Patients who use interpreter services receive significantly more preventive services that have been recommended, attend more office-visits, and have more prescriptions filled compared to English-speaking counterparts[3].
- Providing transportation services for individuals with chronic conditions such as heart disease and diabetes that routinely miss healthcare appointments due to transportation barriers is a cost savings[6].

> I was very confused by the names and numbers from my cholesterol check. I appreciate so much the girls explaining it to me in my own language.
>
> (Translated from Spanish.)

SUPPORTIVE SERVICES

1,398

people received interpretation services.

people assisted with transportation to medical appointments

214

2015-2016

MINORITY HEALTH INITIATIVE

ACTIVITIES AND OUTCOMES

HEALTH IMPACT

- Screenings for pre-diabetes or diabetes using glucose tests and preventative management may be cost effective from a health system perspective[7].

HEALTH SCREENINGS

1,943

individuals were screened for cardiovascular disease, pre-diabetes, diabetes, and/or obesity.

HEALTH IMPACT

- Individuals who take part in the Diabetes Prevention Program (DPP) and lose 5-7% of their weight can cut their risk of developing Type 2 diabetes by 58%[8].
- Diabetes Self-Management Programs (DSME) have been shown to produce both short-term and long-term effects on glycemic control[9].
- After 10 years, people who completed a DPP program were one-third less likely to develop Type 2 diabetes[10].

DIABETES PREVENTION AND MANAGEMENT PROGRAMS

289

people participated in an evidence-based diabetes prevention and management program.

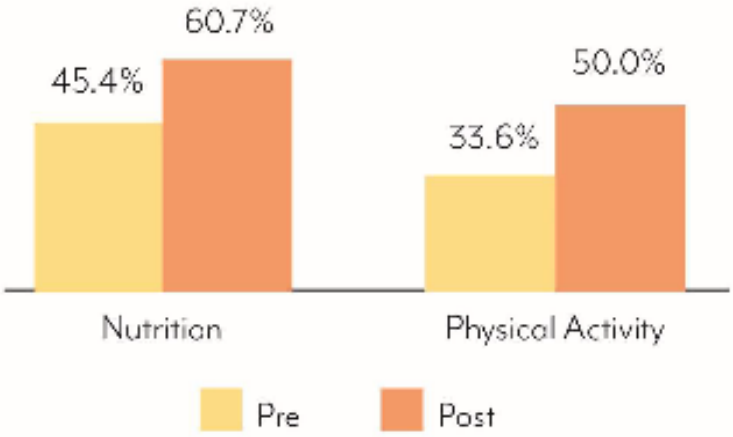
> "The numbers don't lie, I have begun to show signs of improvement and will keep coming back. Now that I am out of the risk zone, I have an interest in becoming a health promoter because I have been so impacted by your program. Your people changed my life, and I want to do what you do."

2015-2016

MINORITY HEALTH INITIATIVE

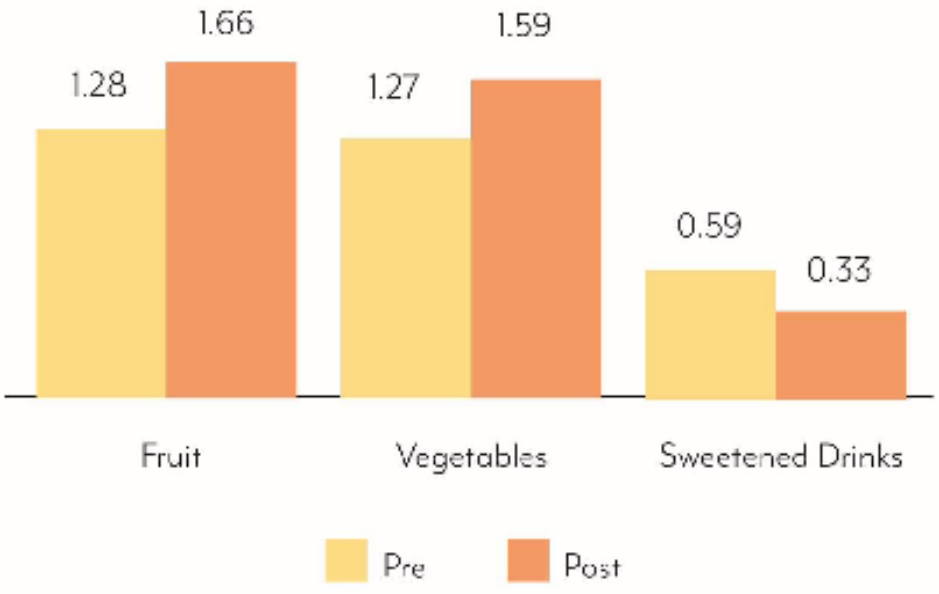
ACTIVITIES AND OUTCOMES

AVERAGE PARTICIPANT SCORES OF KNOWLEDGE QUESTIONS FOR NUTRITION AND PHYSICAL ACTIVITY



Program participants demonstrated knowledge gain, with 119 increasing nutrition knowledge, and 116 increasing physical activity knowledge.

AVERAGE NUMBER OF FRUITS, VEGETABLES, AND SWEETENED DRINKS CONSUMED BY ADULT PARTICIPANTS



Program participants changed their behaviors as a result of participation, with 143 increasing their consumption of fruit, 147 increasing their consumption of vegetables, and 90 drinking fewer sweetened beverages.

2015-2016

MINORITY HEALTH INITIATIVE

ACTIVITIES AND OUTCOMES

AVERAGE NUMBER OF DAYS ADULT PARTICIPANTS WERE PHYSICALLY ACTIVE DURING THE PREVIOUS WEEK

130 program participants increased physical activity.

76 program participants with baseline high blood pressure achieved blood pressure control through MHI participation.

48 program participants with known diabetes and a baseline A1C>9 achieved A1C<9 through MHI participation.

Every 1% reduction in A1C levels is associated with a 21% decrease in diabetes-related deaths and 14% decrease in heart attacks[11].

31 program participants lost at least 5% of their weight during the first year of Minority Health Initiative (MHI).

> "...with diet, exercise, and will power, everything can be done."

> "I have learned to make changes, such as increasing physical activity in my life until it becomes a habit for me. I did not have much energy because of being overweight. The program has helped me continue to stay motivated; group sessions helped a lot as we encourage one another, we share the same problem, and working towards the same goal helped a lot. I have more energy and sleep better as my health has improved. I feel positive and my new look motivates me. My family is very happy to see these changes and it has worked as an inspiration to my family and at my job."

People Served

This page summarizes the clients served by the Minority Health Initiative projects for the period July 1, 2015 through June 30, 2016. These numbers represent 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 lowering of cholesterol or blood pressure; and improvements in healthy behaviors such as increased physical activity, or improved self-management of chronic diseases. "Other" includes Arab, Middle Eastern, Russian, Karen, Portuguese, Eastern Indian, 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	Other or Missing
		Black	American Indian/ Alaska Native	Asian	Two or More Races		
All Ages	3,880	183	348	134	7	2,872	336
0-17	217	11	4	1	0	143	58
18-24	319	22	10	14	0	240	33
25-64	3,041	133	295	85	6	2,307	215
65+	234	6	37	31	0	144	16
Unknown	69	11	2	3	1	38	14

Male							
Age	Total	Non Hispanic				Hispanic	Other or Missing
		Black	American Indian/ Alaska Native	Asian	Two or More Races		
All Ages	2,038	134	166	80	5	1,439	214
0-17	158	6	1	3	1	111	36
18-24	147	12	9	6	0	105	15
25-64	1,545	105	137	46	4	1,109	144
65+	155	6	17	25	0	97	10
Unknown	33	5	2	0	0	17	9

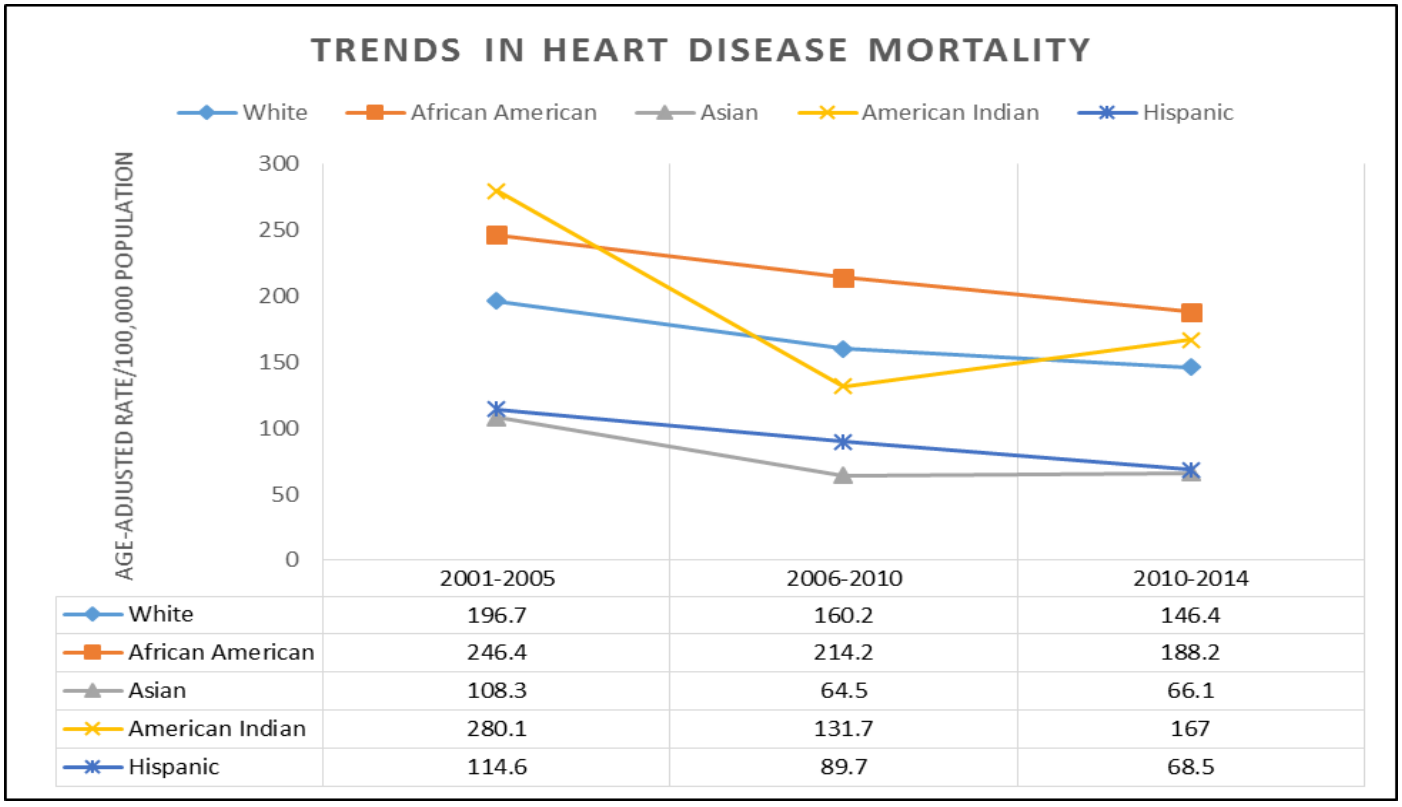
Risk Factors Related to Priority Issues, 2011-2014 ,Nebraska

Health Issue	Race/Ethnicity	Percent
Obesity * Prevalence among adults aged 18+	African American	35.9
	American Indian	42.1
	Asian	13.8
	Hispanic	32.8
	White	28.7
High Blood Pressure ** Prevalence among adults aged 18+	African American	44.8
	American Indian	36.9
	Asian	26.2
	Hispanic	26.2
	White	27.4
Consumed Vegetables Less than 1 time per day ** Prevalence among adults aged 18+	African American	37.6
	American Indian	32.4
	Asian	20.6
	Hispanic	24.6
	White	24.4
Consumed fruits Less than 1 time per day ** Prevalence among adults aged 18+	African American	43.4
	American Indian	50.4
	Asian	31.9
	Hispanic	35.4
	White	40.7
Perceived Health Status: Fair or Poor * Prevalence among adults aged 18+	African American	24.6
	American Indian	26.7
	Asian	8.9
	Hispanic	28.8
	White	11.6

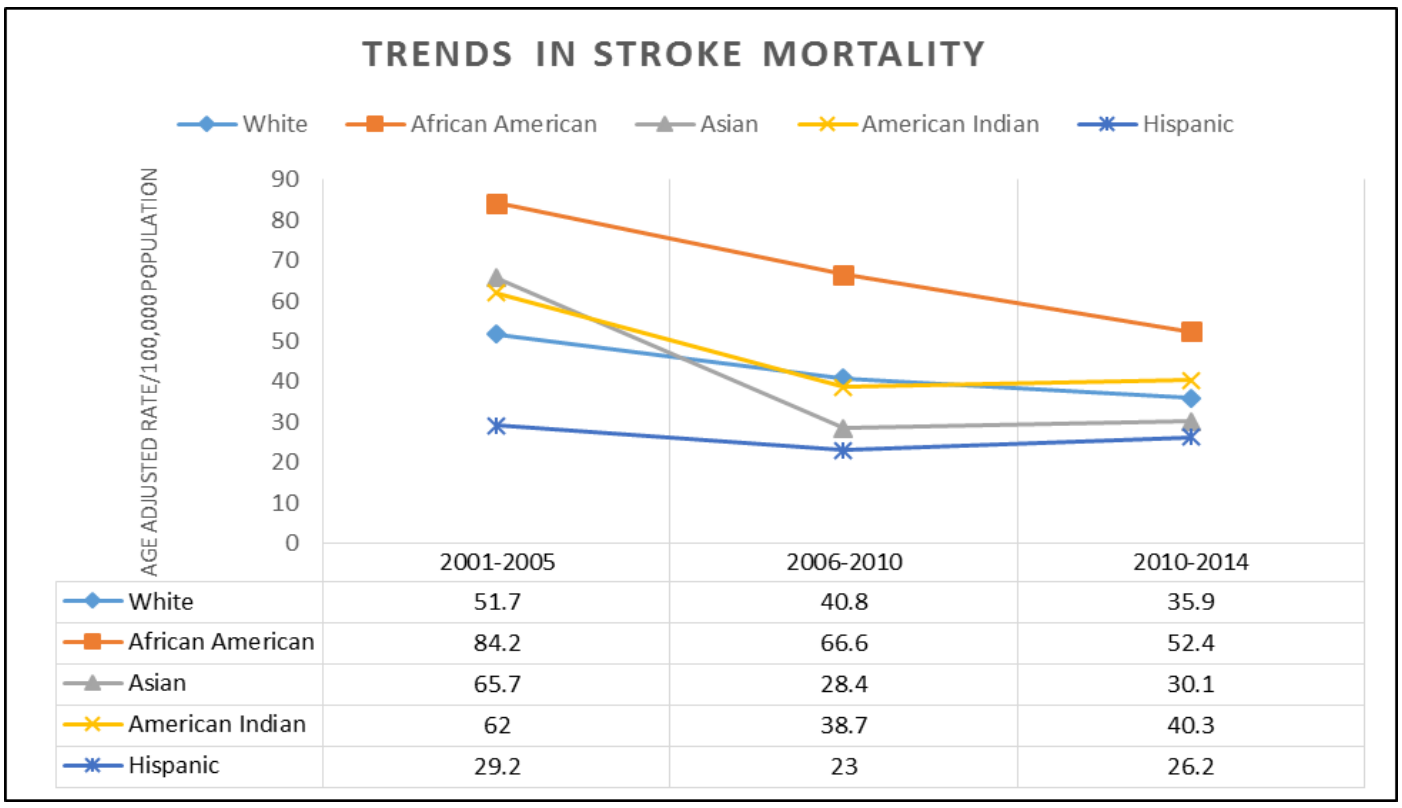
Notes and Data Source: * Nebraska Behavioral Risk Surveillance System (BRFSS) 2011-2014

**Nebraska Behavioral Risk Surveillance System (BRFSS) 2011&2013

Death Rates Related to Priority Issues, 2001-2014 , Nebraska



	2001-2005	2006-2010	2010-2014
White	196.7	160.2	146.4
African American	246.4	214.2	188.2
Asian	108.3	64.5	66.1
American Indian	280.1	131.7	167
Hispanic	114.6	89.7	68.5

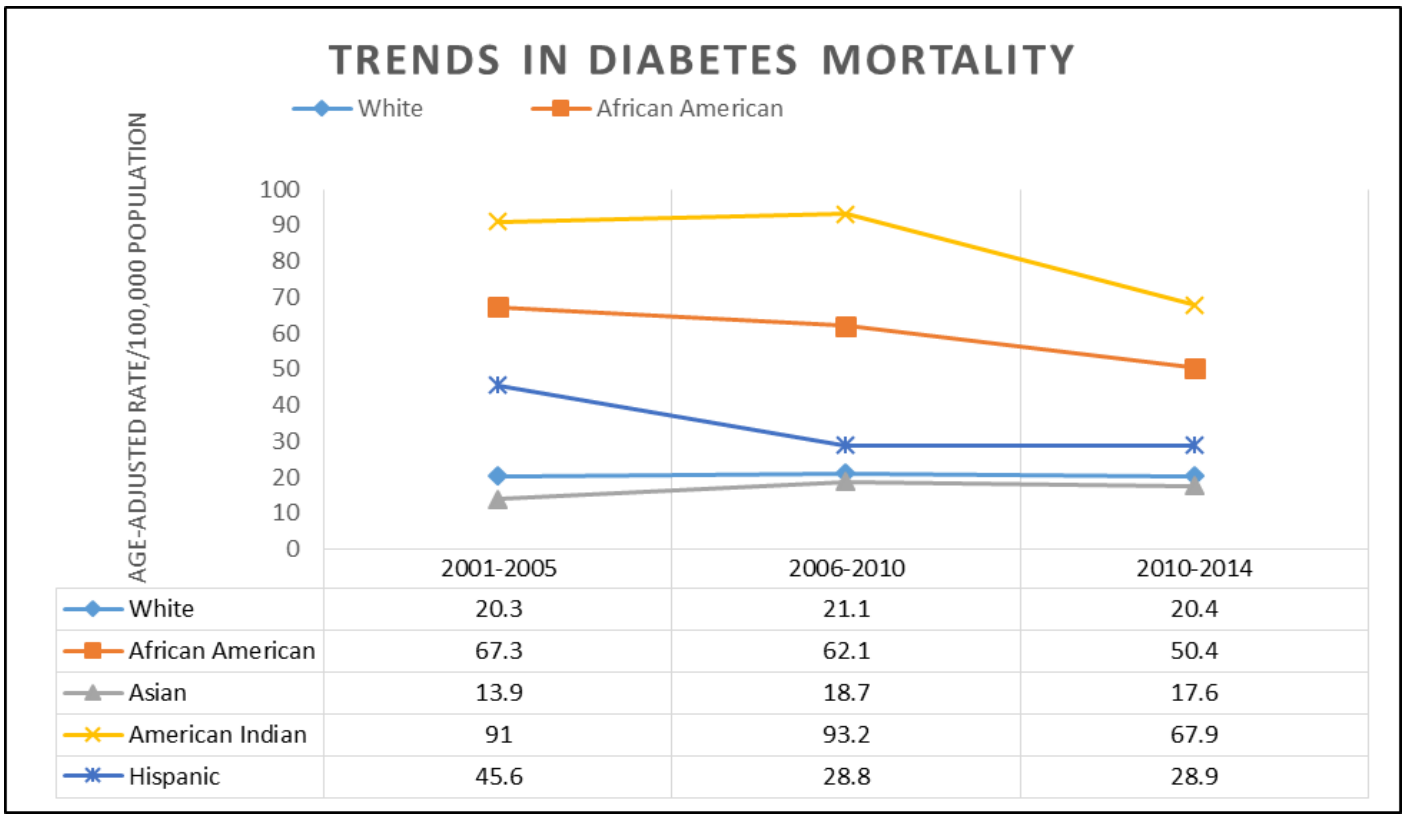


	2001-2005	2006-2010	2010-2014
White	51.7	40.8	35.9
African American	84.2	66.6	52.4
Asian	65.7	28.4	30.1
American Indian	62	38.7	40.3
Hispanic	29.2	23	26.2

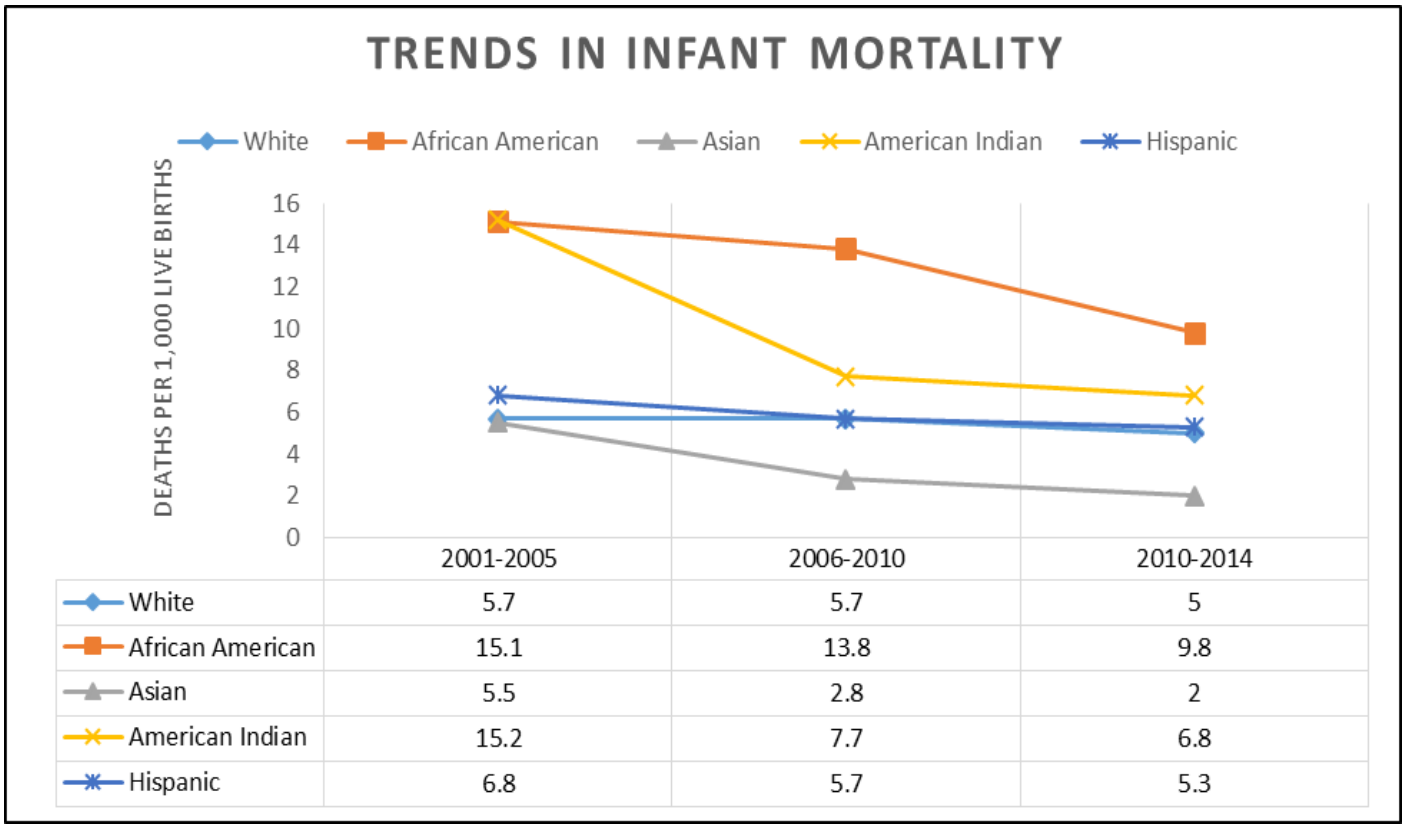
Data Source: Nebraska DHHS Vital Statistics 2001-2014

Note: 2011-2015 data are not available

Death Rates Related to Priority Issues, 2001-2014, Nebraska



	2001-2005	2006-2010	2010-2014
White	20.3	21.1	20.4
African American	67.3	62.1	50.4
Asian	13.9	18.7	17.6
American Indian	91	93.2	67.9
Hispanic	45.6	28.8	28.9



	2001-2005	2006-2010	2010-2014
White	5.7	5.7	5
African American	15.1	13.8	9.8
Asian	5.5	2.8	2
American Indian	15.2	7.7	6.8
Hispanic	6.8	5.7	5.3

Data Source: Nebraska DHHS Vital Statistics 2001-2014
Note: 2011-2015 data are not available

Minority Health Initiative two-year projects (7/2015—6/2017) were awarded to the following organizations:

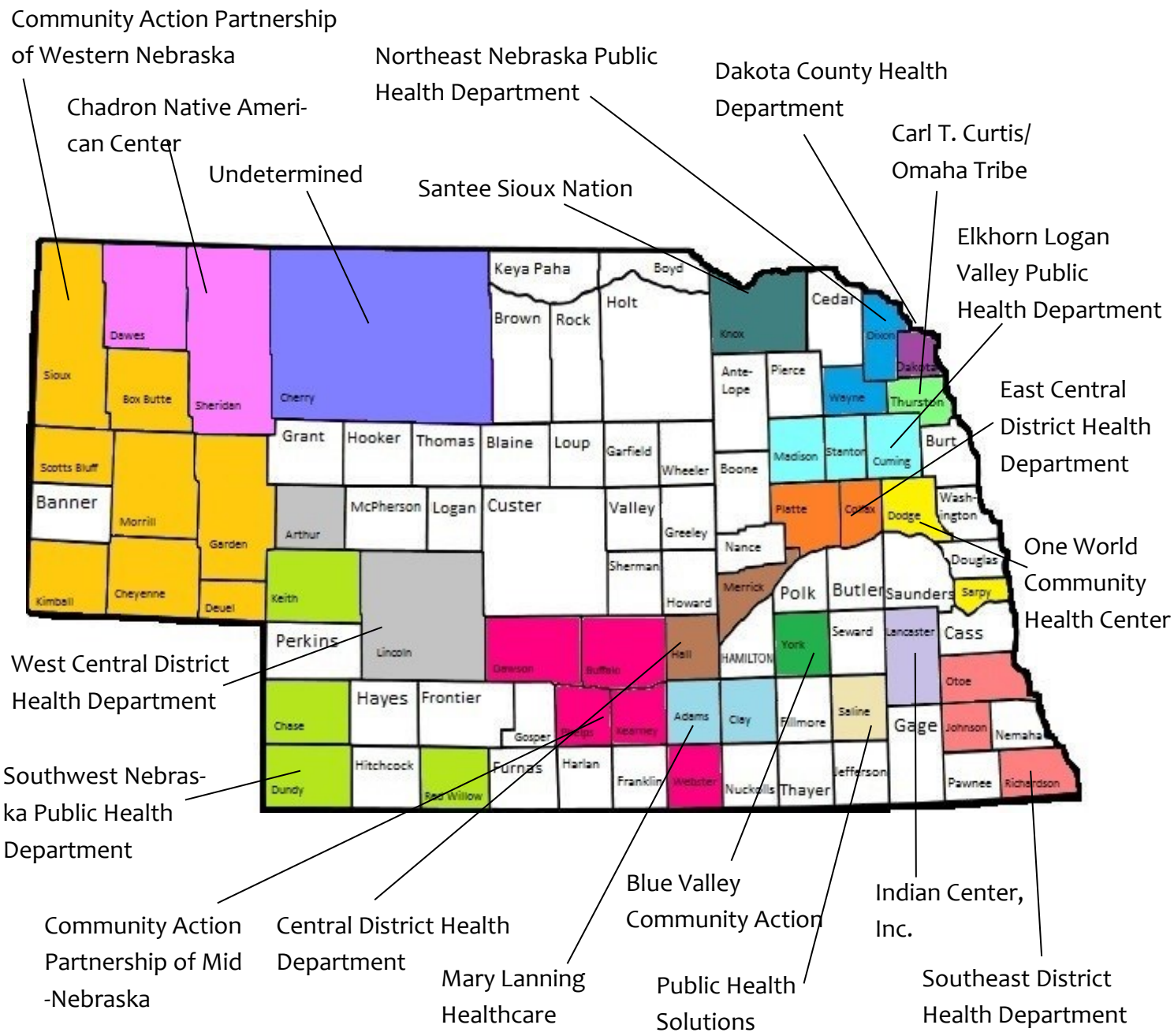
Projects (Congressional Districts 1 & 3)	Amount 1 –Year amount	County(ies)
Blue Valley Community Action	$9,063.48	York
Carl T. Curtis Health Center/Omaha Tribe	$40,506.03	Thurston
Central District Health Department	$156,189.39	Hall, Merrick
Chadron Native American Center	$19,611.82	Dawes, Sheridan
Community Action Partnership of Mid-Nebraska	$143,482.57	Buffalo, Dawson, Kearney, Phelps, Webster
Community Action Partnership of Western Nebraska	$126,657.29	Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sioux
Dakota County Health Department	$90,731.20	Dakota
East Central District Health Department	$92,119.65	Colfax, Platte
Elkhorn Logan Valley Public Health Department	$68,284.63	Cuming, Madison, Stanton
Indian Center, Inc.	$431,045.52	Lancaster
Mary Lanning Healthcare Foundation	$40,669.94	Adams, Clay
Northeast Nebraska Public Health Department	$13,585.58	Dixon, Wayne
One World Community Health Center	$195,906.12	Dodge, Sarpy
Public Health Solutions (contract)	$32,618.88	Saline
Santee Sioux Nation (contract)	$9,767.34	Knox
Southeast District Health Department	$25,416.31	Johnson, Otoe, Richardson
Southwest Nebraska Public Health Department	$19,100.82	Chase, Dundy, Keith, Red Willow
West Central District Health Department	$34,441.22	Arthur, Lincoln
TOTAL	$1,549,197.79	

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

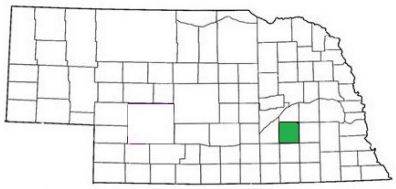
Charles Drew Health Center	$688,550.50 CD 2
One World Community Health Center	$688,550.50 CD 2

Grantee Reports

Page 15 of this document begins the summaries of outcomes of 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 or counties covered by the project, the total funding amount for first year of the project period, the funding priorities and other areas targeted, the number of people served during the first year of the project, and project partners. A brief description of each project is followed by activities implemented and outcomes achieved from July 1, 2015 through June 30, 2016.



York County



Blue Valley Community Action

Target Health Issues
Infant mortality, mental health

Dollars
$9,063.48 per year

Key Project Partners
Blue Valley Behavioral Health
Four Corners Health Department

People Served
42

Through education, guidance and support, the Blue Valley Community Action project provides participants with the skills and knowledge to promote chronic disease prevention, support maternal and child health, reduce obesity, and improve physical activity. In addition, it raises awareness of post-partum depression and other mental health issues related to challenges facing new immigrants.

Strategies

- Increase quality of and access to perinatal health services, including pre/inter-conception health care, prenatal care, labor and delivery services, and postpartum care.

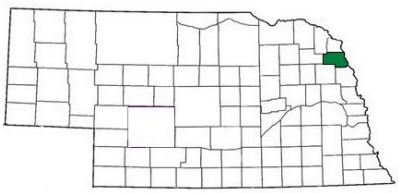
Reach

- Provided case management services for 9 racial & ethnic minorities.
- 9 were assisted with applications for health coverage.
- 9 received referrals to community-based resources and 100% accessed those resources.
- Provided health education on preventative health services to 41 individuals.
- Transportation services provided to 1 individual.
- Interpretation services was provided to 23 individuals.

Outcomes

- Of the 9 case management participants who were pregnant, all 100% accessed prenatal care services during their first trimester.
- Of the 7 case management participants who gave birth, 100% gave birth to a baby with a healthy weight (2500 grams or greater).

Thurston County



Carl T. Curtis Health Education

Target Health Issues
Cardiovascular disease,
diabetes

Dollars
$40,506.03 per year

Key Project Partners
University of Nebraska Medical Center
Omaha Nation Community Response Team
Winnebago Diabetes Program

People Served
58

The Carl T. Curtis Health Center project provides diabetes self-management education to at least 80 participants from the Omaha and Winnebago reservations so as to increase knowledge and gain skills in the management of diabetes.

Strategies

- Increase access and referrals to and use of chronic disease self-management programs (CDSM), including diabetes self-management education (DSME) .

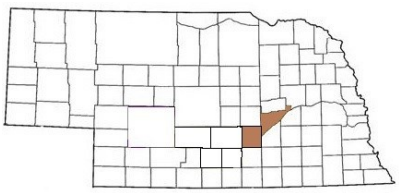
Reach

- 58 individuals participated in a Diabetes Self-Management Education (DSME) course. Of the 58, 35 (60%) completed the program.
- 100% of participants were assisted in developing a self-management plan.

Outcomes

- Out of 26 individuals who completed the DSME and had baseline and follow up data, 46% decreased the number of days that they missed taking their medication within the past 7 days.
- Of the 12 participants who completed the DSME program with a baseline A1C>9, 58% reduced their A1C and 25%reduced their A1C to below 9.
- Out of 12 participants who completed the program DSME with a baseline A1C>9, 25% reduced their A1C to below 9.

Hall & Merrick Counties



Central District Health Department

Target Health Issues
Obesity, diabetes

Key Project Partners
Central Nebraska Council on Alcoholism & Addictions
Grand Island Public Schools

Dollars
$156,189.39 per year

People Served
326

Central District Health Department employs an evidence-based Diabetes Prevention Program to improve access to health services for adult minorities, and implements obesity prevention among minority youth using the evidence-based CATCH (Coordinated Approach to Child Health) Kids program to address physical activity and nutrition.

Strategies

- Ensure access to/and or promote consumption of healthful foods, including fruits, vegetables, and water while limiting access to sugar-sweetened beverages and sodium;
- Ensure access to and/or promote physical activity;
- Increase and/or promote linkages between health systems and community resources for minorities
- Increase use of diabetes prevention programs in community settings for the primary prevention of type 2 diabetes

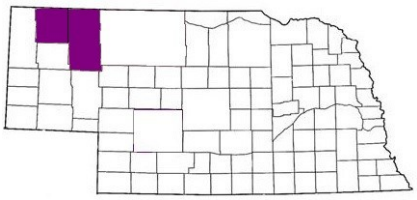
Reach

- 5 CATCH Kids health education series were completed to 116 3-5th grade and 6-7th grade students.
- 121 individuals received health education on nutrition and physical activity.
- 249 individuals received referrals to community-based resources; 134 followed through with accessing those resources.
- 30 individuals were enrolled in the Diabetes Prevention Program.

Outcomes

- Of the 22 individuals involved with NDPP, 14% lost at least 5% of their weight.
- Out of 7 individuals who did not initially have a medical home, 86% were able to establish one.

Dawes & Sheridan Counties



Chadron Native American Center

Target Health Issues
Obesity, diabetes, cardiovascular disease

Dollars
$19,611.82 per year

Key Project Partners
Western Community Health Resources
Panhandle Public Health District

People Served
23

Chadron Native American Center will continue a wellness program targeting American Indians in Dawes and Sheridan counties to include wellness checks and an evidence-based National Diabetes Prevention Program.

Strategies

Increase use of Diabetes prevention programs in community settings for the primary prevention of type 2 diabetes.

Reach

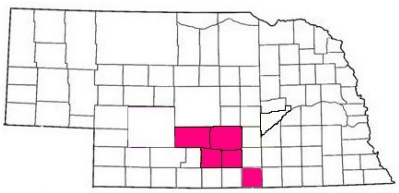
- 23 individuals screened for pre-diabetes.
- All 23 individuals determined to be at risk for diabetes or have pre-diabetes.
- 22 individuals enrolled in the Diabetes Prevention Program, 18 of which were referred by a health care provider.

Outcomes

- Of the 17 NDPP participants, over 41% achieved at least 5% weight loss.
- All NDPP participants with baseline and follow-up weight data lost an average of 9.3 lbs.

Buffalo, Dawson, Kearney, Phelps, & Webster Counties

Community Action Partnership of Mid Nebraska



Target Health Issues
Obesity, diabetes, cardiovascular disease

Dollars
$143,482.57 per year

Key Project Partners
Help Care Clinic

People Served
182

Community Action of Mid Nebraska utilizes a Community Health Worker in Buffalo, Dawson, Kearney, Phelps, and Webster counties to increase linkages between health systems and community resources for minorities for promoting healthier lifestyles. Grant will target minorities who are obese and likely have comorbidity of cardiovascular disease and diabetes.

Strategies

- Increase and/or promote linkages between health systems and community resources for minorities;
- Increase use of Team-Based Care: (i.e., involving physicians, community health workers, nurses, pharmacists, and patient navigators) in health systems.

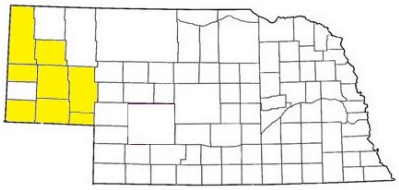
Reach

- 182 people were screened for cardiovascular disease, pre-diabetes, diabetes, and obesity.
- 177 individuals were referred to community-based resources after screenings.
- 69 individuals accessed the community-based resource they were referred to.
- 77 individuals were set up with a self-management plan.
- 79 people were provided with interpretation services; 8 were supported with transportation services.
- 115 people received informal health education by CHWs.
- 40 individuals participated in health education on nutrition and physical activity.

Outcomes

- Of the 18 obese individuals who participated in the Move, Lose, Win program, 44% reduced their weight by an average weight lost of 6 lbs.

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



Community Action Partnership of Western Nebraska (CAPWN)

Target Health Issues
Obesity, diabetes,

Dollars
$126,657.29 per year

Key Project Partners
University of Nebraska Medical Center
Lakota Lutheran Center

People Served
402

CAPWN's Community Health Workers (CHWs) work with local health care facilities to encourage a multidisciplinary team approach to manage patients with high blood pressure and diabetes. The CHWs work to increase the number of referrals for minorities to local community resources and the number of minorities who access community resources. The CHWs provide community screenings to identify individuals who were previously unaware that they had high blood pressure or were pre-diabetic.

Strategies

- Ensure access to and/or promote consumption of healthful foods, including fruits, vegetables, and water, while limiting access to sugar-sweetened beverages and sodium.
- Increase use of team-based care (i.e., involving physicians, community health workers, nurses, pharmacists, and patient navigators) in health systems.
- Increase and/or promote linkages between health systems and community resources for minorities.

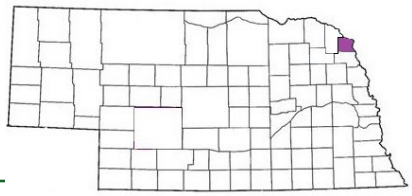
Reach

- 69 people were screened for cardiovascular disease, pre-diabetes, diabetes, and obesity.
- 50 individuals were referred to community-based resources after screenings.
- 11 individuals were set up with a self-management plan.
- 2 people received transportation services, and 27 received language access assistance .
- 11 people received informal health education.
- 15 people received formal health education via a partnership between CAPWN and SNAP Ed.
- 19 people were helped to establish a medical home.

Outcomes

- Of the 304 individuals with high blood pressure, 36% achieved blood pressure control.
- Of the 87 individuals with diabetes and an A1C>9, 22% achieved an A1C lower than <9.

Dakota County



Dakota County Health Department

Target Health Issues
Obesity, diabetes

Dollars
$90,731.20 per year

Key Project Partners
South Sioux City Public Library
University of Nebraska County Extension

People Served
193

Dakota County Health Department utilizes Community Health Workers within the county to implement the Road to Health education program and work with the minority population to educate and implement methods that directly impact negative effects of diabetes by guiding them toward healthy eating choices and routine physical activity.

Strategies

- Increase and/or promote linkages between health systems and community resources for minorities;
- Ensure access to and/or promote consumption of healthful foods, including fruits, vegetables and water, while limiting access to sugar-sweetened beverages and sodium; and,

Reach

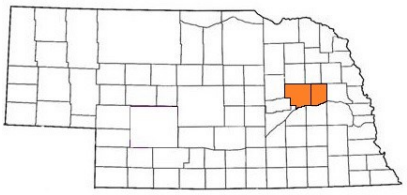
- 110 racial and ethnic minority people received health screenings for cardiovascular disease, pre-diabetes, diabetes, and obesity.
- 21 individuals found to be at risk for or have high blood pressure.
- 25 individuals were referred to community-based resources after screenings, and 16 of those individuals accessed those resources.
- 53 people were provided with case management services.
- 72 persons received Interpretation services.
- 13 individuals received health education.

Outcomes

- Of the 53 individuals receiving case management, 60% have a self-management plan.

Colfax & Platte Counties

East Central District Health Department



Target Health Issues
Obesity, diabetes,
cardiovascular disease

Key Project Partners
CHI Health Alegent Creighton Clinic
Divine Mercy Catholic Church
Good Neighbor Community Health Center
St. Bonaventure Catholic Church

Dollars
$92,119.65 per year

People Served
604

East Central District Health Department works to reduce the incidence and economic burden of diabetes and improves the quality of life for minority persons who have or are at-risk for diabetes.

Strategies

- Increase use of team-based care (i.e., involving physicians, community health workers, nurses, pharmacists, and patient navigators) in health systems.
- Increase and/or promote linkages between health systems and community resources for minorities.
- Ensure access to and/or promote physical activity.

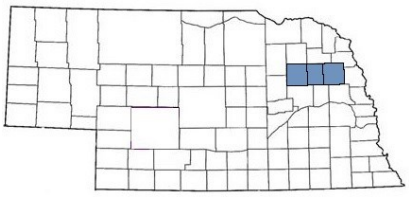
Reach

- 155 racial and ethnic minorities received health screenings for cardiovascular disease, pre-diabetes, and diabetes.
- 406 people were provided with case management services.
- 406 case management participants received at least 1 face-to-face contact with a CHW.
- 396 individuals report adhering to their medication regimen.
- 31 participants received health education on physical activity.
- 21 individuals were enrolled into a physical activity and health education program.

Outcomes

- Of the 75 individuals with high blood pressure, 24% achieved blood pressure control.
- Of the 42 individuals with diabetes and an A1C>9, 45% achieved an A1C<9.
- Among participants who lowered their A1c, the average decrease was by 2 points (from 11.4 to 9.4).

Cuming, Madison, & Stanton Counties



Elkhorn Logan Valley Public Health Department

Target Health Issues
Obesity

Dollars
$68,284.63 per year

Key Project Partners
Midtown Health Center, Inc.

People Served
68

Elkhorn Logan Valley Public Health Department program activities are directed at decreasing the prevalence of obesity among minority citizens within their service area by implementing obesity self-management programs, promoting the consumption of healthful foods for infants and toddlers, assisting with the development and adoption of policies at childcare centers with high minority enrollment, and promoting breastfeeding and education to minority women.

Strategies

- Ensure access to and/or promote consumption of healthful foods, including fruits, vegetables and water, while limiting access to sugar-sweetened beverages and sodium.
- Ensure access to and/or promote physical activity.
- Ensure access to baby-friendly environments and/or promote breastfeeding.

Reach

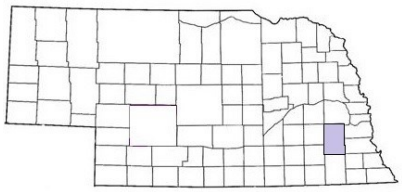
- 43 minority people completed the Eating Smart and Being Active (ESBA) health education curriculum.
- 6 participants received breastfeeding education classes.
- 18 families participated in the nutrition education classes.

Outcomes

- Of the 43 ESBA program participants who had pre and post weight data, 17% lost at least 5% of his/her weight.

Lancaster County

Indian Center, Inc.



Target Health Issues
Obesity, diabetes,

Dollars
$431,045.52 per

Key Project Partners
Asian Cultural & Community Center
El Centro de las Americas
Good Neighbor Community Center
Lincoln-Lancaster Health Department
Nebraska Urban Indian Health Coalition
Ponca Tribe of Nebraska
Clyde Malone Community Center
University of Nebraska Medical Center – College of Dentistry

People Served
2,457

The Indian Center project impacts obesity, diabetes, and cardiovascular disease by directing activities at increasing healthcare capacity and decreasing health disparities among minorities in their service area via a coalition of nine partner organizations that serve minorities within Lancaster County.

Strategies

- Ensure access to and/or promote consumption of healthful foods, including fruits, vegetables and water, while limiting access to sugar-sweetened beverages and sodium.
- Ensure access to and/or promote physical activity.

Reach

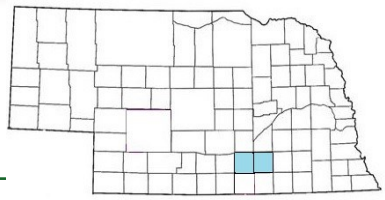
- 412 individuals were screened for cardiovascular disease, pre-diabetes, diabetes, and/or obesity.
- 204 individuals were referred to community-based resources after screening.
- 233 individuals received follow-up from a community health worker after referral.
- 223 individuals followed through with accessing a community-based resource after referral.
- 247 people were followed by a case management program.
- 989 people utilized interpretation services; 93 were provided with transportation.
- 1,572 health education classes on nutrition were delivered.
- 2,779 health education classes on physical activity were provided.
- 114 people attended at least one health education class on chronic disease management.
- 423 individuals were assisted with establishing a dental home.

Outcomes

- Of 149 participants, 28% achieved blood pressure control.
- Of the 20 individuals who had baseline A1C measurement of above 9, 30% were able to achieve an A1C of below 9.
- Of 103 participants who were diagnosed with Diabetes and had a follow-up, 75% showed improvement in A1C score.
- Among 214 program participants, 7% lowered their body mass index to within a healthy range (lower than ≤30).

Adams & Clay Counties

Mary Lanning Healthcare Foundation



Target Health Issues
Obesity, diabetes,

Dollars
$40,669.94 per year

Key Project Partners
South Heartland District Health Department
Hastings Family YMCA
Community Health Clinic

People Served
213

Mary Lanning Healthcare Foundation, *El Paquete Total* focuses on a "Total Family" wellness concept by offering individual disease management using the evidence–based American Association of Diabetes Educators (AADE) program, self-care behaviors, and education and support programs to family members (home visits, diabetes disease management, case management interventions, and advocacy).

Strategies

- Ensure access to and/or promote consumption of healthful foods, including fruits, vegetables and water, while limiting access to sugar-sweetened beverages and sodium.
- Ensure access to and/or promote physical activity.
- Increase use of team-based care (i.e., involving physicians, community health workers, nurses, pharmacists, and patient navigators) in health systems.

Reach

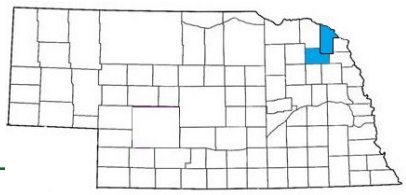
- 18 youth participated in the CATCH (Coordinated Approach to Child Health) Kids health education series.
- 17 participants received health education on nutrition.
- 44 participants received health education on physical activity.
- 190 individuals were assisted with developing a self-management plan.
- 74 individuals were enrolled into an exercise facility.

Outcomes

- Of 90 individuals with high blood pressure, 13% achieved blood pressure control.
- Out of 10 program participants with an A1C >9, 10% achieved an A1C<9 and 90% reduced their A1C by an average of 1.1.
- Out of 82 program participants, 42% lost weight with an average weight loss of 5.4 lbs.

Dixon & Wayne Counties

Northeast Nebraska Public Health Department



Target Health Issues
Cardiovascular disease,

Dollars
$13,585.58 per year

Key Project Partners
Salem Lutheran Church

People Served
101

The Northeast Nebraska Public Health Department project is designed to identify people at-risk for developing cardiovascular disease and/or diabetes and provide them with education and guidance for development of preventive goals intended to decrease their health risk, while providing continuous support from Community Health Workers (CHWs) to encourage reaching those goals.

Strategies

- Implement identification of patients with undiagnosed hypertension and people with pre-diabetes.
- Increase and/or promote linkages between health systems and community resources for minorities.
- Ensure access to and/or promote consumption of healthful foods, including fruits, vegetables and water, while limiting access to sugar-sweetened beverages and sodium.

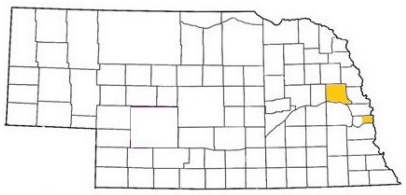
Reach

- 76 people screened for cardiovascular disease.
- 40 individuals found to be at risk for or have high blood pressure.
- 4 individuals received assistance from CHWs to access healthcare and/or community resources.
- 17 people received case management services for hypertension .
- 29 individuals received Interpretation services.
- 8 people participated in health education activities.
- 45 people were supported with application assistance.

Outcomes

- Of the 15 individuals with high blood pressure, 27% achieved blood pressure control.

OneWorld Community Health Center



Target Health Issues
Cardiovascular disease, dia-

Dollars
$195,906.12 per year

Key Project Partners
Dr. Richard Stacy, UNO

People Served
624

OneWorld Community Health Center implements promotora (community health worker) programs in Sarpy and Dodge Counties. The promotoras learn about heart disease, diabetes and obesity in addition to nutrition and exercise. The also learn how to screen for heart disease, diabetes and obesity so as to follow-up with individuals at risk and connect those individuals to community resources in order to manage and improve their health conditions.

Strategies

- Increase use of Team-Based Care (i.e., involving physicians, community health workers, nurses, pharmacists, and patient navigators) in health systems.
- Implement identification of patients with undiagnosed hypertension and people with pre-diabetes.
- Increase and/or promote linkages between health systems and community resources for minorities.

Reach

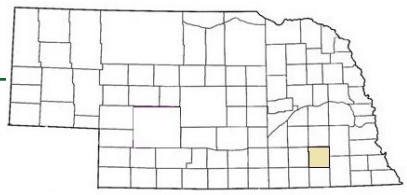
- 563 people received health screenings for cardiovascular disease, pre-diabetes, diabetes, and obesity.
- 219 individuals were referred to community-based resources after screenings.
- 91 people were provided with case management services.
- 52 individuals were assisted with developing a self management plan.
- 517 participants received health education.
- 61 promotoras were trained.

Outcomes

- Out of 9 people without a medical home 22% were able to establish a medical home.
- Of 17 participants with high blood pressure, 29% achieved blood pressure control.
- Out of 11 program participants, 82% reduced their BMI.

Saline County

Public Health Solutions



Target Health Issues
Diabetes

Dollars
$32,618.88 per

Key Project Partners
N/A

People Served
271

The Public Health Solutions program utilizes evidence-based diabetes prevention programs and includes a Community Health Worker (CHW) in the program. The goal is to increase awareness about diabetes, provide health screenings to identify those at risk of developing diabetes, pre-diabetic, and diabetic people in their service area and thereby minimize the detrimental impact of diabetes on the minority population. The project applies a multi-generational approach by targeting young women, families, and men to manage/prevent diabetes.

Strategies

- Implement identification of patients with undiagnosed hypertension and people with pre-diabetes.
- Increase use of diabetes prevention programs in community settings for the primary prevention of type 2 diabetes.
- Increase and/or promote linkages between health systems and community resources for minorities.

Reach

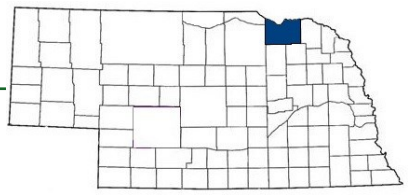
- 265 people were screened for cardiovascular disease, pre-diabetes, diabetes, and obesity.
- 189 individuals accessed community-based resources from program referrals.
- 33 individuals enrolled into the National Diabetes Prevention Program (NDPP).
- 69 participants enrolled into the Diabetes Self Management Education (DSME)
- 83 people received additional supportive services (childcare, CPR training, dental clinic, flu shot, FOBT kit, Tai-Chi class, assistance with Medicaid or SNAP applications).

Outcomes

- Out of 69 DSME participants, 75% achieved some weight loss and 17% achieved weight loss of at least 5%.
- Out of 33 NDPP participants, 67% achieved some weight loss and 9% achieved weight loss of at least 5%.

Knox County

Santee Sioux Nation



Target Health Issues
Diabetes

Dollars
$9,767.34 per

Key Project Partners
N/A

People Served
44

The Santee Sioux Nation project provides diabetes self-management education (DSME) to the Native American minority population of Knox County. The project participants gain knowledge and skills in the management of diabetes on the Santee Sioux reservations. Participants will be tracked for biometric improvements and knowledge gain with annual follow up to assess knowledge retention and biometric stability.

Strategies

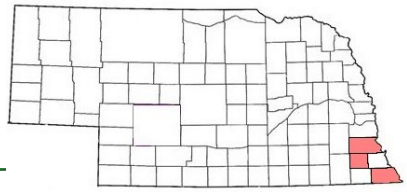
Increase access and referrals to and use of chronic disease self-management programs (CDSM), including diabetes self-management education (DSME)

Reach

- 44 people participated in the Diabetes Self Management Education (DSME) course.

Outcomes

- For the 29 individuals involved in the program over the course of 1 year, rates of medication adherence increased from 66% to 90%.
- Out of 8 individuals, 50% reduced their A1C from baseline to follow-up.



Southeast District Health

Target Health Issues
Obesity, diabetes, and cardiovascular disease

Dollars
$25,416.31 per year

Key Project Partners
N/A

People Served
61

The Southeast Nebraska District Health Department concentrates on increasing and/or promoting linkages between health systems and community resources for minorities by engaging community partners and evidence-based interventions to achieve positive impact in their service community.

Strategies

- Increase and/or promote linkages between health systems and community resources for minorities .

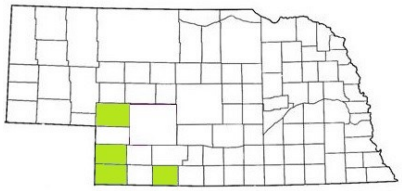
Reach

- 29 people completed health screenings for cardiovascular disease, pre-diabetes, diabetes, and obesity.
- 40 individuals were referred to the immunization clinic.

Outcomes

- Among 61 individuals, 10 (16%) of people are receiving support to secure a medical home.

Chase, Dundy, Keith, & Red Willow Counties



Southwest Nebraska Public Health Department

Target Health Issues
Cardiovascular disease, diabetes, obesity and immunizations

Dollars
$19,100.82 per year

Key Project Partners
WIC clinics; local physicians

People Served
13

Southwest Nebraska Public Health Department is providing health screenings for cardiovascular disease, diabetes, and obesity and delivering health education for prevention and management of chronic disease. In addition, they refer at-risk individuals to community resources and follow-up with referred clients to ensure compliance with referrals.

Strategies

- Increase and/or promote linkages between health systems and community resources for minorities .

Reach

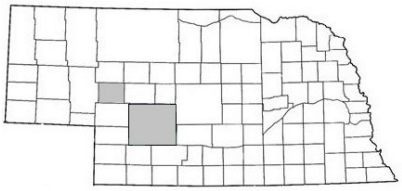
- 12 people were screened for cardiovascular disease, pre-diabetes, and diabetes.
- 13 individuals demonstrated knowledge gain regarding prevention, health screenings, and/or community resources.
- 5 individuals were referred to community-based resources after screenings, and all 4 of those individuals (80%) accessed those resources.

Outcomes

- Assisted 5 individuals in developing a self-management plan.

Arthur & Lincoln Counties

West Central District Health Department



Target Health Issues
Obesity, cardiovascular disease, and diabetes

Dollars
$34,441.22 per year

Key Project Partners
North Platte Public Schools
University of Nebraska Extension Service
Community Connections , Great Plains Health
West Central District Health Department

People Served
170

West Central District Health Department serve as members of the care delivery team by advocating for clients. The Community Health Worker (CHW) collaborates with a team consisting of a physician, nurse or allied health worker to deliver health education or basic screening services while the providers conduct medical exams.

Strategies

- Ensure access to and/or promote consumption of healthful foods, including fruits, vegetables, and water, while limiting access to sugar-sweetened beverages and sodium.
- Ensuring access to and/or promote physical activity.
- Increase and/or promote linkages between health systems and community resources for minorities in Lincoln County.

Reach

- Implemented health education classes on nutrition for 38 participants.
- 17 participants completed health education classes on physical activity.
- 5 individuals were supported with transportation services.
- 5 individuals received interpretation services.

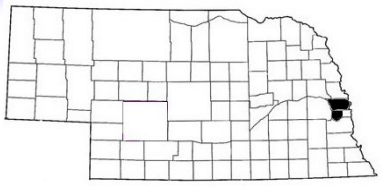
Outcomes

- Out of 18 participants, 11% lost weight.

Douglas County

Charles Drew Health Center

Federally Qualified Health Care Funding



Target Health Issues

Cardiovascular disease, asthma, diabetes, obesity, infant mortality, oral health, depression, substance abuse

Dollars

$688,550.50 per year

People Served

10,000+

Also included in the appropriation is annual funding to be distributed equally among Federally Qualified Health Centers (FQHC) in the second Congressional District including 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.

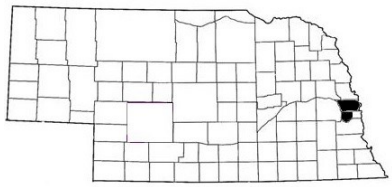
Activities and Outcomes July 1, 2015—June 30, 2016

- 8,122 interpretation/translation services provided. Predominate languages consist of Karen (4299) and Somali/Mai Mai (1375).
- 87% of patients 12 years and over were screened for depression and had a follow-up plan documented if patient considered depressed.
- *Diabetes:* CDHC has a total of 900 adult patients, 52 years and over, with a diagnosis of Type I or Type II diabetes. 68% of our diabetic patients had a HbA1c less than 9% from July 1, 2015 – June 30, 2016.
- *Asthma:* The current number of Asthma patients 9-40 years with a diagnosis of mild, moderate or severe persistent asthma is 169; 87% of those patients are being treated with an accepted Inhaled Corticosteroid or an accepted alternative medicine.
- *Cardiovascular:* CDHC has 5,674 adult patients, 52 -85 years, with a diagnosis of hypertension. The percentage of cardiovascular patients with controlled hypertension (BP less than 140/90) has remained steady at 58%. The percent of adult patients with a diagnosis of Coronary Artery Disease (CAD) who were prescribed a lipid-lowering therapy was 88%.
- *Prenatal:* 657 women were seen for prenatal care and 579 prenatal patients who delivered during July 2015 – June 2016. The percentage of women initiating their prenatal care during the first trimester is 58%. The percentage of births <2500 grams was 4.4%.
- *Obesity:* The percentage of patients 6-17 years with weight assessment and counseling for nutrition and physical activity increased from 80% to 82% . The percentage of adult patients with weight screening and follow-up increased from 51% to 65%.
- *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 89%.
- *Immunizations:* The percentage of children who were fully immunized by their 6nd birthday is 69%.

Douglas County

OneWorld Community Health Center

Federally Qualified Health Care Funding



Target Health Issues

Diabetes, cardiovascular disease, infant health, depression, pediatric oral health, asthma, and pediatric and adult weight management

Dollars

$688,550.50 per year

People Served

35,557

Also included in the appropriation is annual funding to be distributed equally among Federally Qualified Health Centers (FQHC) in the second Congressional District including OneWorld Community 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.

Activities and Outcomes July 1, 2015—June 30, 2016

- 153,453 visits were provided to 35,557 unique patients.
- 1,474 prenatal patients were provided services. 82% began care during first trimester. 5.6% of babies were low birth weight.
- 94.4% of prenatal patients delivered at/above the healthy birth weight indicator (greater than >2,400 grams).
- 17,602 uninsured people received medical services.
- 13,867 patients were provided with interpretation for medical services.
- 1,893 patients diagnosed with hypertension received medical services.
- 96% of adult patients were screened and counseled for tobacco use.
- 2.817 patients diagnosed with depression and other mood disorders were provided with therapeutic supports.
- 4,260 patients received pediatric dental services.
- 247 people with persistent asthma were placed on a pharmacological treatment plan.
- 11,925 adult patients (18+ years older) had a documented BMI and follow up plan if determined to be under/overweight.
- 8,210 children and adolescents had a documented Body Mass Index (BMI) percentile and received counseling on nutrition and physical activity.
- 1,317 patients brought their hypertension under control and 76% were minorities.
- 80.1% of patients diagnosed with diabetes achieved HbA1c results below <8%.

Definitions of Key Terms

A1C: (also known as HbA1c, glycated hemoglobin or glycosylated hemoglobin) is a blood test that correlates with a person's average blood glucose level over a span of a few months. It is used as a screening and diagnostic test for pre-diabetes and diabetes. A healthy A1C target is <9.

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]

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