NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health

2015-2017 Minority Health Initiative Annual Report

12/1/2017

§ 71-1628.07

2015-2017 MINORITY HEALTH INITIATIVE Annual Report

December 1, 2017

In accordance with Nebraska State Statute 71-1628.07

NEBRASKA

Good Life. Great Mission.

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Division of Public Health

Office of Health Disparities and Health Equity

From the Administrator…

This report was created by the Nebraska Department of Health and Human Services, Office of Health Disparities and Health Equity (OHDHE) for the Nebraska Legislature. This report highlights the 2016-2017 Minority Health Initiative (MHI) project activities and the 2015-2017 overall project outcomes. 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. The Office of Health Disparities and Health Equity used a competitive request for applications process.

This report covers the 2015-2017 Minority Health Initiative project period. Eighteen projects were awarded funding for the 2015-2017 period; an additional project, Nebraska Minority Resource Center (NMRC) was awarded funds only in year 2 to provide services in Cherry County. Also included in the appropriation is annual funding to be distributed equally among the federally qualified health centers in the second Congressional District. The funds are 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 support the 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 encourages the development and enhancement of innovative health services to eliminate health disparities which disproportionately impact minority populations through collaborations among various partners to advance health equity for minorities in Nebraska. Populations addressed include racial and ethnic minorities, American Indians, refugees, and immigrants.

During the 2015-2017 project period, the Office of Health Disparities and Health Equity added new components to the grant to improve program outcomes. These components included the use of evidence based strategies, performance measures, alignment of strategies with those of the Department's Chronic Disease Program, and the use of community health workers to provide case management and other services that support improved health outcomes. The Office of Health Disparities and Health Equity recognizes that community and clinical linkages have an important role in reducing 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 Office of Health Disparities and Health Equity 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 2015-2017 Minority Health Initiative projects is producing positive change and improved health outcomes for minority populations in Nebraska. New evaluation methods employed during this project period allowed the evaluators to track individual participants across the various strategies implemented in the 2-year project period. 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. The use of evidence based strategies resulted in achievements of blood pressure control, lowered diabetes hemoglobin A1C rates, and at least 5% of weight loss, for many individuals during the two years of MHI funding.

On behalf of the Office of Health Disparities and Health Equity, The MHI grantees, and all of the individuals served through the funding, 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 minority.health@nebraska.gov.

Table of Contents

2015-2017

MINORITY HEALTH INITIATIVE

ACTIVITIES AND OUTCOMES

SELF MANAGEMENT

716

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

> Being in the program encouraged me to move forward with my goal of losing weight and increasing my physical activity.

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

2,002

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 EDUCTION

2,947

minorities participated in formal health education.

233

minorities participated in informal health education.

> The health classes helped me be more aware of the importance of good nutrition and to be physically active as well. Now, I try to apply and put into action what I have learned.

2015-2017

MINORITY HEALTH INITIATIVE

ACTIVITIES AND OUTCOMES

DENTAL HOME

649

people were assisted to find a dentist.

"I would recommend to my friends. They provide first class service."

"My doctor said my numbers are improving, and I am excited to report my blood results to my doctor."

MEDICATION

872

people were assisted with adhering to their medication regimen.

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[5].
- Providing transportation services for individuals with chronic conditions such as heart disease and diabetes that routinely miss health care appointments due to transportation barriers is a cost savings[6].

"I never understood what the labs meant until it translated to me by an interpreter."

SUPPORTIVE SERVICES

3,612

people received interpretation services.

913

people assisted with transportation

2015-2017

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

5,113

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 contral[9].
- After 10 years, people who competed a DPP program were one-third less likely to develop Type 2 diabetes[10].

DIABETES PREVENTION AND MANAGEMENT PROGRAMS

649

People participated in an evidence-based diabetes prevention or management program.

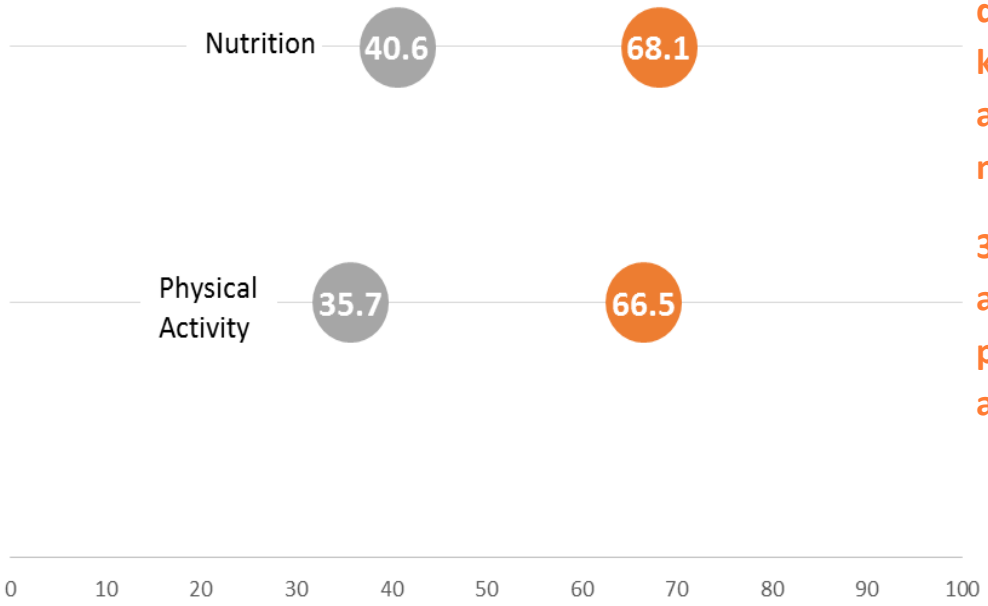
"I learned so much about healthy eating and exercise and how important that is to keep my diabetes under control. I have not been able to see a doctor for a while due to my finances and not having insurance. This course taught me how I can have a better lifestyle and keep my diabetes under control."

2015-2017

MINORITY HEALTH INITIATIVE

ACTIVITIES AND OUTCOMES

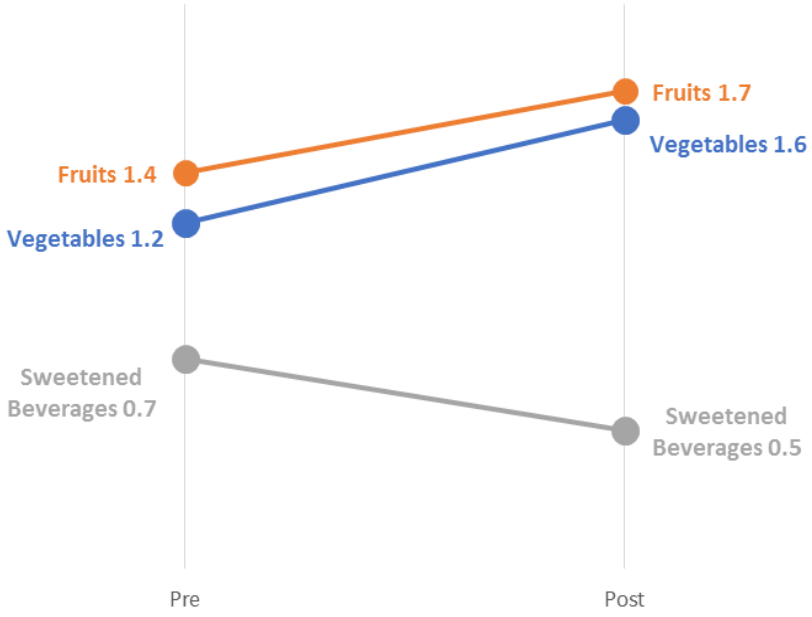
The average nutrition and physical activity knowledge scores increased from pre- to post-test.



418 program participants demonstrated increased knowledge, attitudes, and/or perceptions of nutrition

372 increased knowledge, attitudes, and/or perceptions of physical activity.

The average number of fruits and vegetables consumed increased while the average number of sweetened beverages consumed decreased from pre to post.



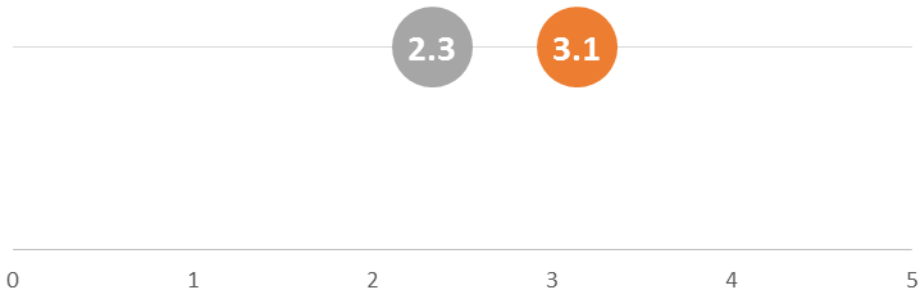
During the 2-year project period, program participants improved their healthy eating behaviors, with 1,118 indicating increased consumption of nutritious foods and/or reduced consumption of sugar-sweetened beverages.

2015-2017

MINORITY HEALTH INITIATIVE

ACTIVITIES AND OUTCOMES

The average number of days participants were physically active during the previous week increased from pre- to post-test.



1,385 program participants Increased the number of days they were physically active

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

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

There was an overall average decrease in all MHI participant A1C scores of 0.6 points (from 9.0 to 8.4).

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

50 program participants lost at least 5% of their baseline weight through MHI participation.

Of program participants who lost any weight, the average weight loss was 7.4 pounds.

275 program participants who did not initially have a medical home were able to establish one

"After learning about my high blood pressure, I decided to get a blood pressure cuff to use at home so I can keep track of it myself."

"The program helped us a lot, especially the first 16 weeks. Within 16 weeks, we immediately saw results. The program is very good, but we are the ones we have to do our part to get better results. My A1C dropped a lot because of the program!"

"I knew that my parents both have diabetes, but I hadn't ever thought about checking to see if I had it. I think this is a very serious disease, and so I am glad this program let me know that I need to see a doctor about my blood sugar and try to eat better."

"I lost 10 pounds and my blood pressure has gone down."

People Served

This page summarizes the clients served by the Minority Health Initiative projects for the period July 1, 2015 through June 30, 2017. These numbers represent the total number of people who received services by all of the projects during the two-year project period. "Other" includes Arab, Middle Eastern, Russian, Karen, Portuguese, Eastern Indian, and persons who chose not to identify their race and/or ethnicity.

Female							
Age	Total	Non Hispanic				Hispanic	Other
		Black	American Indian/ Alaska Native	Asian	Two or More Races		
All Ages	7,656	307	560	396	10	5,413	970
0-17	436	17	7	3	0	293	116
18-24	697	31	21	28	0	512	105
25-64	5,941	246	451	283	9	4,292	660
65+	499	8	68	80	0	292	51
Unknown	83	5	13	2	1	24	38

Male							
Age	Total	Non Hispanic				Hispanic	Other
		Black	American Indian/ Alaska Native	Asian	Two or More Races		
All Ages	4,249	226	282	221	6	2,882	632
0-17	417	22	6	4	1	279	105
18-24	329	14	19	15	0	225	56
25-64	3,120	173	221	125	5	2,171	425
65+	344	11	26	77	0	206	24
Unknown	39	6	10	0	0	1	22

Risk Factors Related to Priority Issues, 2011-2015 ,Nebraska

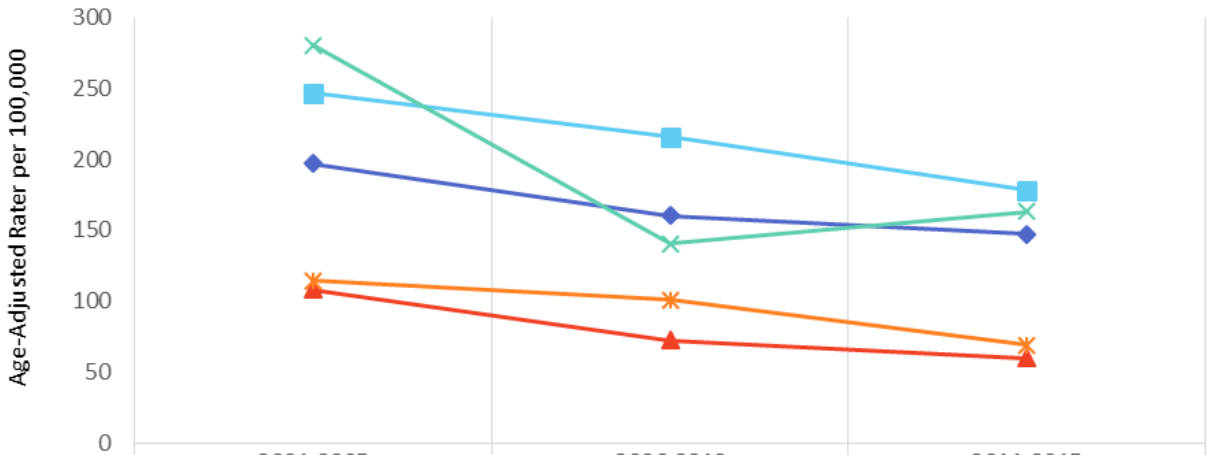
Health Issue	Race/Ethnicity	Percent
Obesity * Prevalence among adults aged 18+	African American	36.5
	American Indian	43.3
	Asian	13.9
	Hispanic	33.3
	White	29.1
High Blood Pressure ** Prevalence among adults aged 18+	African American	42.7
	American Indian	34.2
	Asian	25.9
	Hispanic	27.3
	White	27.4
Consumed Vegetables Less than 1 time per day ** Prevalence among adults aged 18+	African American	36.6
	American Indian	28.0
	Asian	18.4
	Hispanic	25.1
	White	24.5
Consumed fruits Less than 1 time per day ** Prevalence among adults aged 18+	African American	41.9
	American Indian	46.4
	Asian	34.2
	Hispanic	35.3
	White	41.1
Perceived Health Status: Fair or Poor * Prevalence among adults aged 18+	African American	23.6
	American Indian	26.2
	Asian	10.3
	Hispanic	29.5
	White	11.4

Notes and Data Source: * Nebraska Behavioral Risk Surveillance System (BRFSS) 2011-2015

**Nebraska Behavioral Risk Surveillance System (BRFSS) 2011&2013&2015

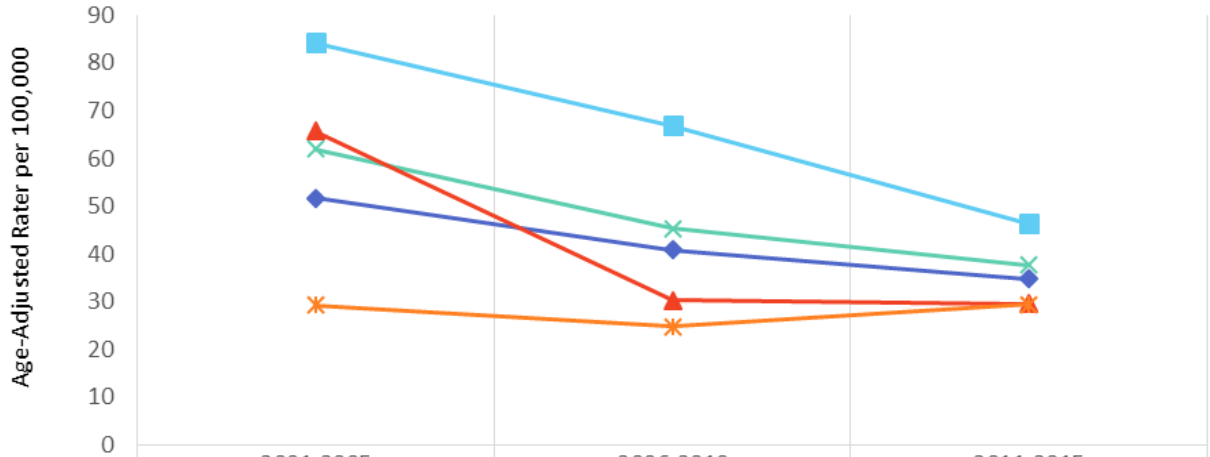
Death Rates Related to Priority Issues, 2001-2015 , Nebraska

Heart Disease Mortality Trends



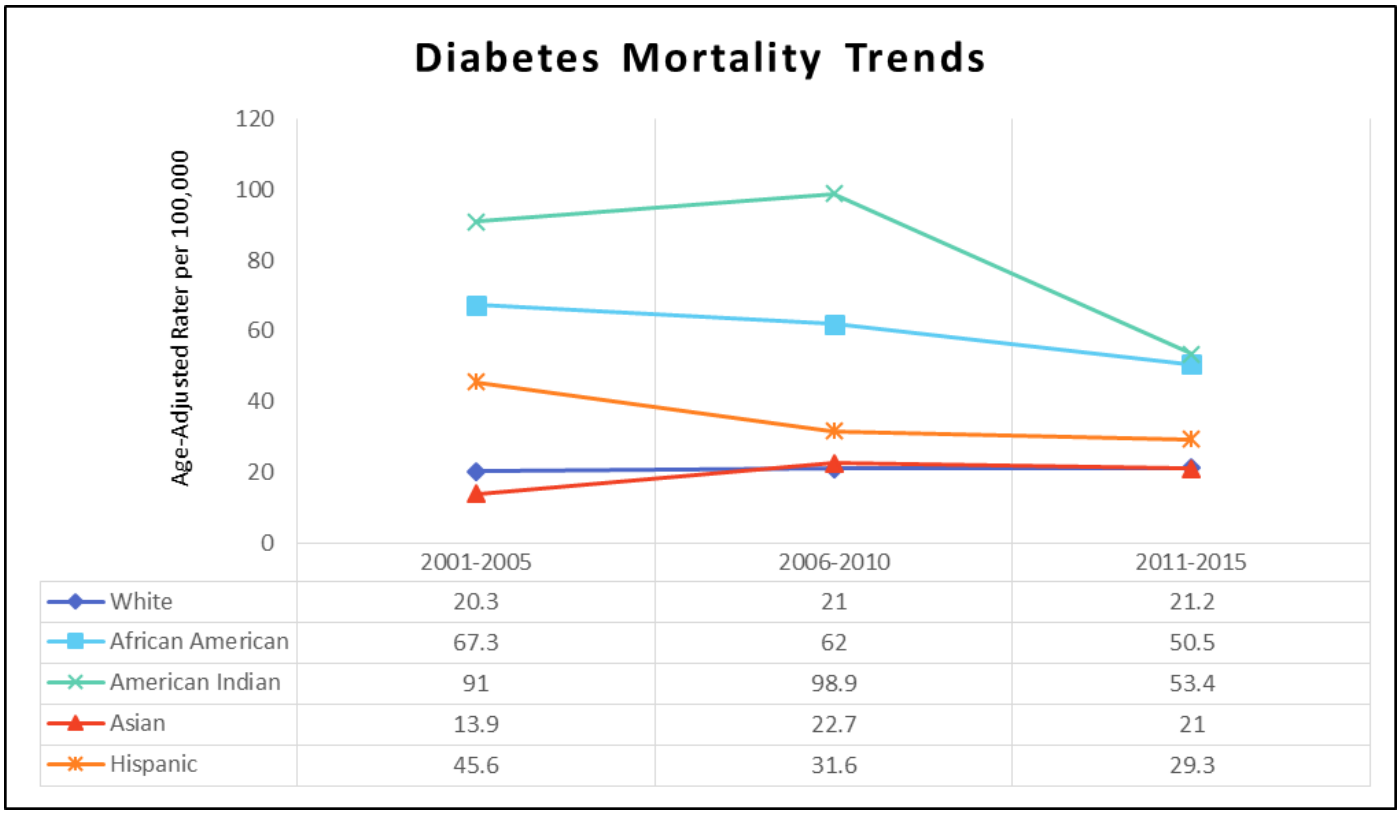
	2001-2005	2006-2010	2011-2015
White	196.7	160.4	147.4
African American	246.4	215.7	177.9
American Indian	280.1	140.3	163.1
Asian	108.3	72.4	60
Hispanic	114.6	100.7	69.3

Stroke Mortality Trends

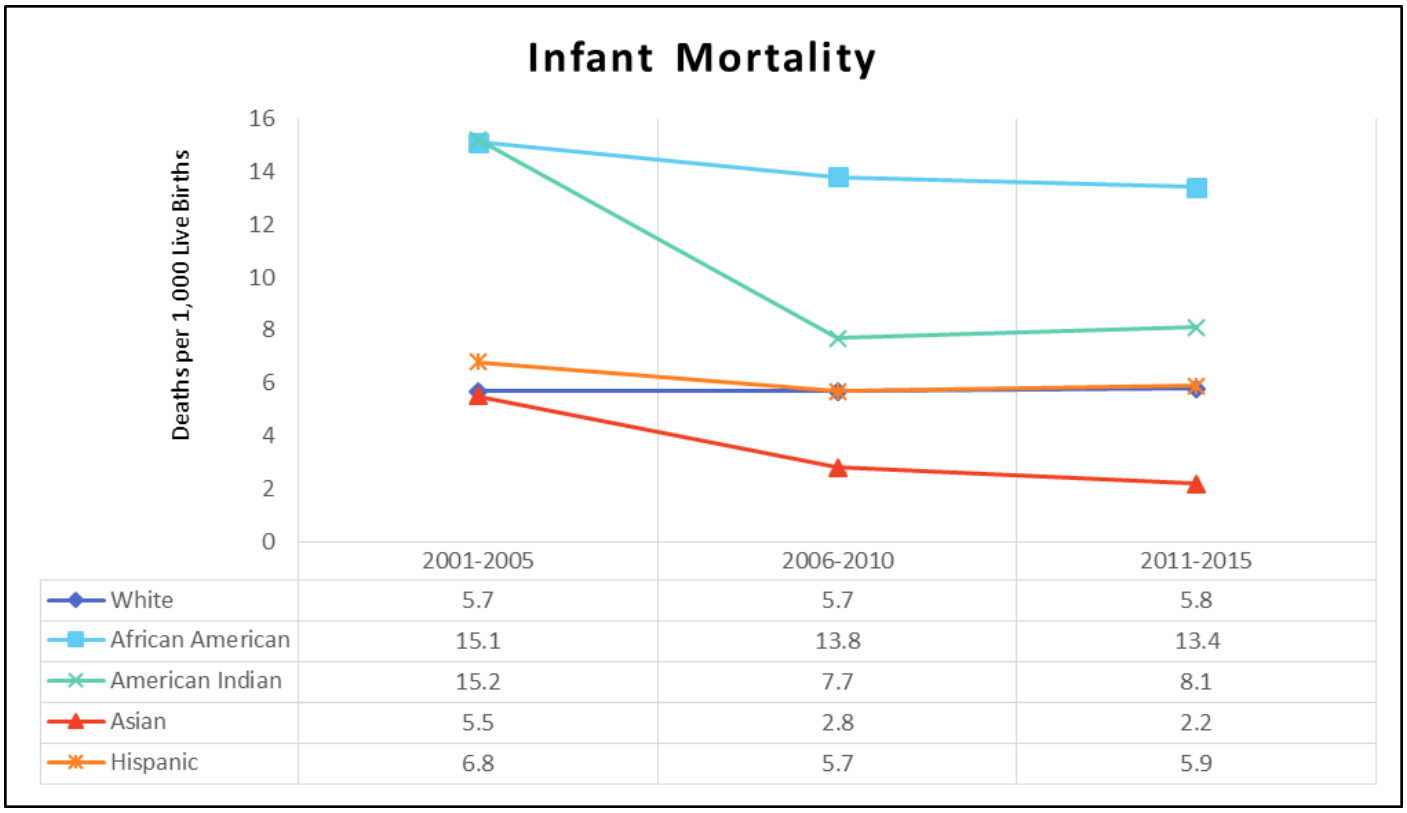


	2001-2005	2006-2010	2011-2015
White	51.7	40.8	34.8
African American	84.2	66.9	46.3
American Indian	62	45.3	37.7
Asian	65.7	30.3	29.6
Hispanic	29.2	24.8	29.4

Death Rates Related to Priority Issues, 2001-2015, Nebraska



	2001-2005	2006-2010	2011-2015
White	20.3	21	21.2
African American	67.3	62	50.5
American Indian	91	98.9	53.4
Asian	13.9	22.7	21
Hispanic	45.6	31.6	29.3



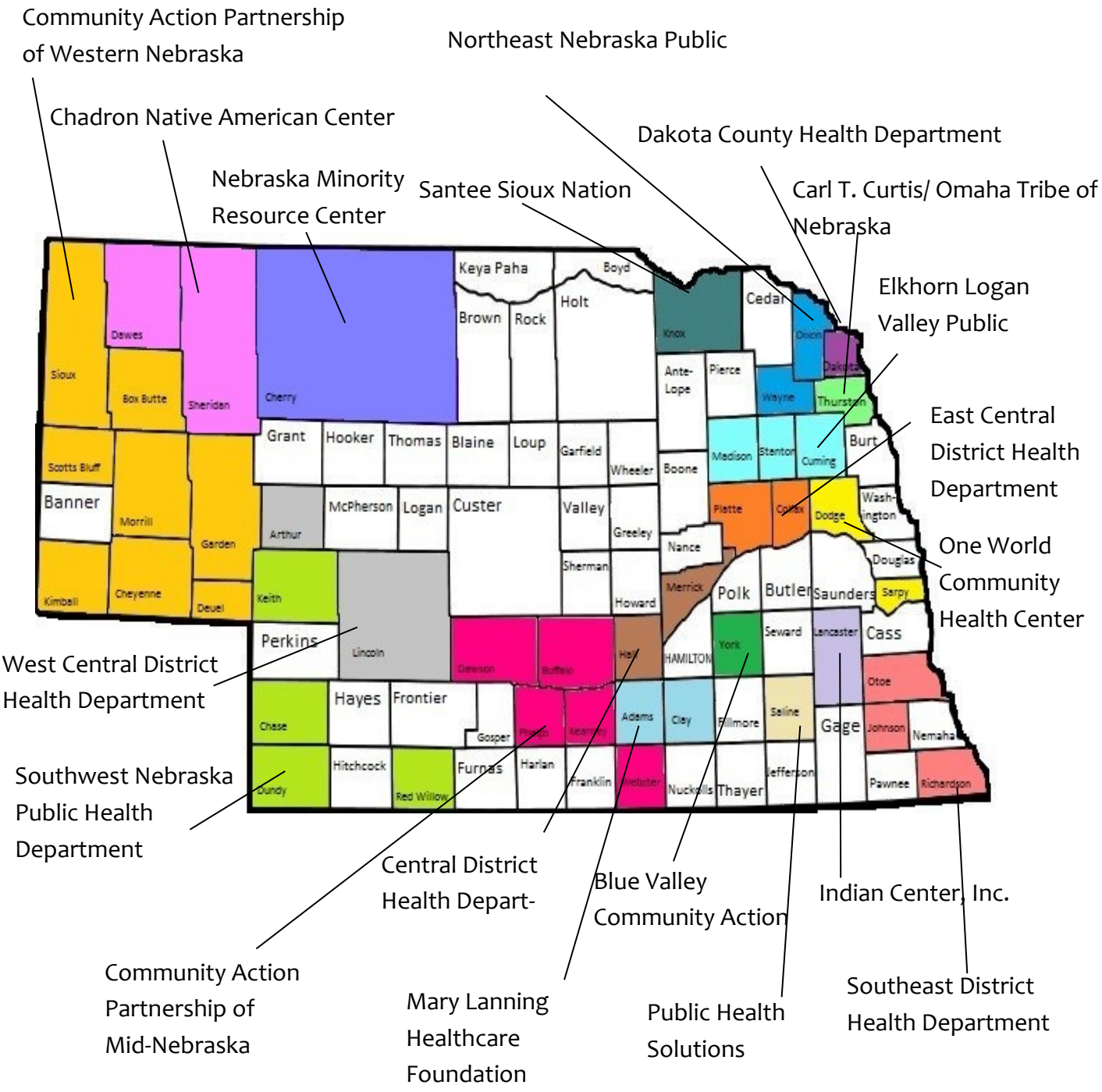
	2001-2005	2006-2010	2011-2015
White	5.7	5.7	5.8
African American	15.1	13.8	13.4
American Indian	15.2	7.7	8.1
Asian	5.5	2.8	2.2
Hispanic	6.8	5.7	5.9

Data Source: Nebraska DHHS Vital Statistics 2001-2015

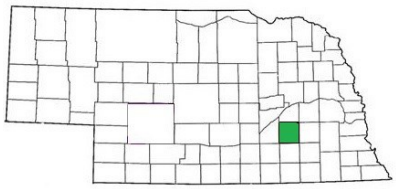
Minority Health Initiative two-year projects (7/2015—6/2017) were awarded to the following organizations:		
Projects (Congressional Districts 1 & 3)	**2–Year Amount**	**County(ies)**
Blue Valley Community Action	$18,126.96	York
Carl T. Curtis Health Center/Omaha Tribe	$81,012.07	Thurston
Central District Health Department	$312,378.78	Hall, Merrick
Chadron Native American Center	$39,223.65	Dawes, Sheridan
Community Action Partnership of Mid-Nebraska	$286,965.15	Buffalo, Dawson, Kearney, Phelps, Webster
Community Action Partnership of Western Nebraska	$253,314.57	Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sioux
Dakota County Health Department	$181,462.40	Dakota
East Central District Health Department	$184,239.30	Colfax, Platte
Elkhorn Logan Valley Public Health Department	$136,569.26	Cuming, Madison, Stanton
Indian Center, Inc.	$862,091.05	Lancaster
Mary Lanning Healthcare Foundation	$81,339.89	Adams, Clay
Nebraska Minority Resource Center (contract)	$5,000.00	Cherry
Northeast Nebraska Public Health Department	$27,171.16	Dixon, Wayne
One World Community Health Center	$391,812.24	Dodge, Sarpy
Public Health Solutions (contract)	$65,237.76	Saline
Santee Sioux Nation (contract)	$19,534.69	Knox
Southeast District Health Department	$50,832.61	Johnson, Otoe, Richardson
Southwest Nebraska Public Health Department	$38,201.64	Chase, Dundy, Keith, Red Willow
West Central District Health Department	$68,882.43	Arthur, Lincoln
TOTAL	$3,103,395.00	
Federally qualified health centers (Congressional District 2) For a one-year period		
Charles Drew Health Center	$688,550.50	
One World Community Health Center	$688,550.50	

Grantee Reports

Page 15 of this document begins the summaries of outcomes of individual project grants in Congressional Districts 1 and 3. The project summary pages are arranged alphabetically by grantee name, and include the county or counties covered by the project, the total funding amount for the two year project period, the funding health issue(s) targeted, the number of people served during the two years of the project, and project partners. A brief description of each project is followed by strategies implemented and outcomes achieved from July 1, 2015 through June 30, 2017. Pages 52 and 53 report on the funding allocated to the Federally Qualified Health Centers in Congressional District 2, the health issues targeted, and the number of people served during the second year only of the project.



York County



Blue Valley Community Action

Target Health Issues
Infant mortality, mental health

Dollars
$9,063.48 per year
$18,126.96 for two years

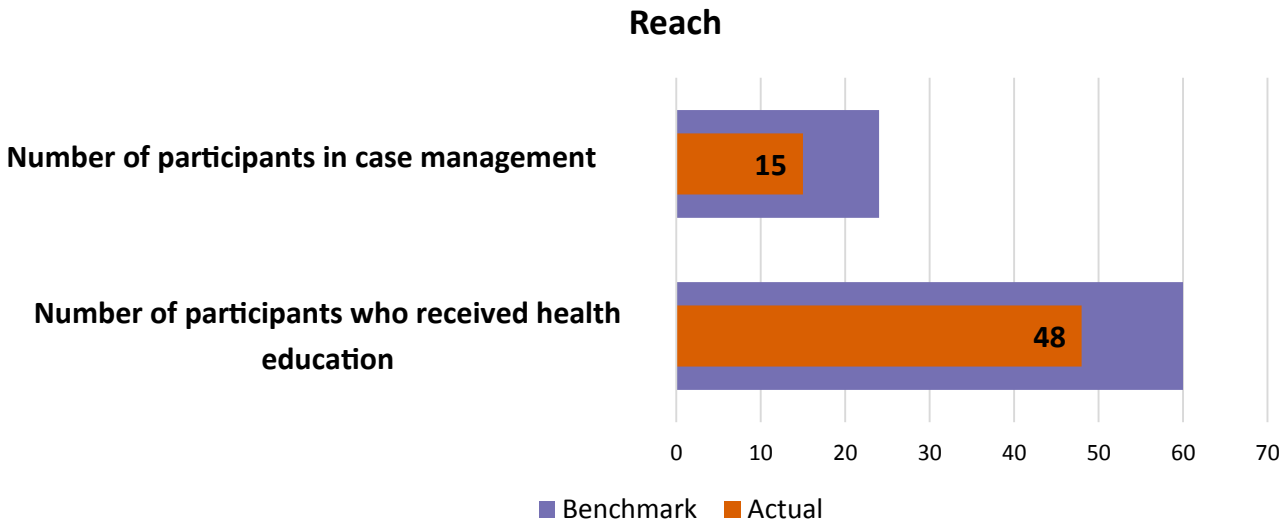
Key Project Partners
Blue Valley Behavioral Health
Four Corners Health Department

People Served
55

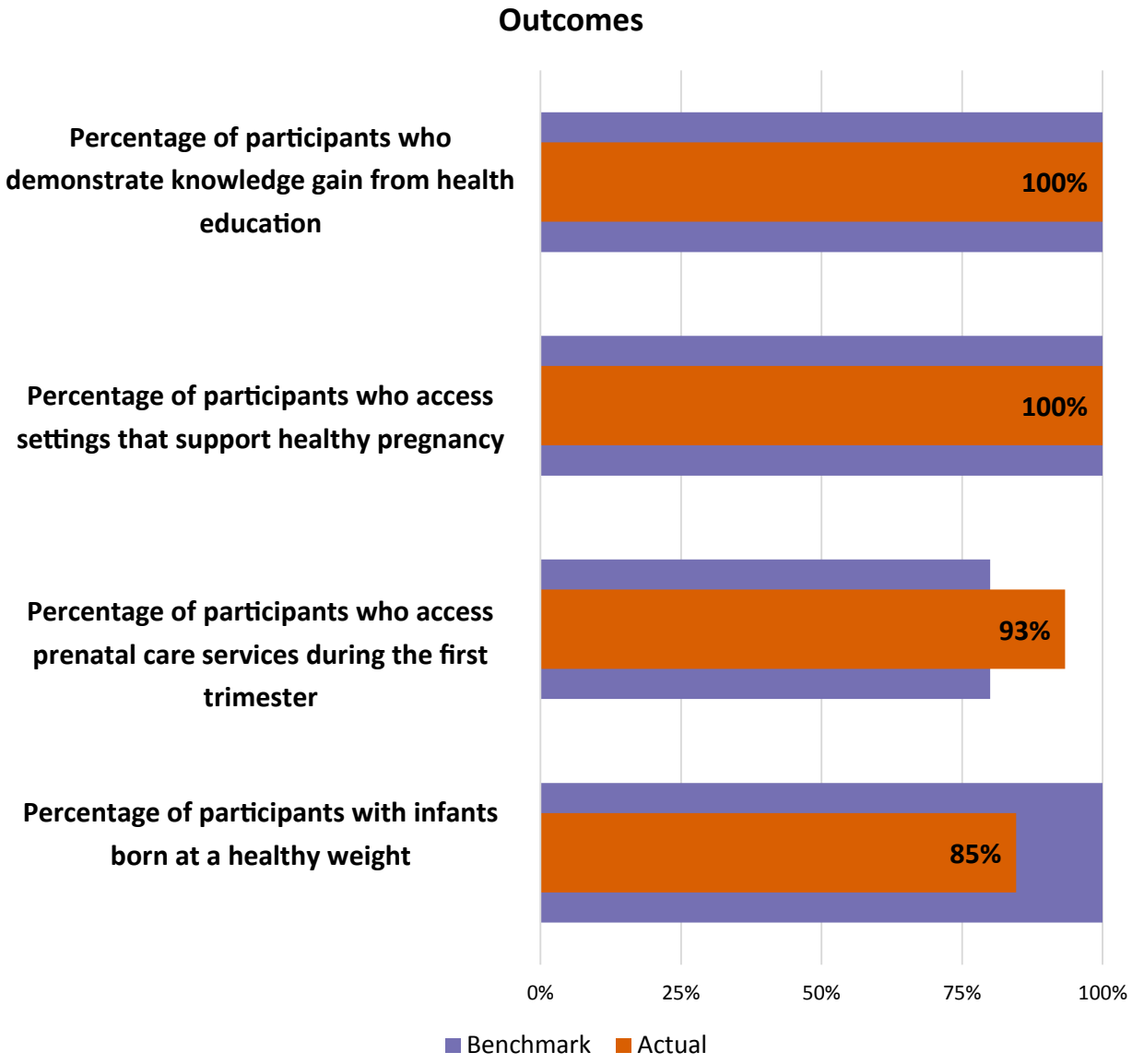
Through education, guidance and support, the Blue Valley Community Action project provided participants with the skills and knowledge to promote chronic disease prevention, support maternal and child health, reduce obesity, and improve physical activity. In addition, it raised awareness of post-partum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

Strategies

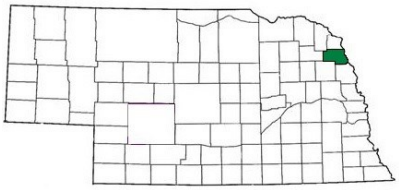
- Increase quality of and access to perinatal health services, including pre/inter-conception health care, prenatal care, labor and delivery services, and postpartum care.



York County (Continued)



Thurston County



Carl T. Curtis Health Education Center/Omaha Tribe

Target Health Issues
Cardiovascular disease,
diabetes

Dollars
$40,506.03 per year
$81,012.07 for two years

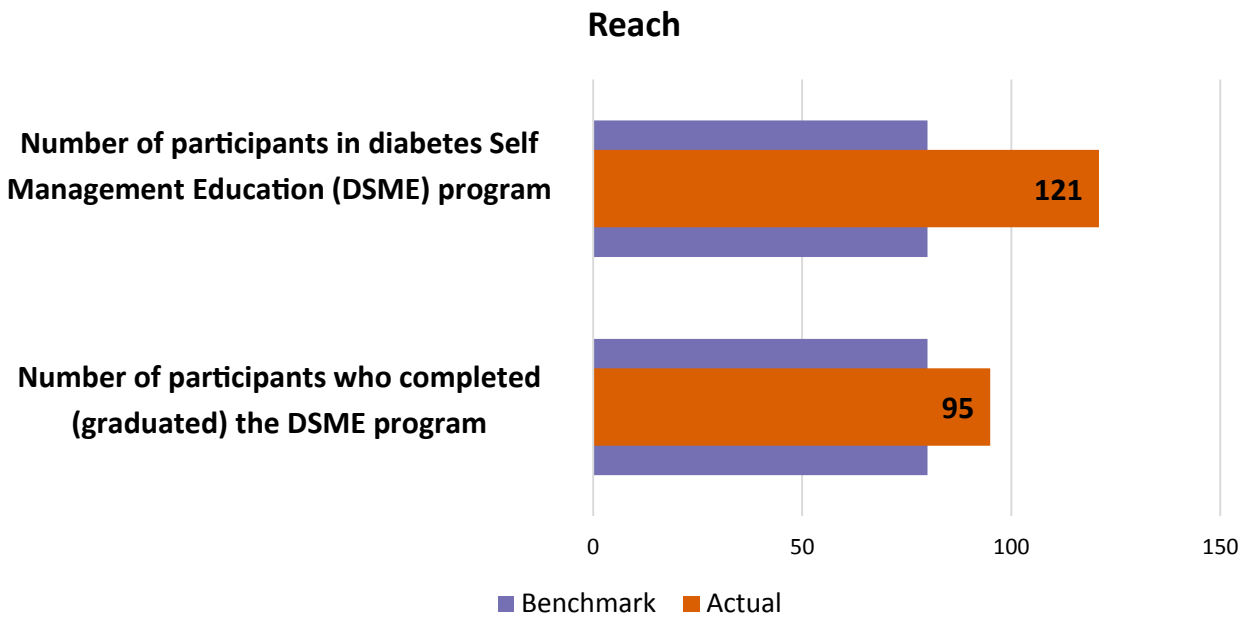
Key Project Partners
University of Nebraska Medical Center
Omaha Nation Community Response Team
Winnebago Diabetes Program

People Served
125

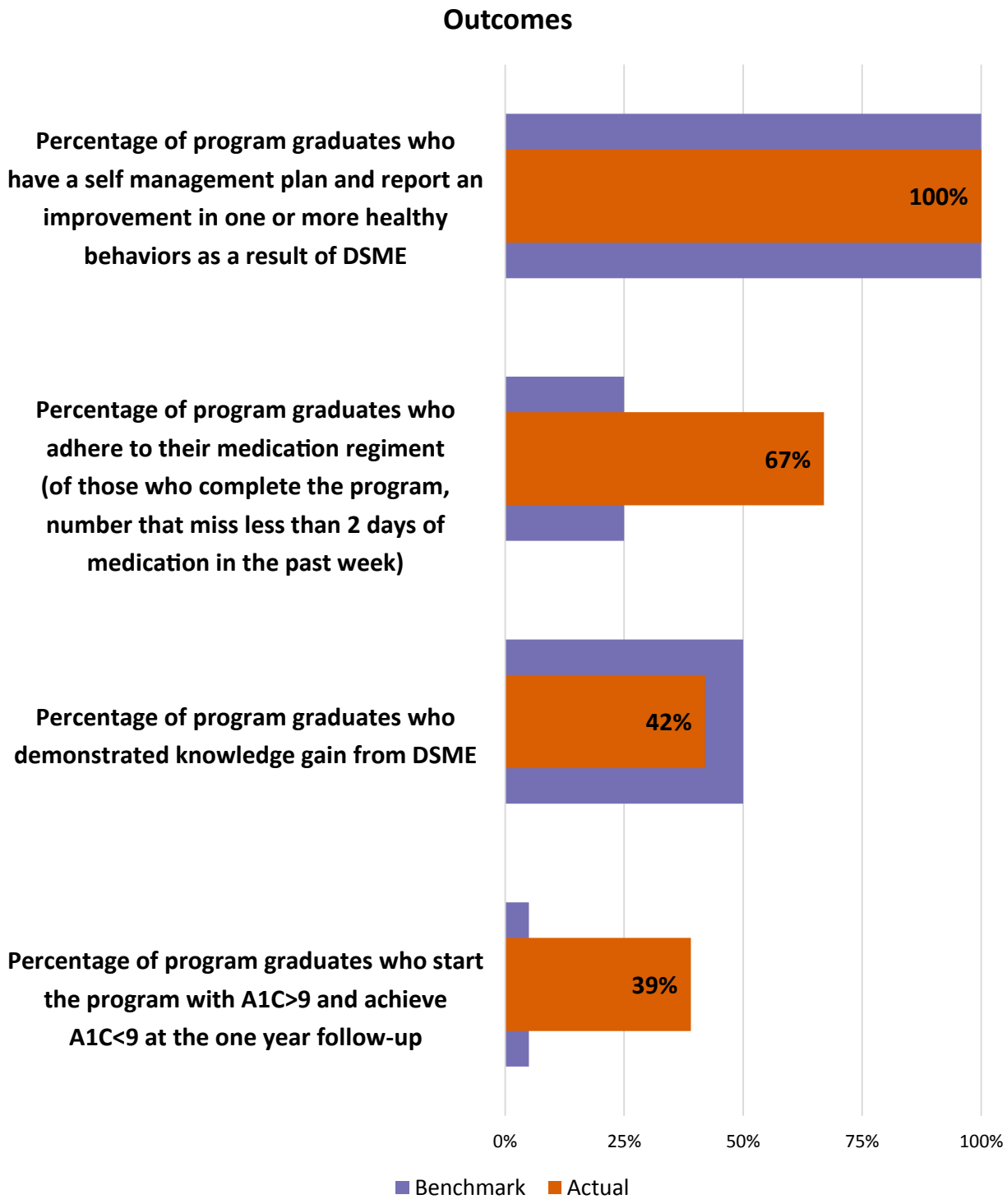
The Carl T. Curtis Health Center project provided diabetes self-management education to at least 80 participants from the Omaha and Winnebago reservations to increase knowledge and gain skills in the management of diabetes.

Strategies

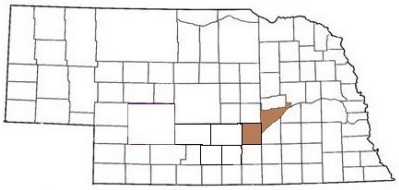
- Increase access, referrals, and use of chronic disease self-management programs (CDSM), including diabetes self-management education (DSME).



Thurston County (Continued)



Hall & Merrick Counties



Central District Health Department

Target Health Issues
Obesity, diabetes

Dollars
$156,189.39 per year
$312,278.78 for two years

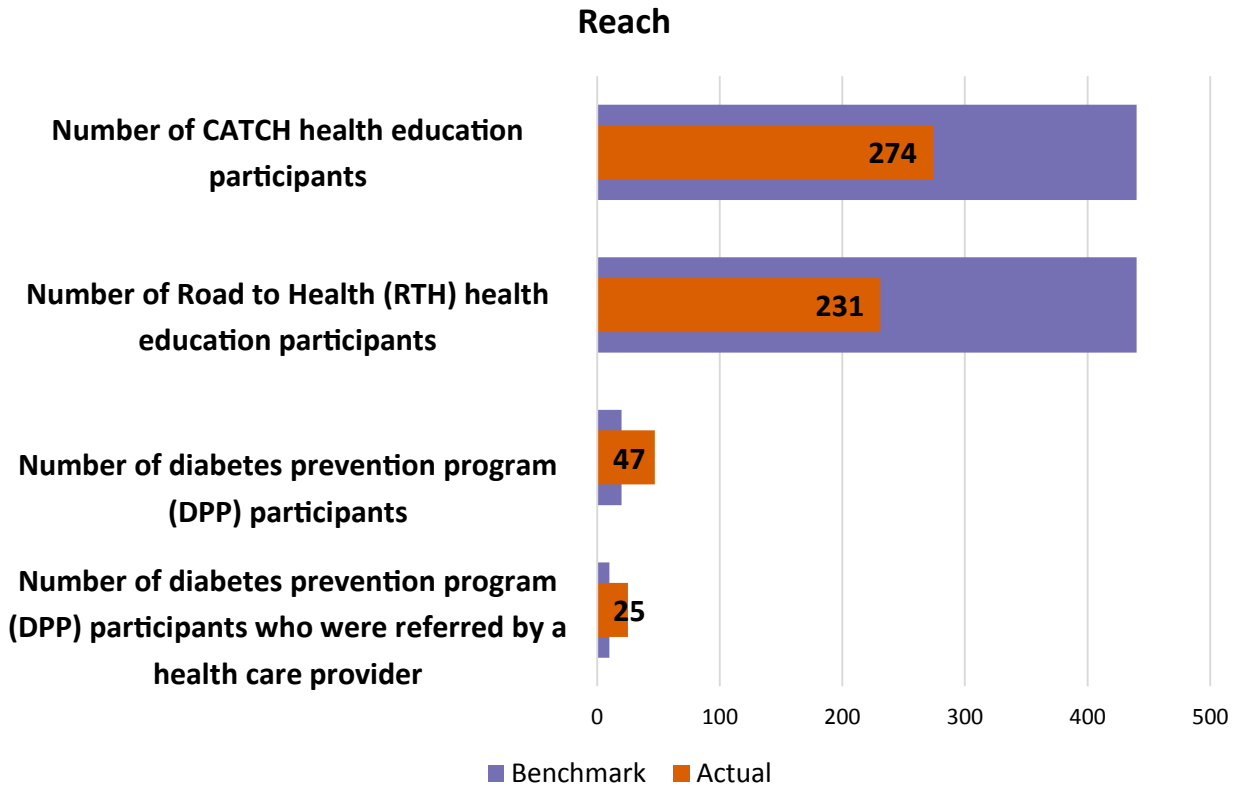
Key Project Partners
Central Nebraska Council on Alcoholism & Addictions
Grand Island Public Schools

People Served
739

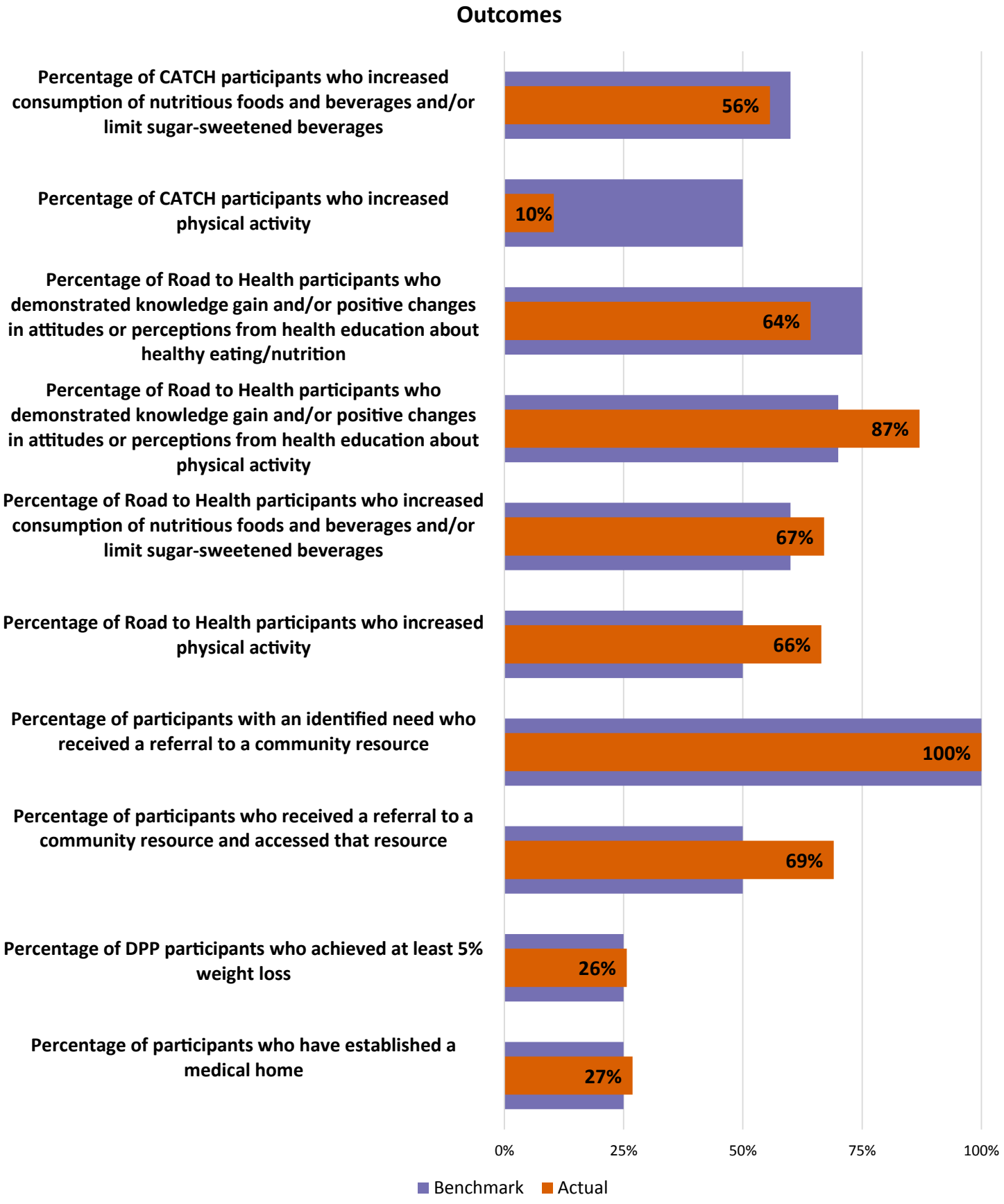
Central District Health Department employed an evidence-based Diabetes Prevention Program "Road to Health" (RTH) to improve access to health services for adult minorities, and implemented obesity prevention among minority youth using the evidence-based CATCH (Coordinated Approach to Child Health) Kids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

Strategies

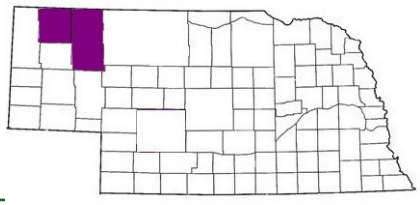
- Ensure access to/and or promote consumption of healthful foods, including fruits, vegetables, and water while limiting access to sugar-sweetened beverages and sodium; and,
- Ensure access to and/or promote physical activity.



Hall & Merrick Counties (Continued)



Dawes & Sheridan Counties



Chadron Native American Center

Target Health Issues
Obesity, diabetes, cardiovascular disease

Key Project Partners
Western Community Health Resources
Panhandle Public Health District

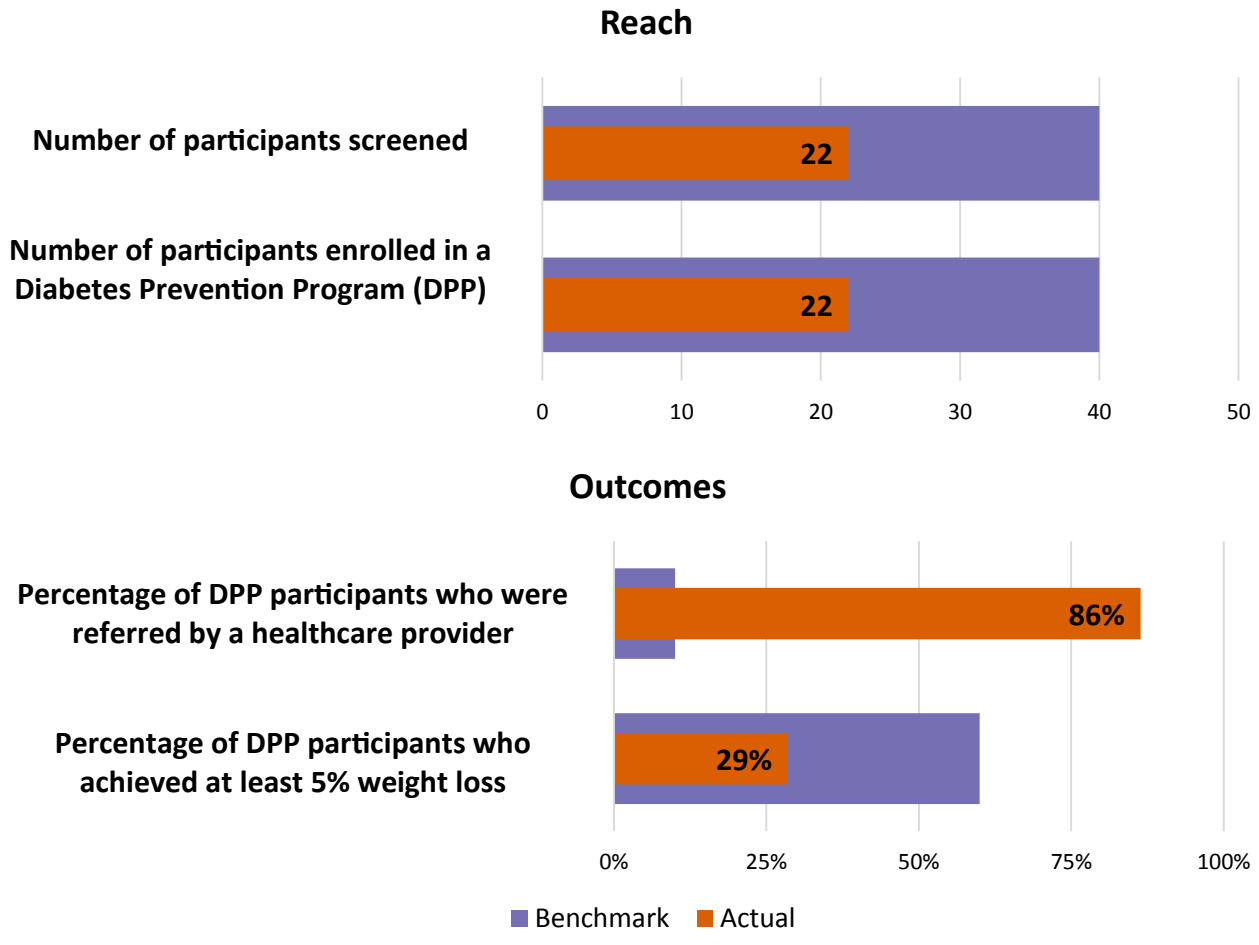
Dollars
$19,611.82 per year
$39,223.65 for two years

People Served
22

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

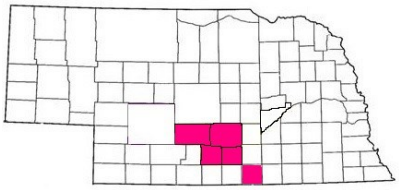
Strategies

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



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
$286,965.15 for two years

Key Project Partners

Help Care Clinic

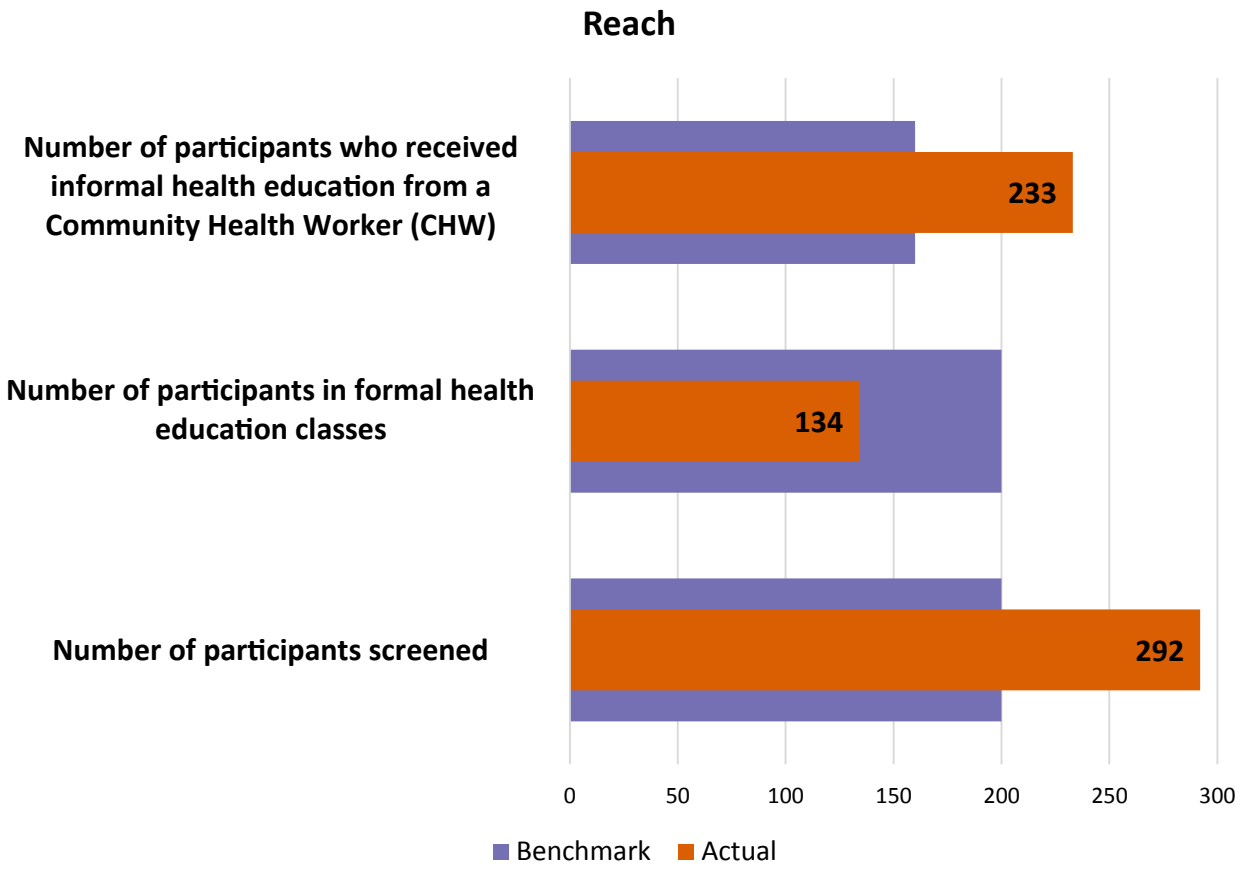
People Served

296

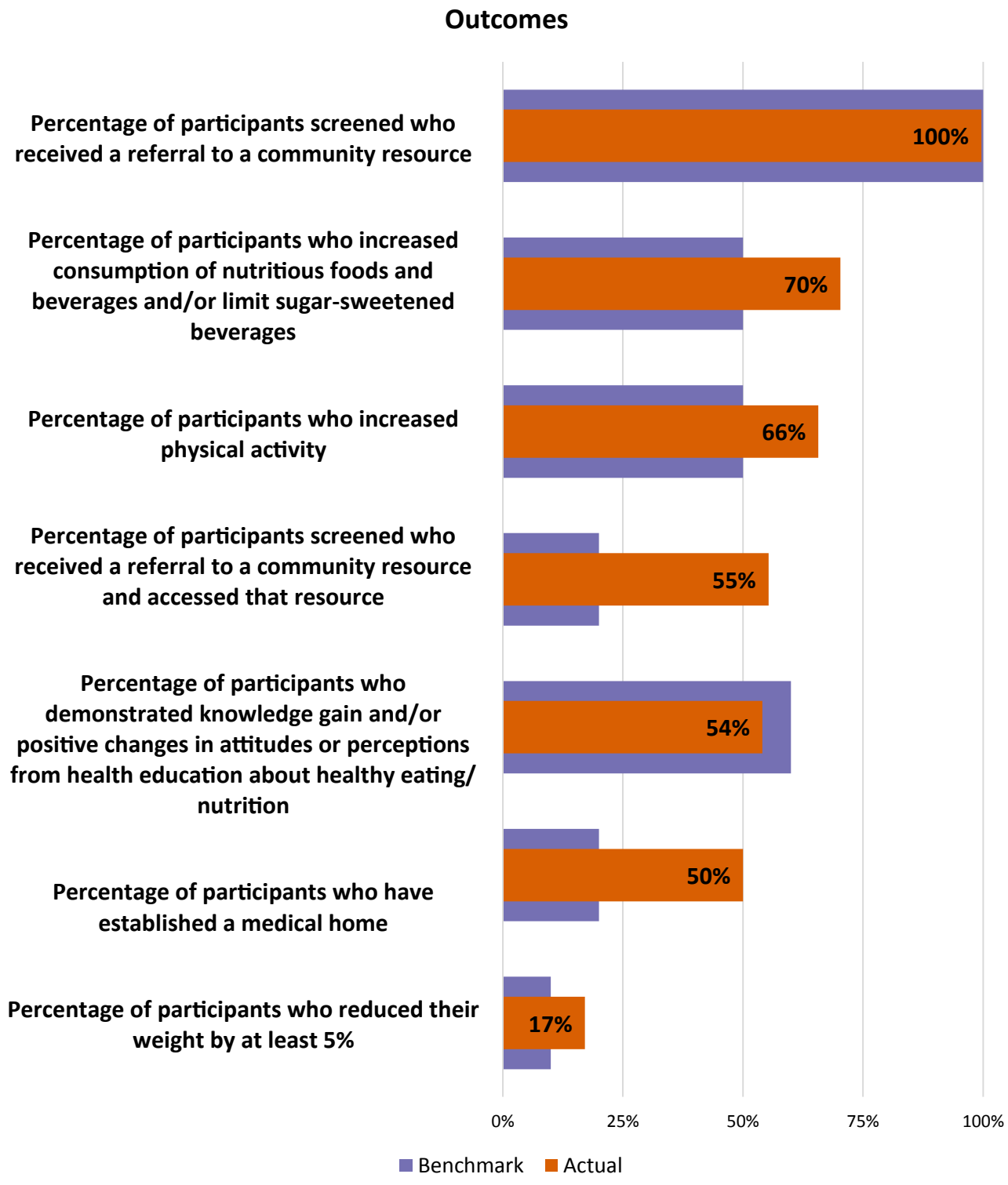
Community Action of Mid Nebraska utilized a Community Health Worker in Buffalo, Dawson, Kearney, Phelps, and Webster counties to increase linkages between health systems and community resources for minorities for promoting healthier lifestyles.

Strategies

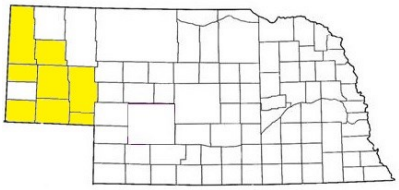
∝ Increase and/or promote linkages between health systems and community resources for minorities.



Buffalo, Dawson, Kearney, Phelps, & Webster Counties (Continued)



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



Community Action Partnership of Western Nebraska

Target Health Issues
Obesity, diabetes
cardiovascular disease

Dollars
$126,657.29 per year
$253,314.57 for two years

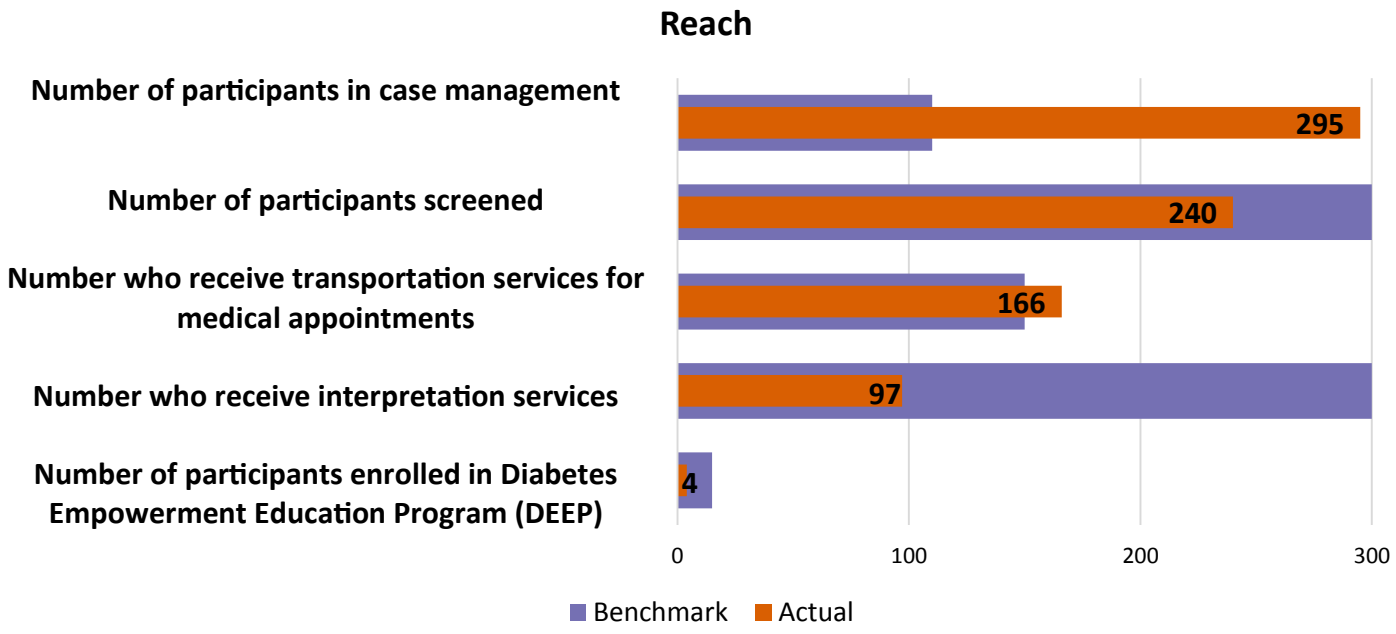
Key Project Partners
University of Nebraska Medical Center

People Served
580

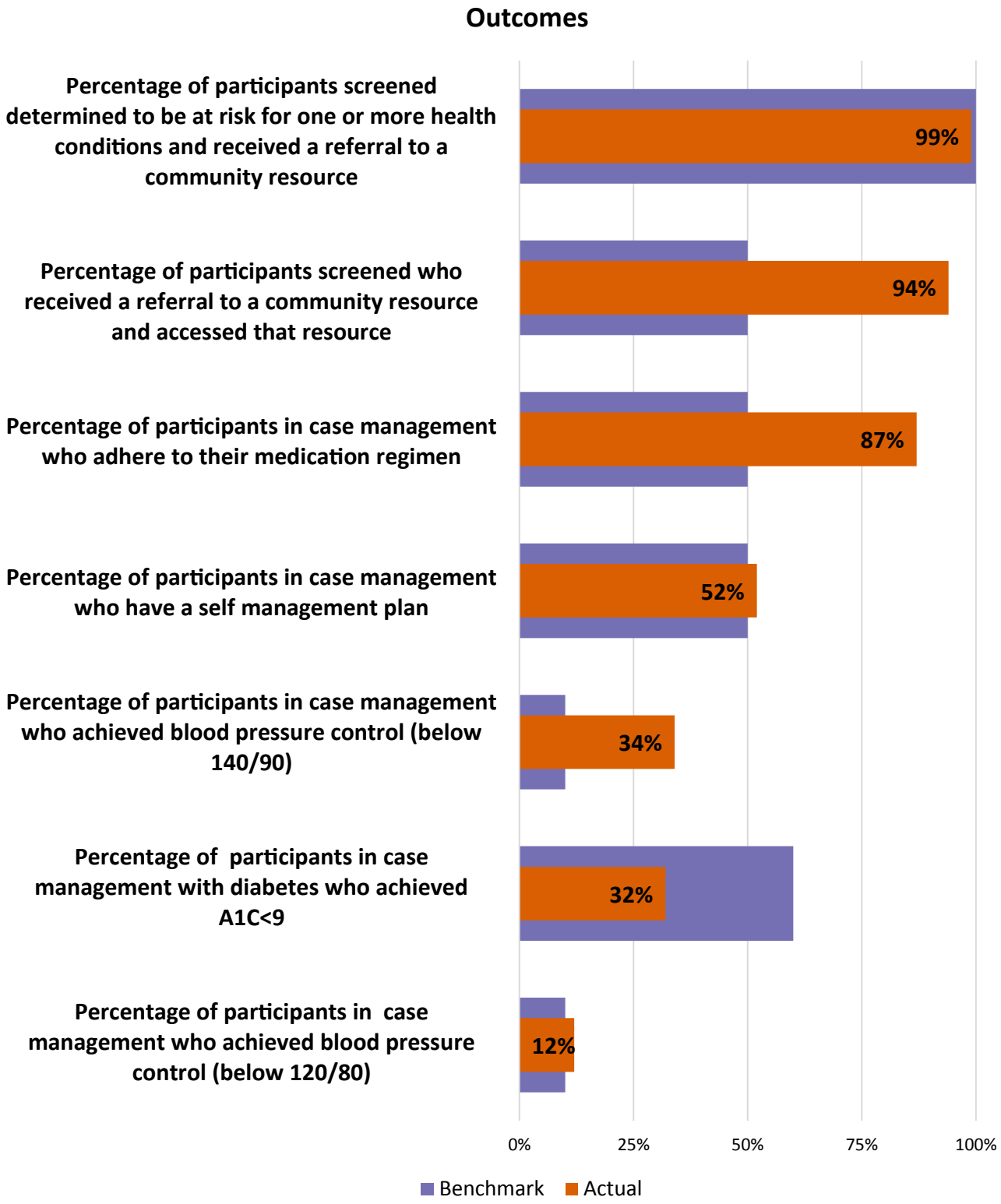
CAPWN's Community Health Workers (CHWs) worked with local health care facilities to encourage a multidisciplinary team approach to manage patients with high blood pressure and diabetes. The CHWs worked to increase the number of referrals for minorities to local community resources and the number of minorities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

Strategies

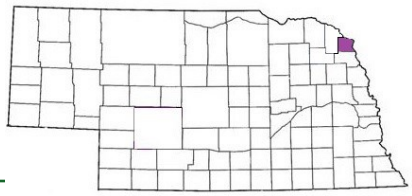
- Ensure access to and/or promote consumption of healthful foods, including fruits, vegetables, and water, while limiting access to sugar-sweetened beverages and sodium;
- Increase use of team-based care (i.e., involving physicians, community health workers, nurses, pharmacists, and patient navigators)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



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



Dakota County



Dakota County Health Department

Target Health Issues
Obesity, diabetes

Dollars
$90,731.20 per year
$181,462.40 for two years

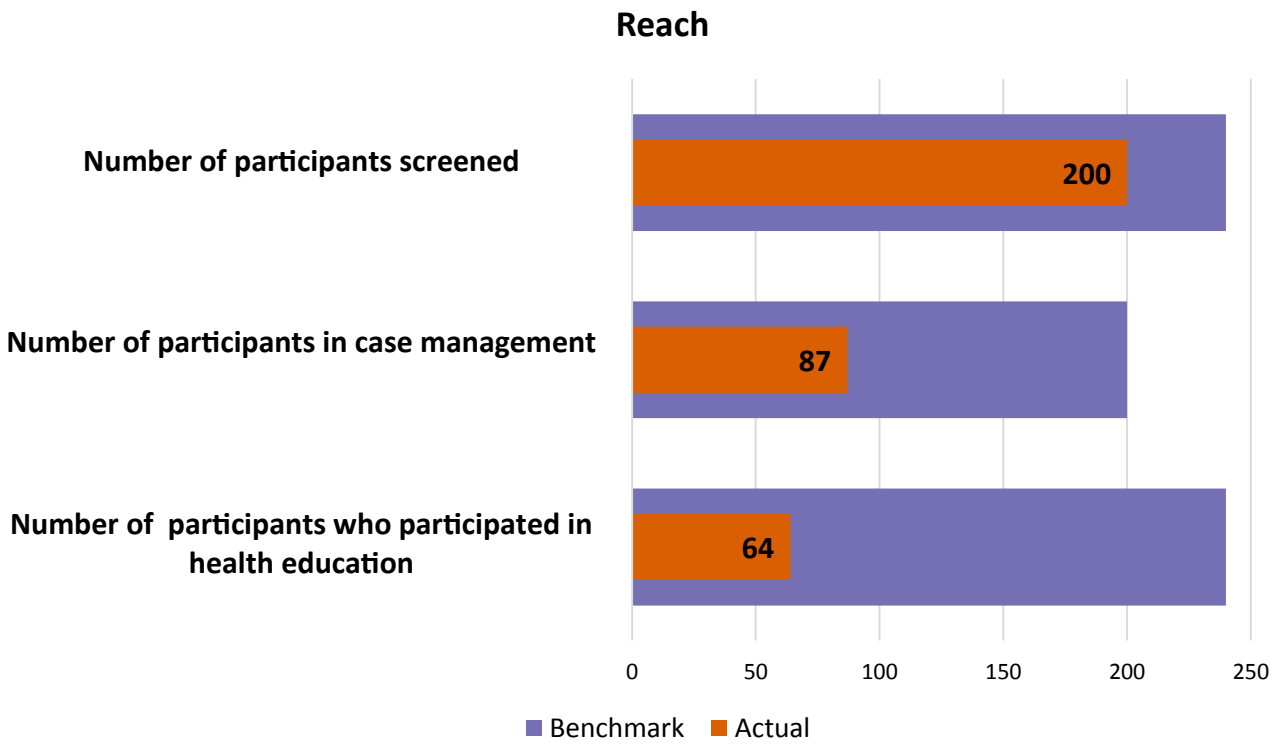
Key Project Partners
South Sioux City Public Library
University of Nebraska County Extension

People Served
346

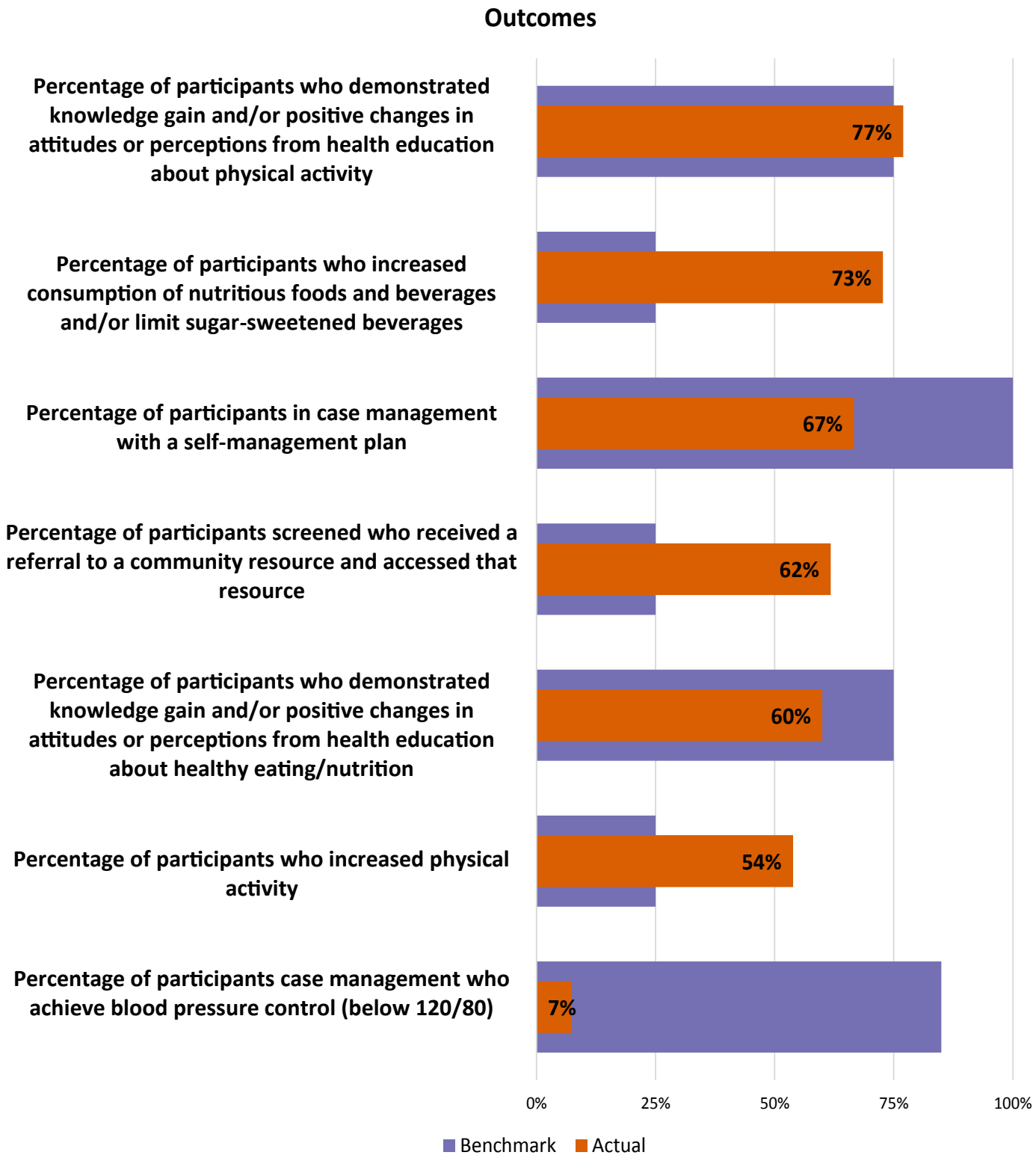
Dakota County Health Department utilized Community Health Workers within the county to implement the Road to Health education program and worked with the minority population to educate and implement methods that directly impacted negative effects of diabetes by guiding them toward healthy eating choices 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,
- Ensure access to and/or promote physical activity.

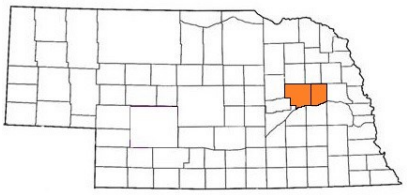


Dakota County (Continued)



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

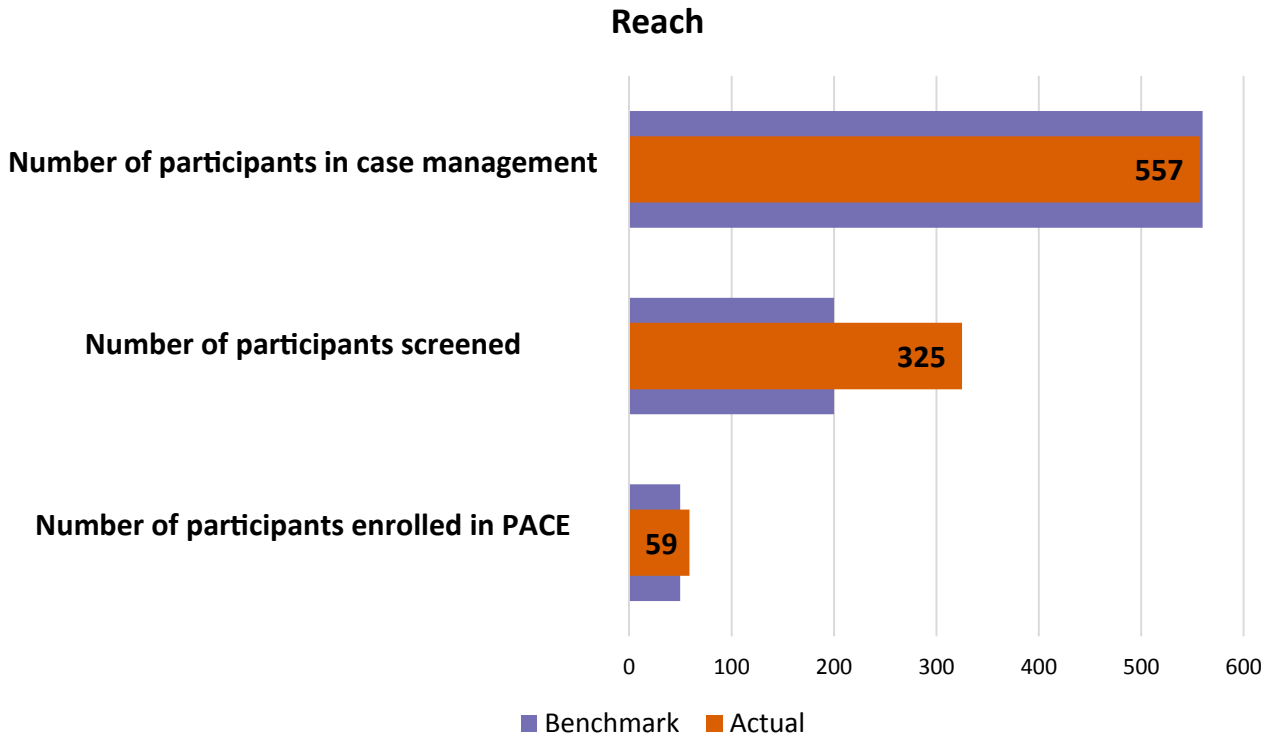
Dollars
$92,119.65 per year
$184,239.30 for two years

People Served
917

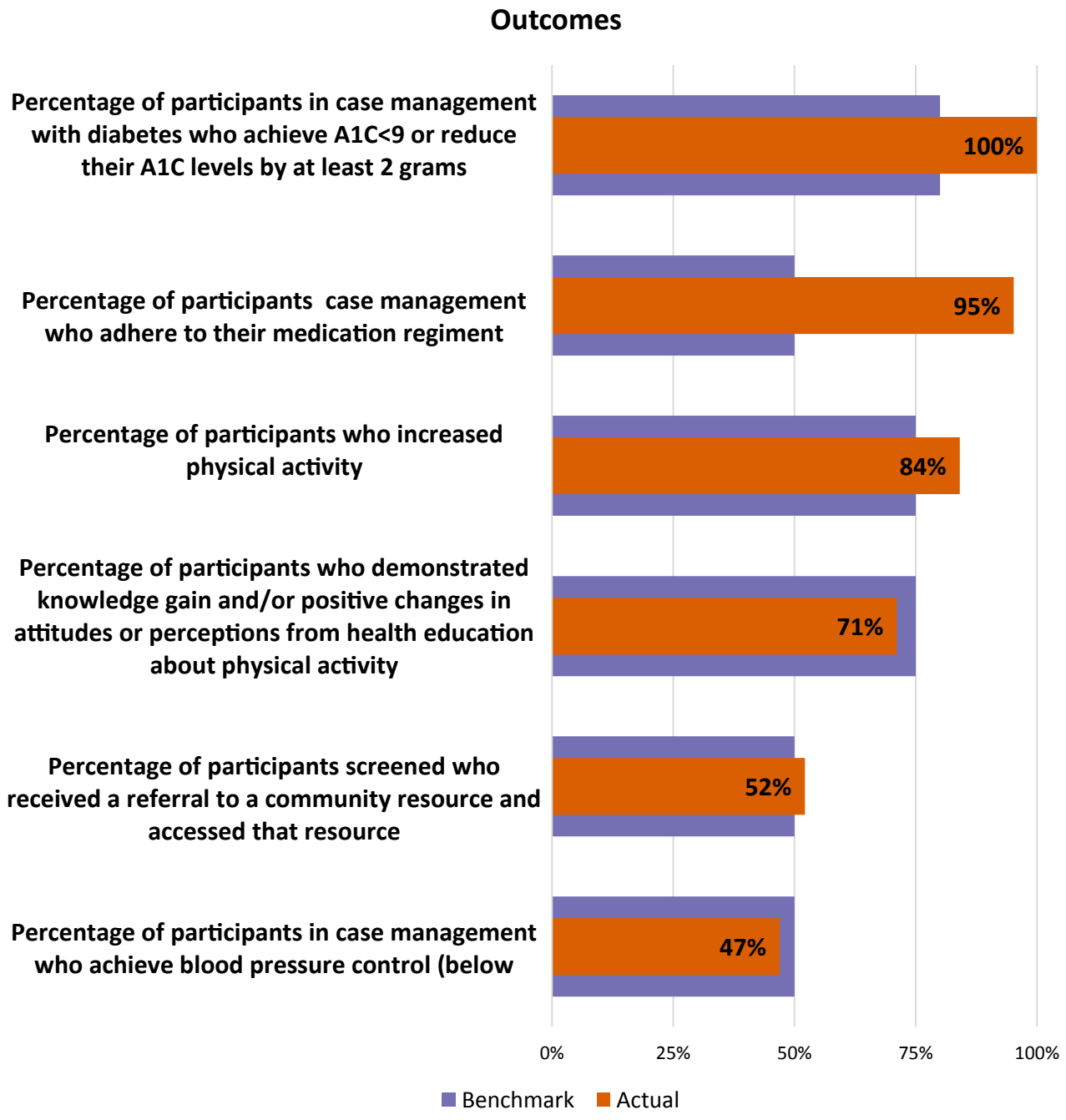
East Central District Health Department worked to reduce the incidence and economic burden of diabetes and improved the quality of life for minority persons who have or were at-risk for diabetes.

Strategies

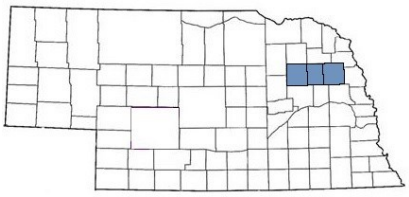
- Increase use of team-based care (i.e., involving physicians, community health workers, nurses, pharmacists, and patient navigators) in health systems;
- Increase and/or promote linkages between health systems and community resources for minorities; and,
- Ensure access to and/or promote physical activity.



Colfax & Platte Counties (Continued)



Cuming, Madison, & Stanton Counties



Elkhorn Logan Valley Public Health Department

Target Health Issues
Obesity

Key Project Partners
Midtown Health Center, Inc.

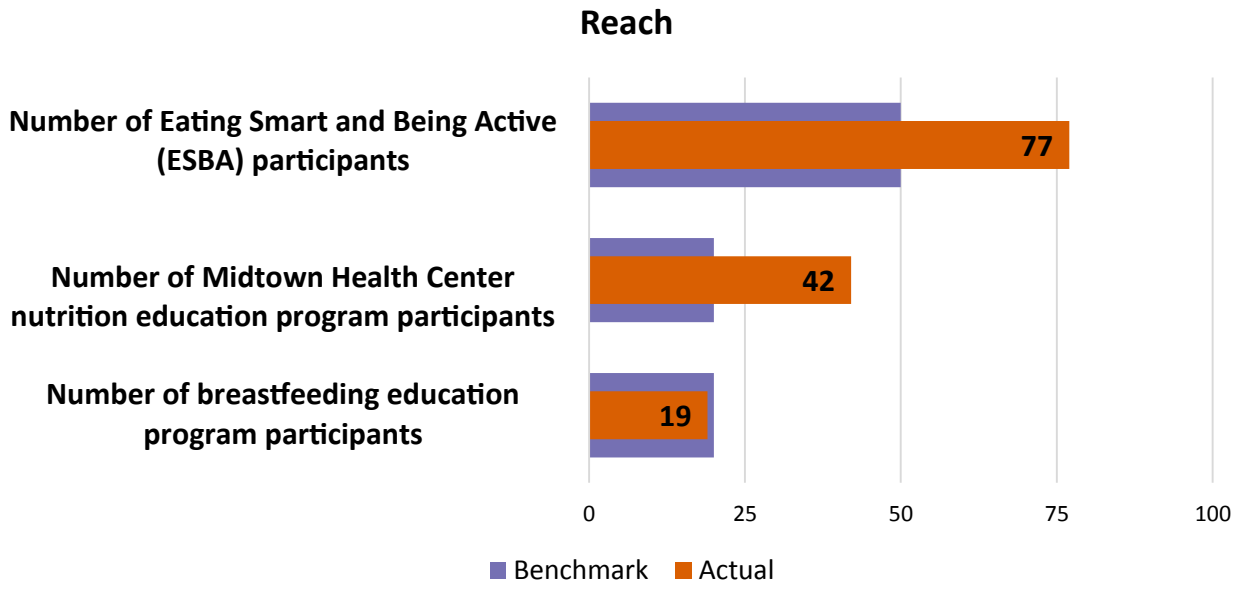
Dollars
$68,284.63 per year
$136,569.26 for two years

People Served
138

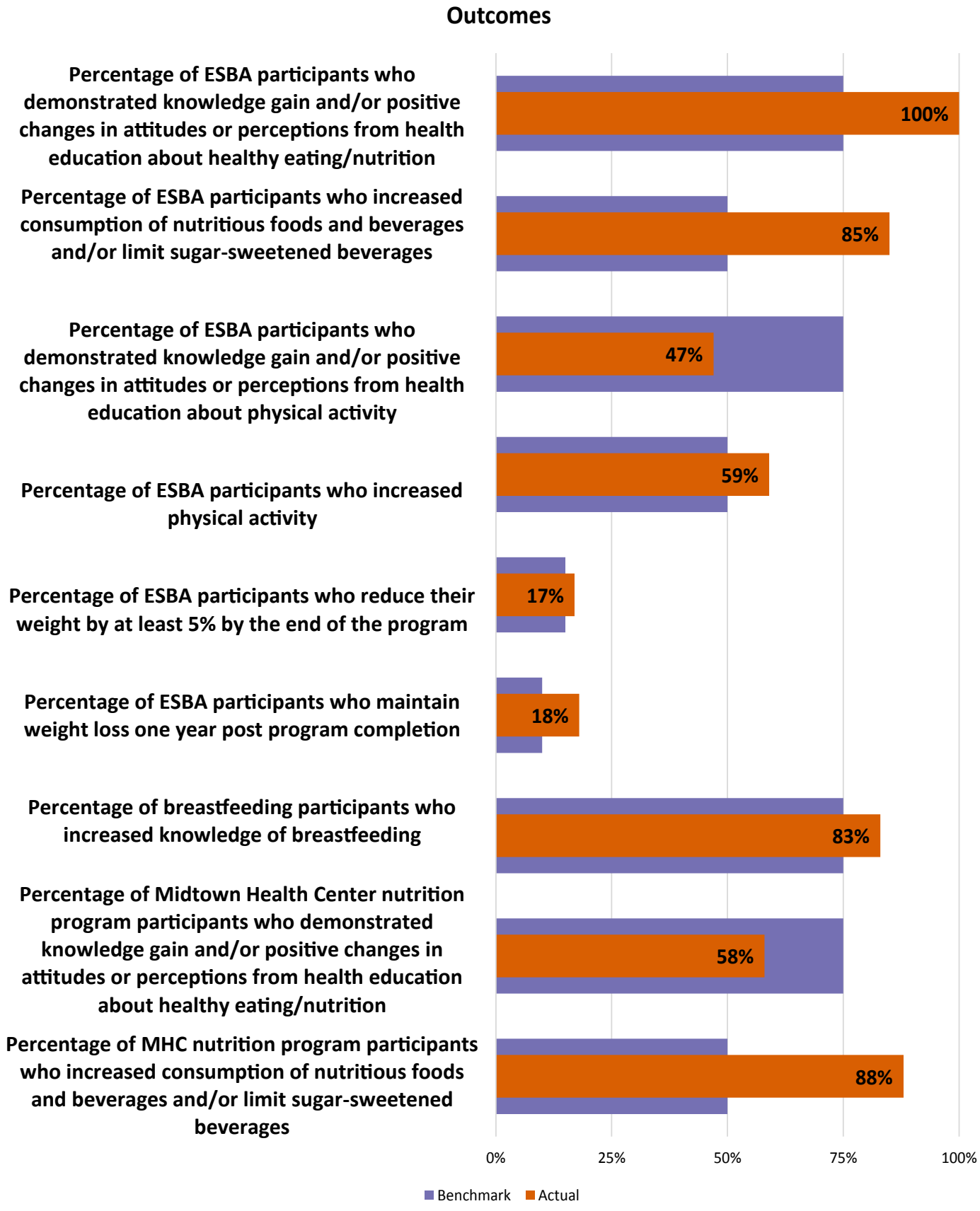
Elkhorn Logan Valley Public Health Department program activities were directed at decreasing the prevalence of obesity among minority citizens within their service area by implementing obesity self-management programs, promoting the consumption of healthful foods for infants and toddlers, assisting with 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; and,
- Ensure access to and/or promote physical activity.
- Ensure access to baby-friendly environments and/or promote breastfeeding.

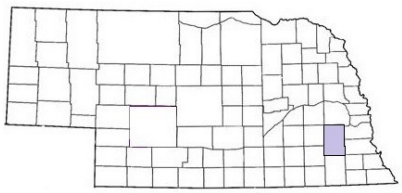


Cuming, Madison, & Stanton Counties (Continued)



Lancaster County

Indian Center, Inc.



Target Health Issues
Obesity, diabetes,
cardiovascular disease

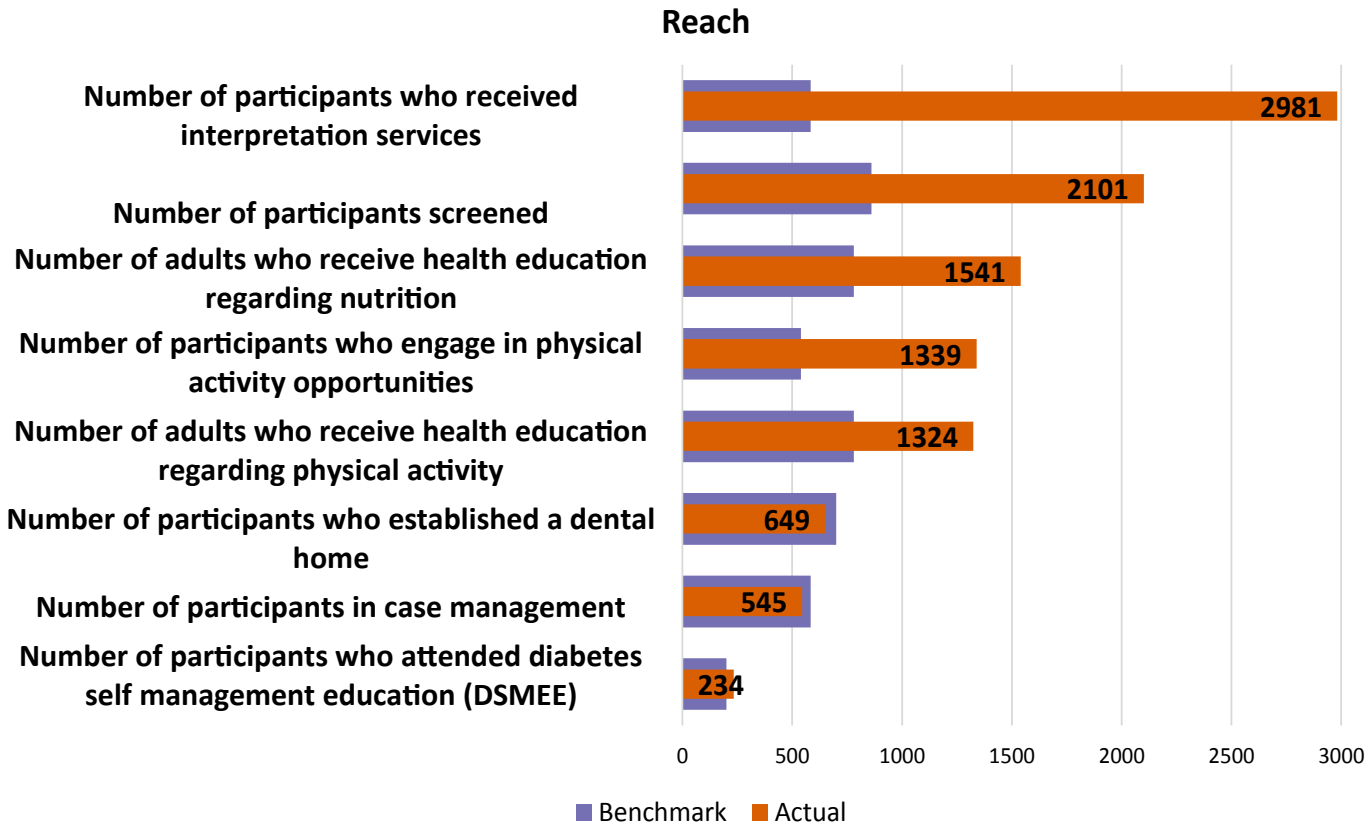
Dollars
$431,045.52 per year
$862,021.05 for two years

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

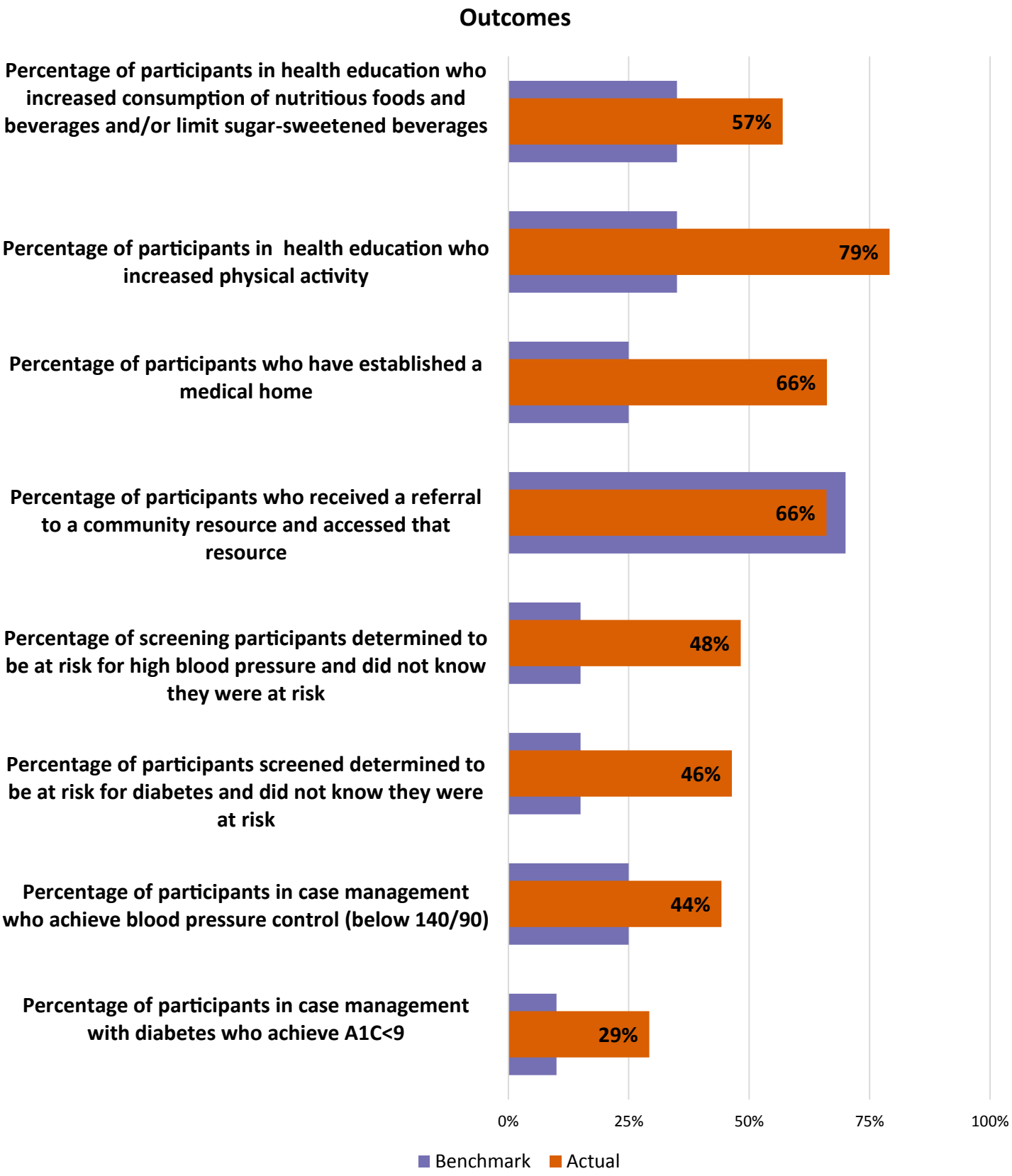
People Served
5,973

The Indian Center project impacted obesity, diabetes, and cardiovascular disease by directing activities at decreasing health disparities among minorities in their service area through 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.

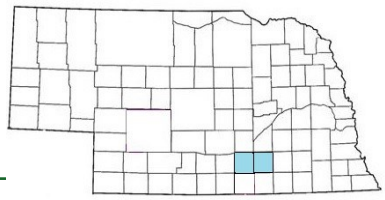


Lancaster County (Continued)



Adams & Clay Counties

Mary Lanning Healthcare Foundation



Target Health Issues
Obesity, diabetes, cardiovascular disease

Key Project Partners
South Heartland District Health Department
Hastings Family YMCA

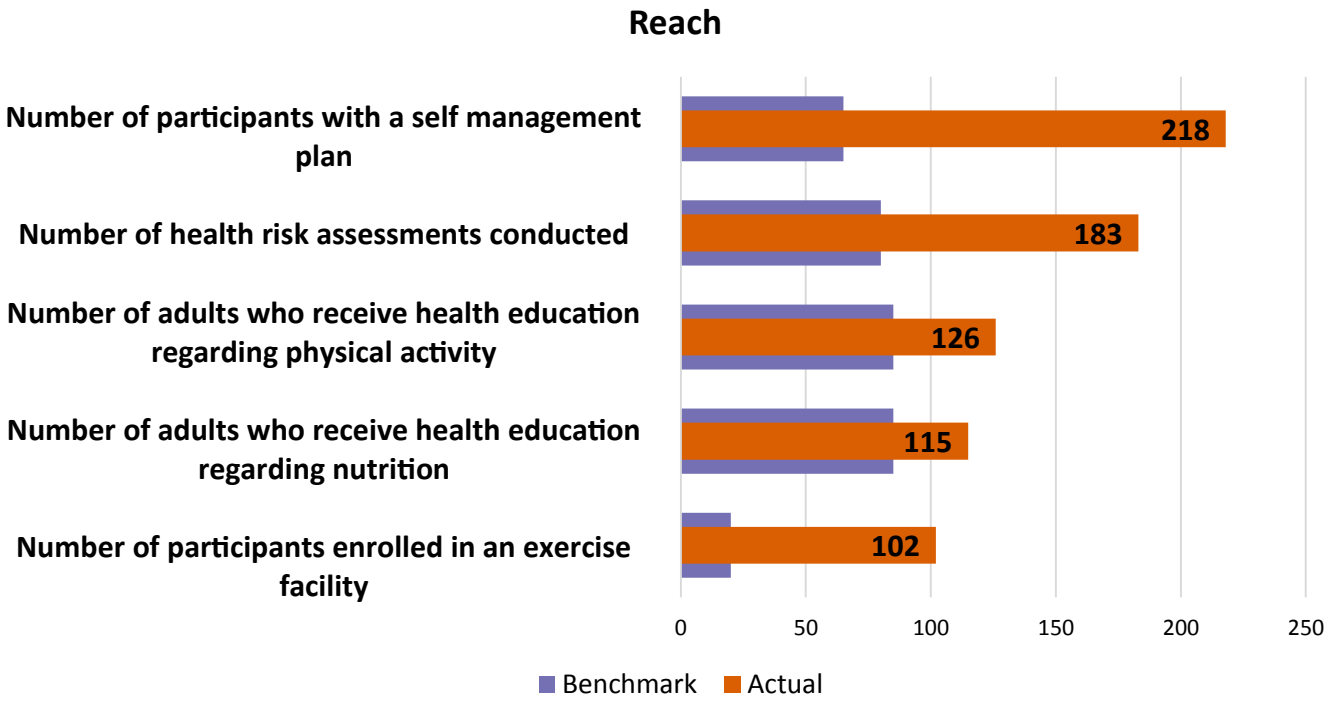
Dollars
$40,669.94 per year
$81,339.89 for two years

People Served
272

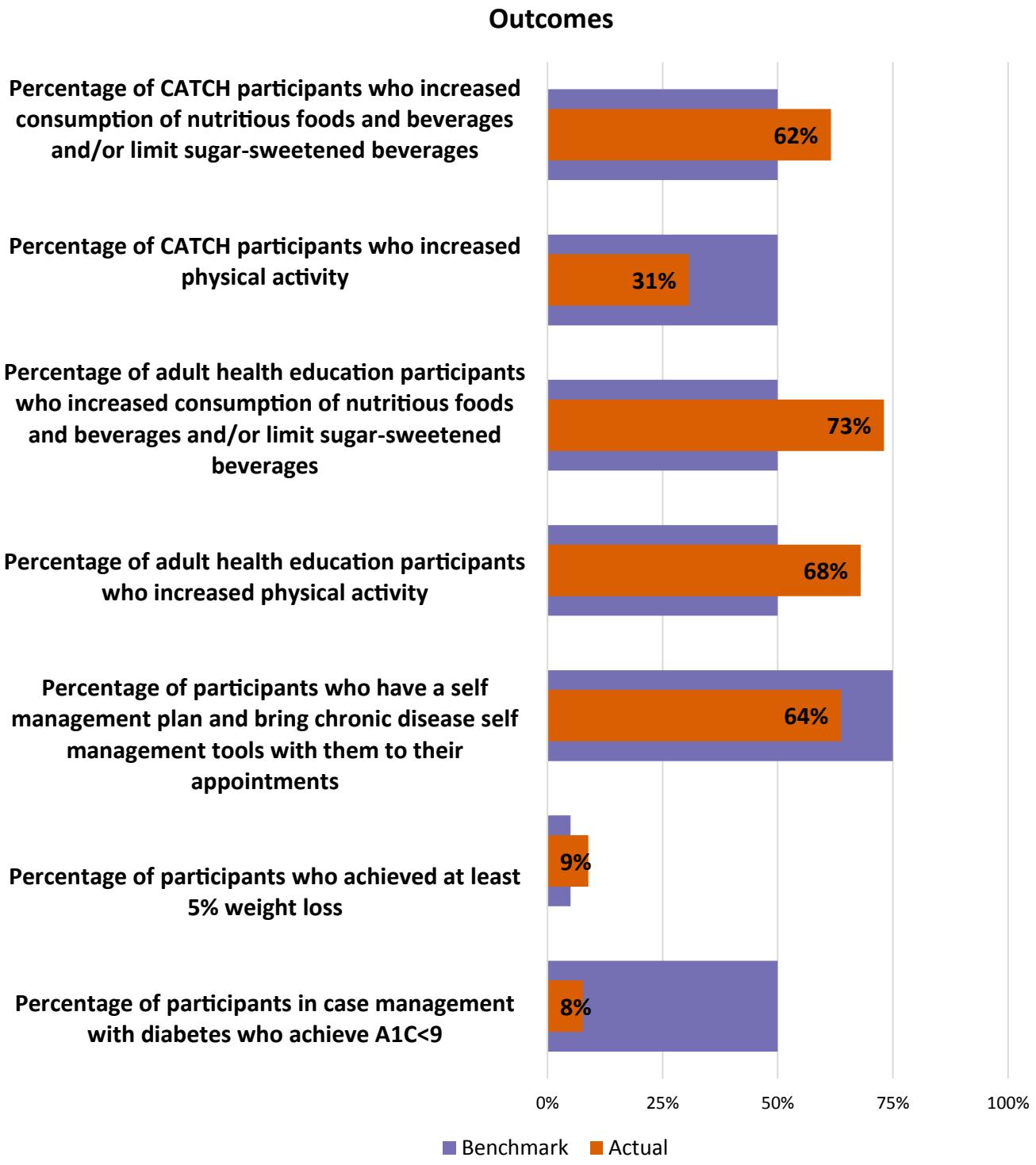
Mary Lanning Healthcare Foundation, *El Paquete Total* focused on a "Total Family" wellness concept by offering individual disease management using the evidence–based American Association of Diabetes Educators (AADE) program, self-care behaviors, and education and support programs to family members (home 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; and,
- Increase use of team-based care (i.e., involving physicians, community health workers, nurses, pharmacists, and patient navigators) in health systems.

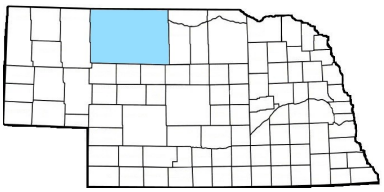


Adams & Clay Counties (Continued)



Cherry County

Nebraska Minority Resource Center



Target Health Issues
Diabetes, cardiovascular disease

Dollars
$5,000.00 for 9 months only

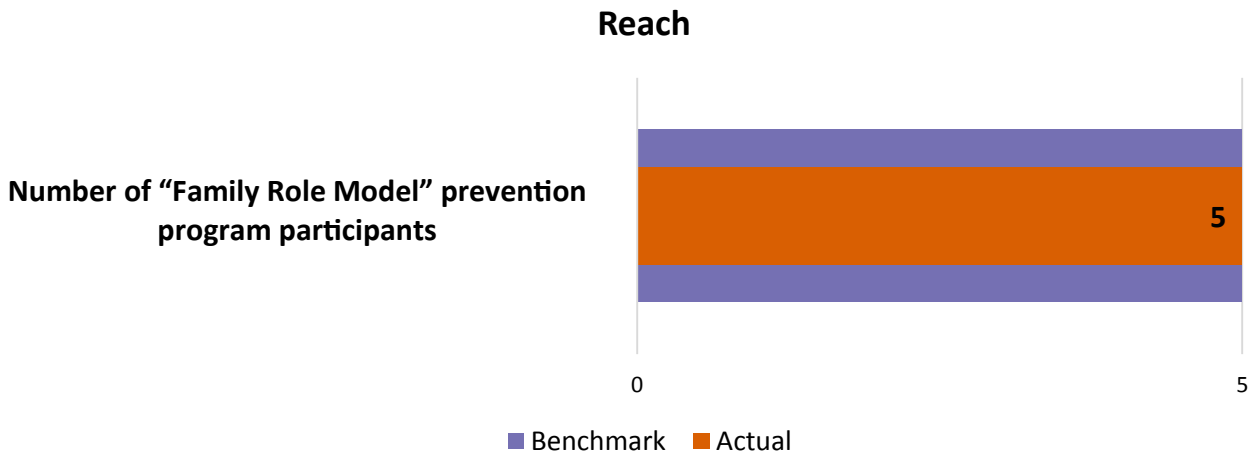
Key Project Partners
N/A

People Served
5

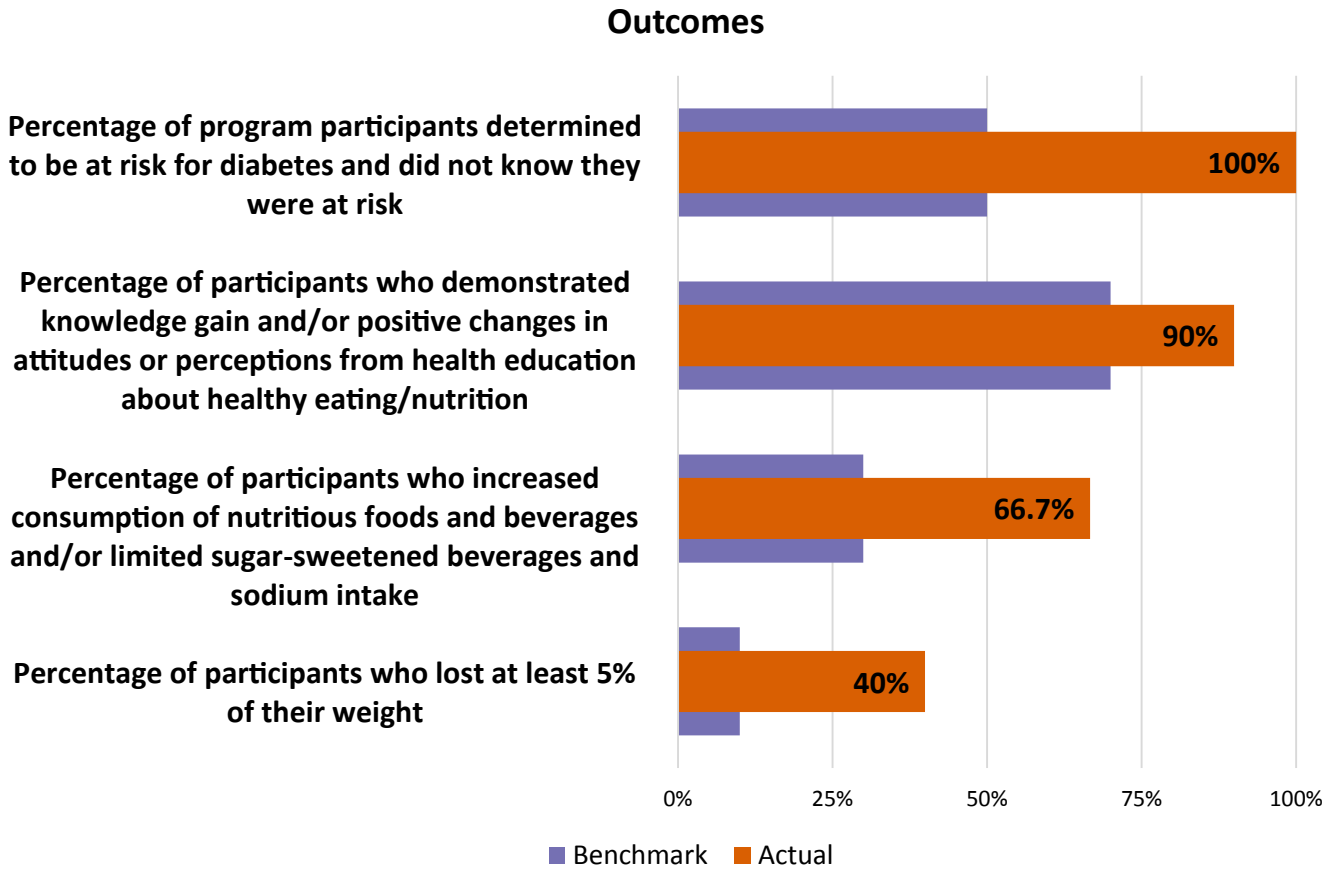
The Nebraska Minority Resource Center implemented a "Family Role Model" prevention program whereby an adult cohort group identified as at-risk for diabetes and cardiovascular disease were equipped with nutrition workshops and other resources that were applied to healthy lifestyle practices; those practices were observed by family and others who emulated those healthy lifestyle practices.

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; and,
- Implement identification of patients with undiagnosed hypertension and people with pre-diabetes.

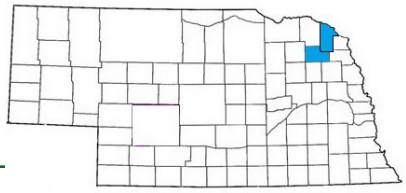


Cherry County (Continued)



Dixon & Wayne Counties

Northeast Nebraska Public Health Department



Target Health Issues
Cardiovascular disease, diabetes

Dollars
$13,585.58 per year
$27,171.16 for two years

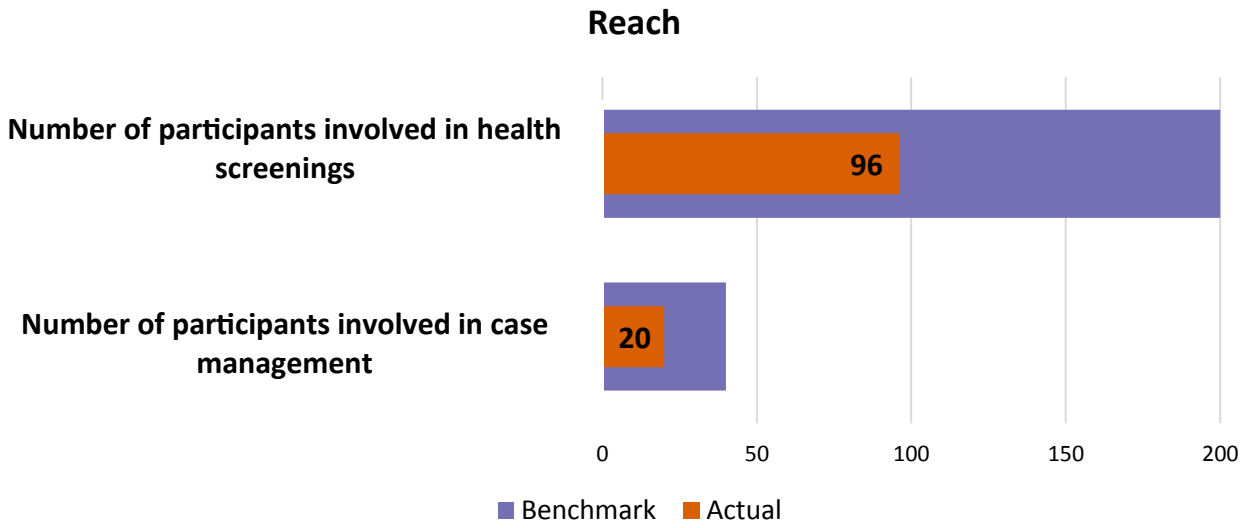
Key Project Partners
Salem Lutheran Church

People Served
138

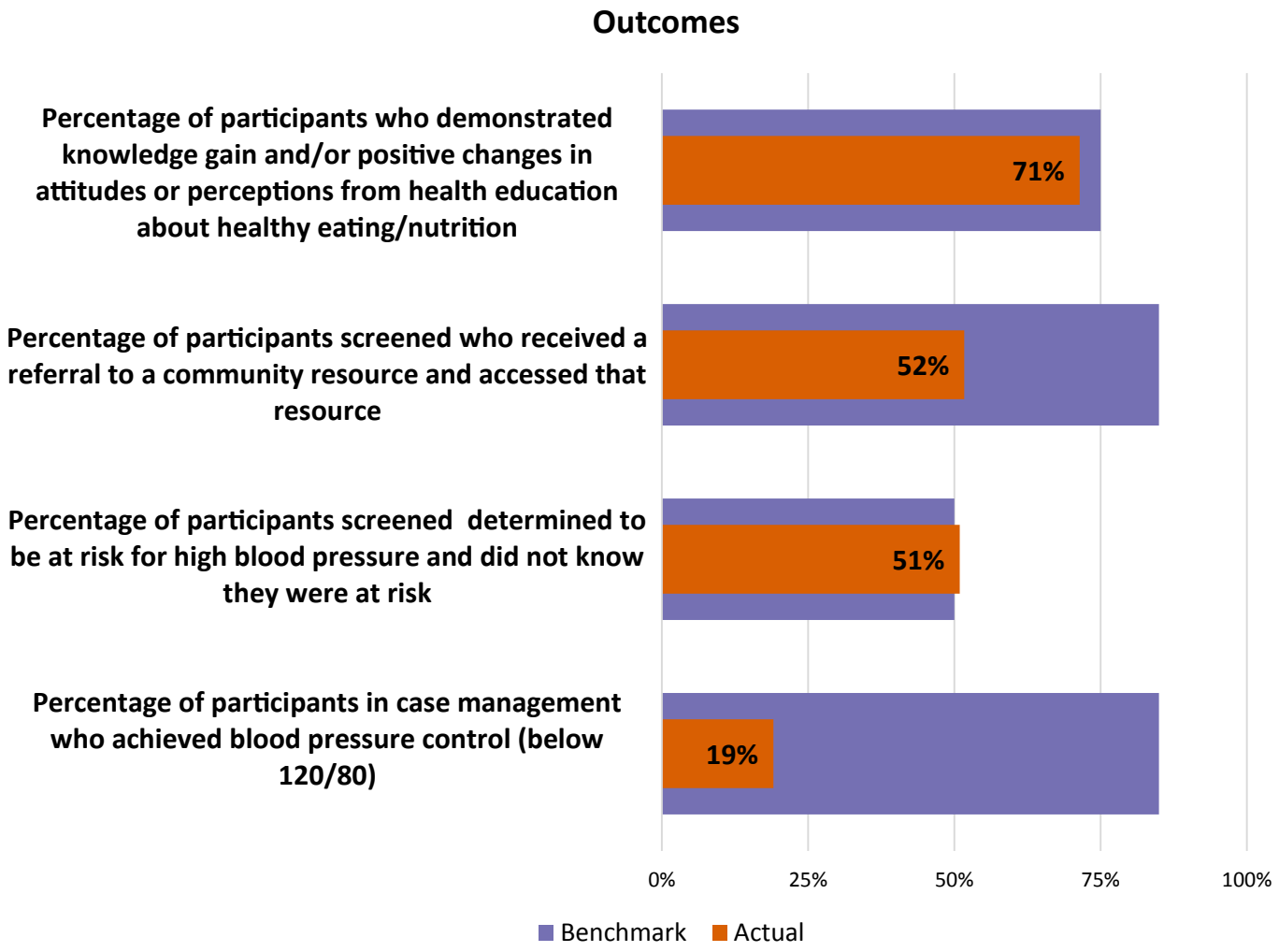
The Northeast Nebraska Public Health Department project identified people at-risk for developing cardiovascular disease and/or diabetes and provided them with education and guidance for development of preventive goals intended to decrease their health risk. Continuous support was provided by Community 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; and,
- Ensure access to and/or promote consumption of healthful foods, including fruits, vegetables and water, while limiting access to sugar-sweetened beverages and sodium.

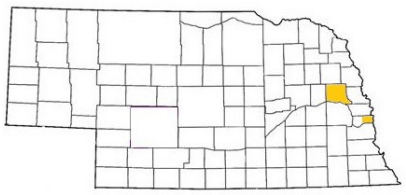


Dixon & Wayne Counties (Continued)



Dodge & Sarpy Counties

OneWorld Community Health Center



Target Health Issues
Cardiovascular disease, diabetes and obesity

Key Project Partners
Dr. Richard Stacy, UNO

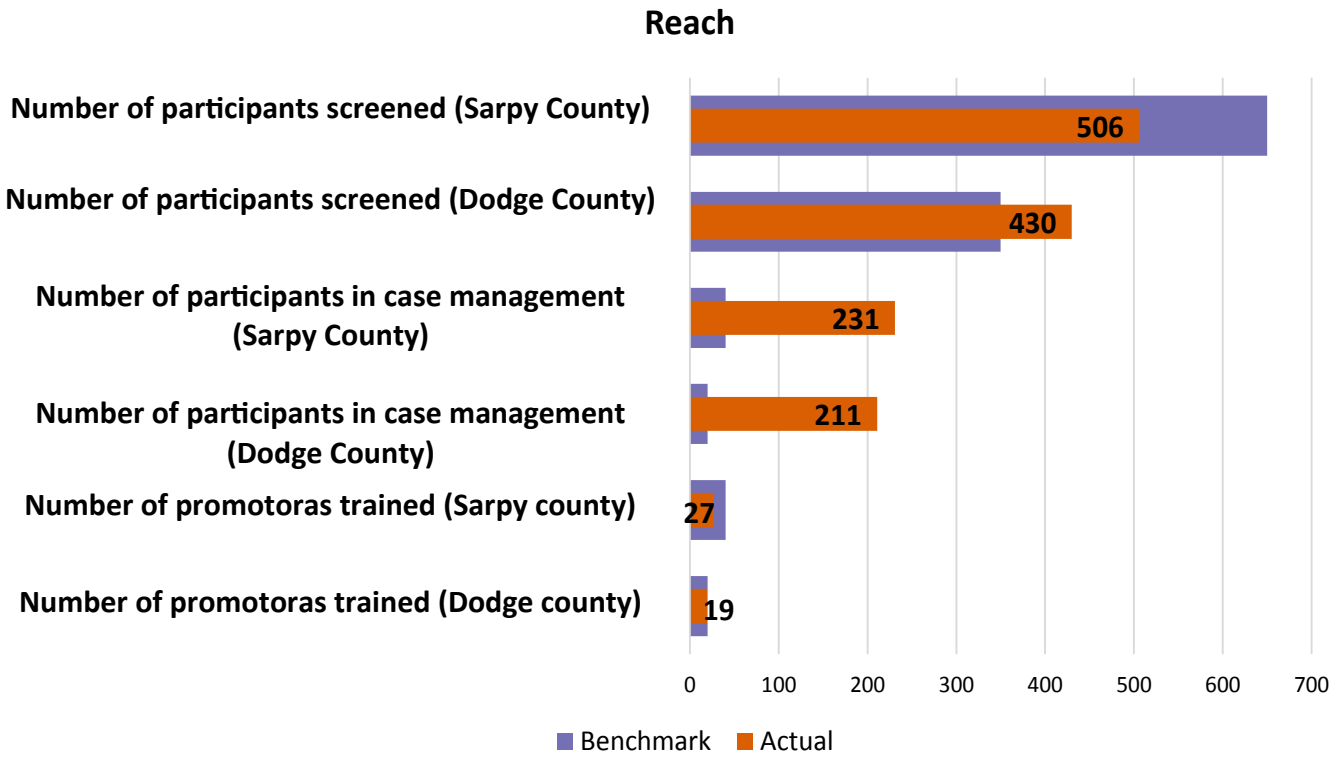
Dollars
$195,906.12 per year
$391,812.24 for two years

People Served
1,157

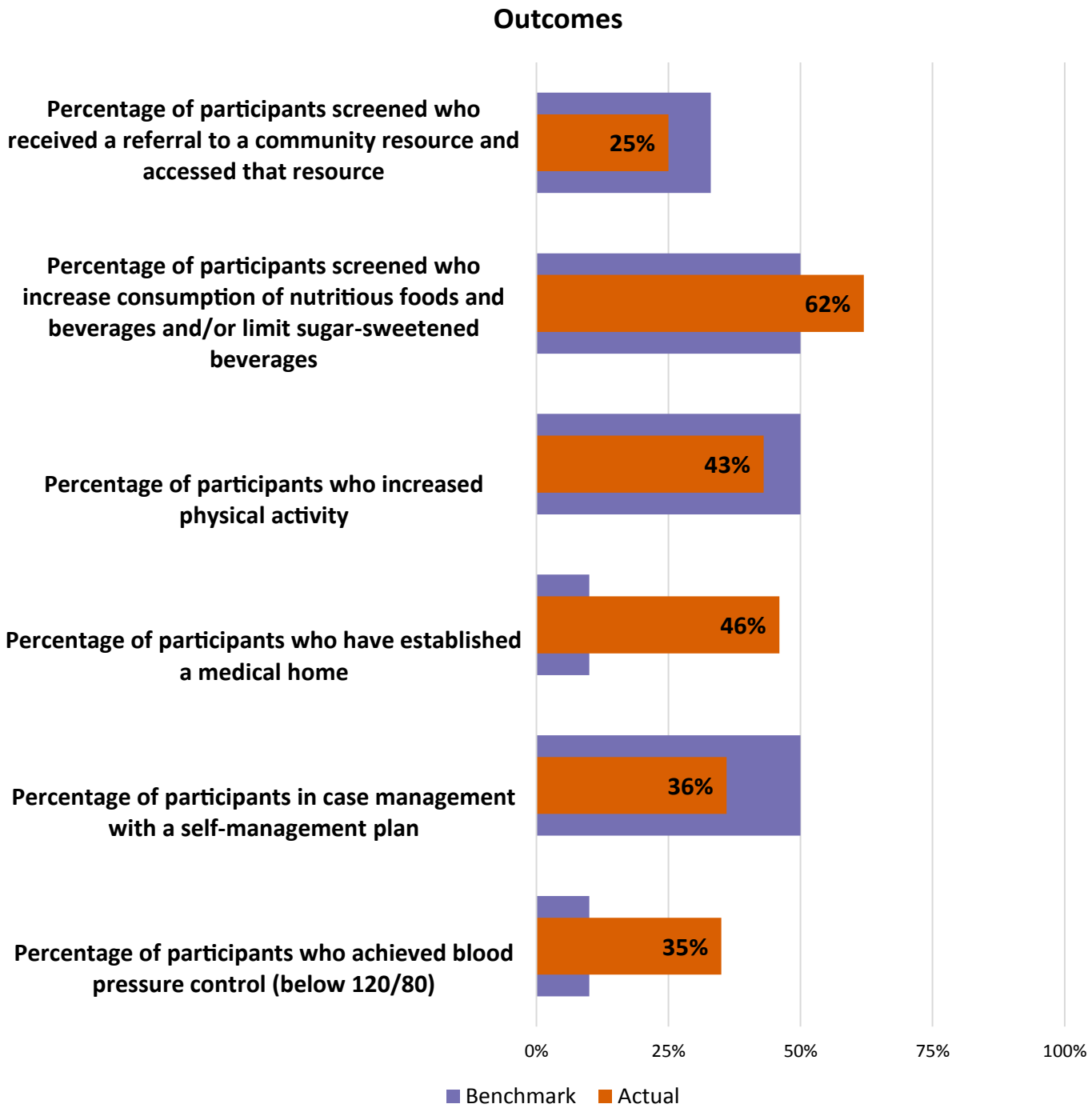
OneWorld Community Health Center implemented promotora (Hispanic community health worker) programs in Sarpy and Dodge Counties. The promotoras learned about heart disease, diabetes and obesity in addition to nutrition and exercise. They also learned how to screen for heart disease, diabetes and obesity so as to follow-up with at-risk individuals 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; and,
- Implement identification of patients with undiagnosed hypertension and people with pre-diabetes.

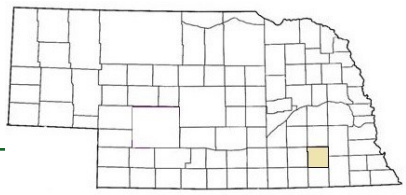


Dodge & Sarpy Counties (Continued)



Saline County

Public Health Solutions



Target Health Issues
Diabetes

Dollars
$32,618.88 per year
$65,237.76 for two years

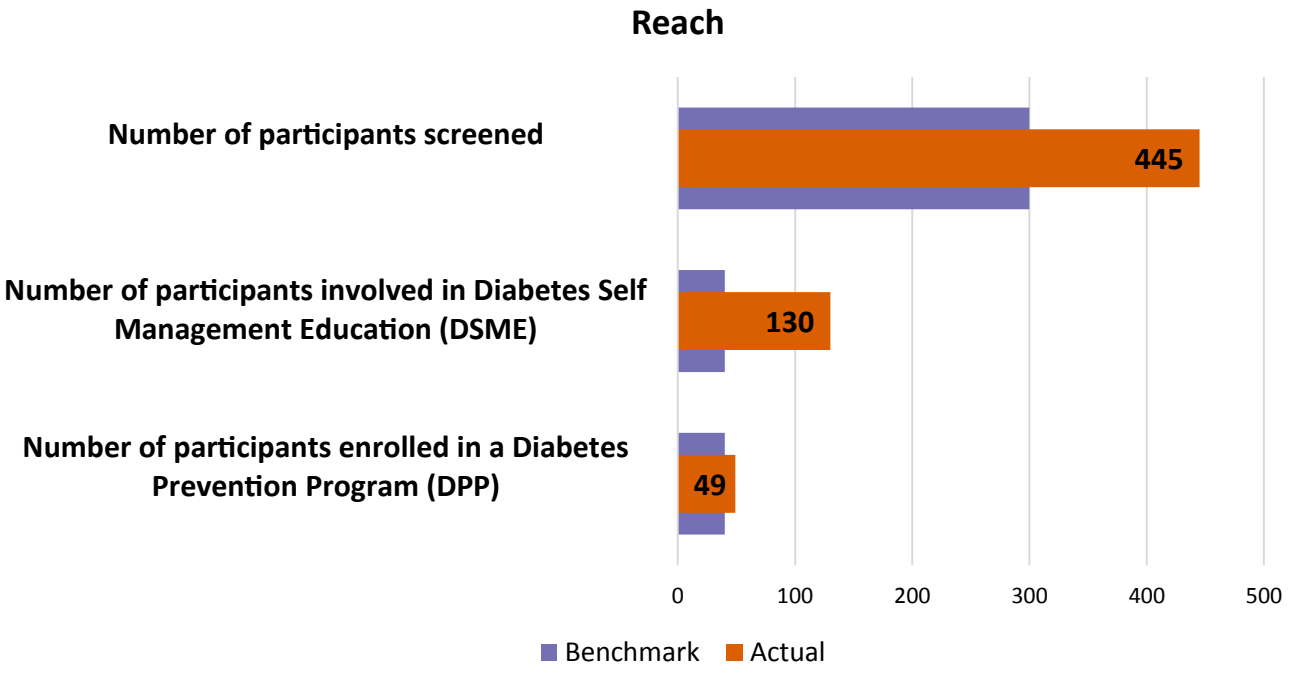
Key Project Partners
N/A

People Served
450

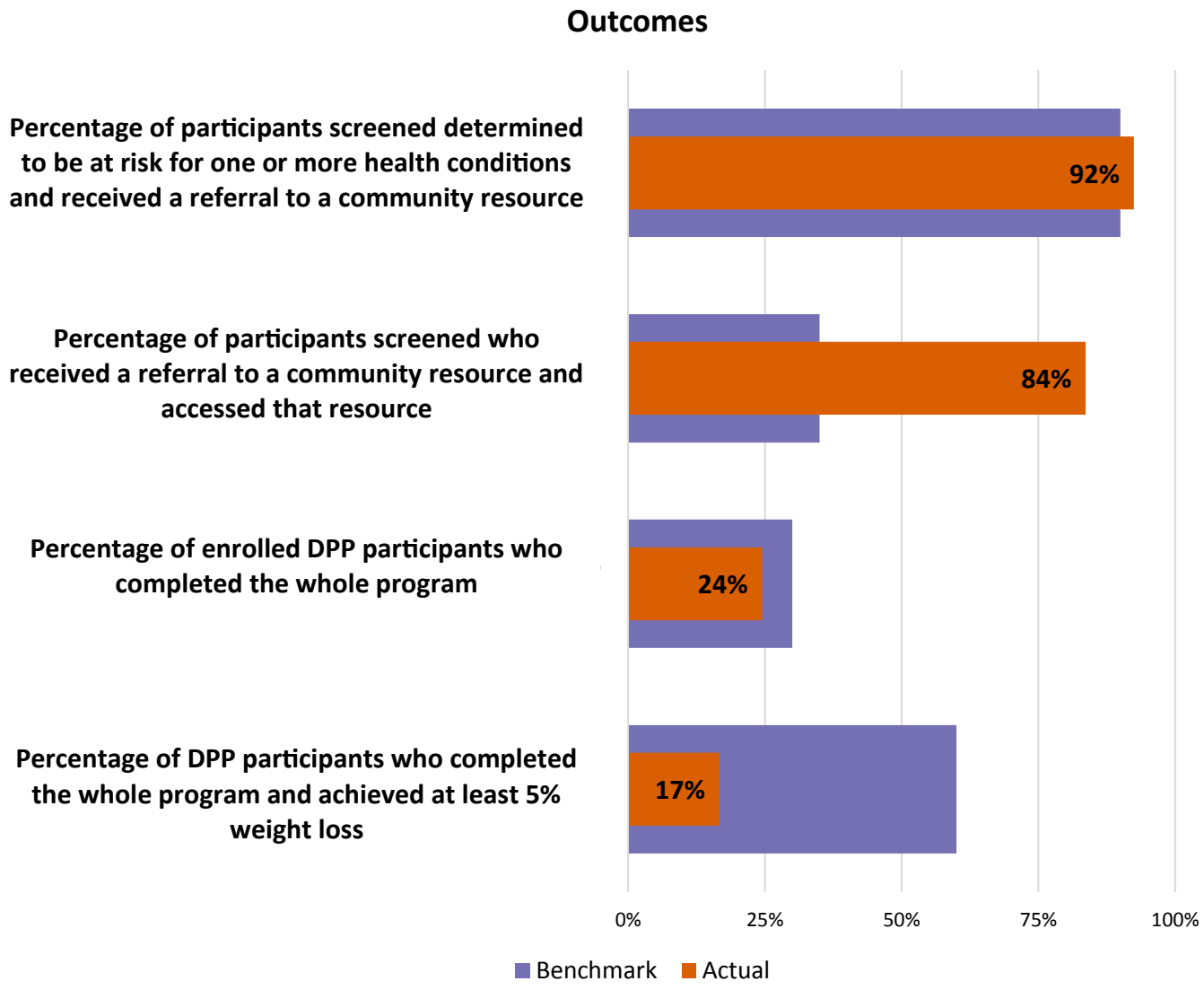
The Public Health Solutions program utilized evidence-based diabetes prevention programs and included a Community Health Worker (CHW) in the program. The goal was to increase awareness about diabetes, provide health screenings to identify those at-risk of developing diabetes, pre-diabetic, and diabetic people in their service area and thereby minimize the detrimental impact of diabetes on the minority population. The project applied a multi-generational approach by targeting young women, families, and men to manage and/or 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; and,
- Increase and/or promote linkages between health systems and community resources for minorities.

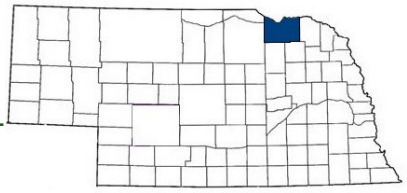


Saline County (Continued)



Knox County

Santee Sioux Nation



Target Health Issues
Diabetes

Key Project Partners
N/A

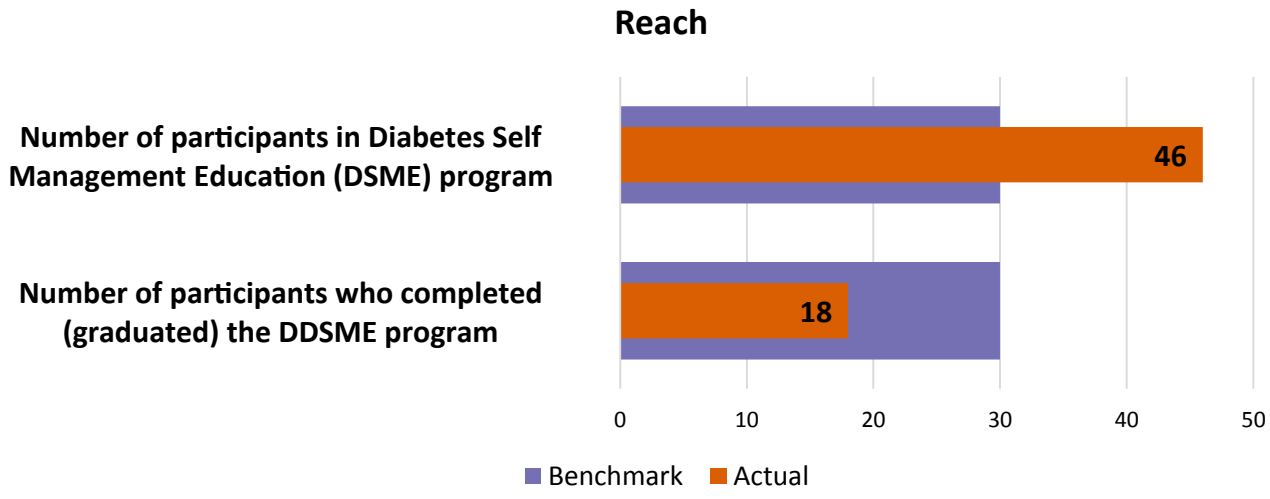
Dollars
$9,767.34 per year
$19,534.69 for two years

People Served
46

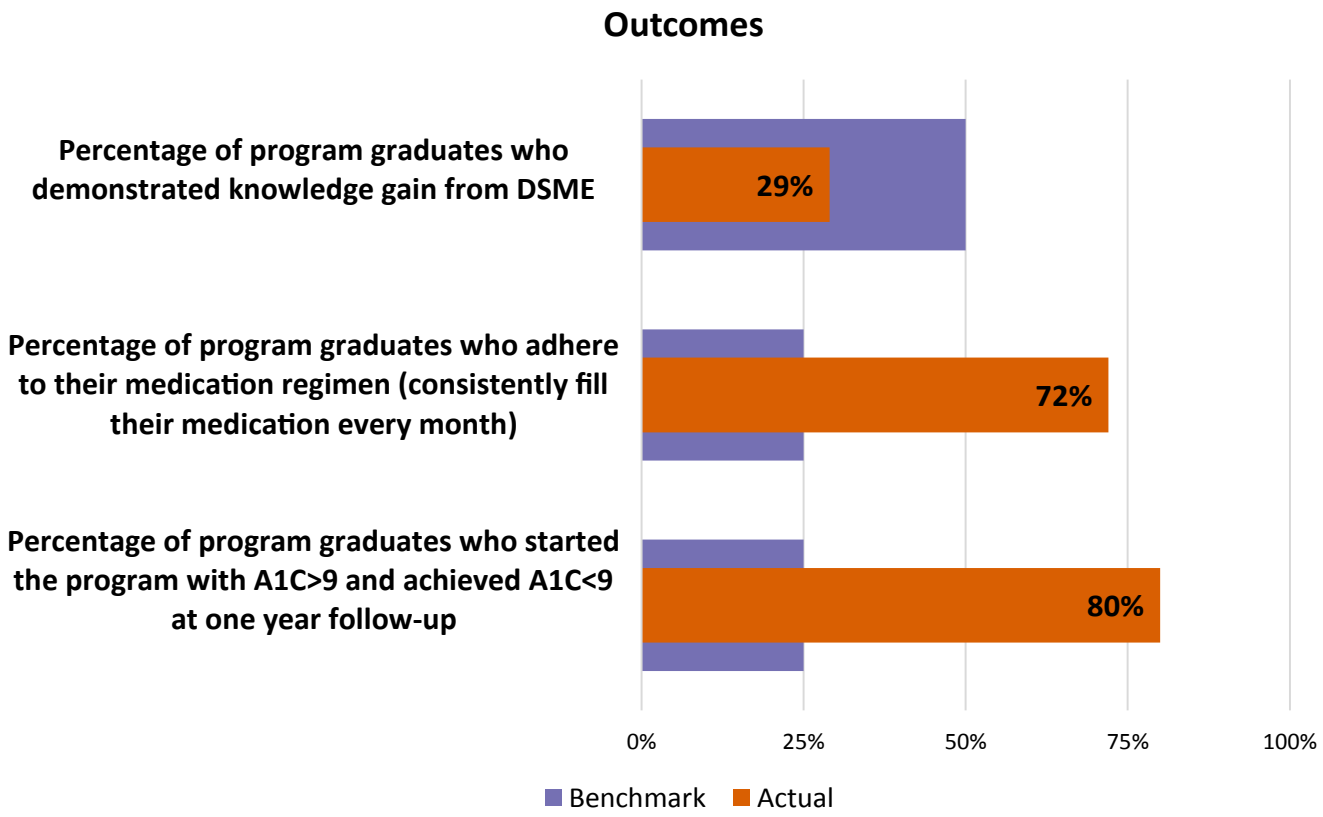
The Santee Sioux Nation project provided diabetes self-management education (DSME) to the Native American minority population of Knox County. The project participants gained knowledge and skills in the management of diabetes on the Santee Sioux reservations. Participants were tracked for biometric improvements and knowledge gain accompanied by an 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).

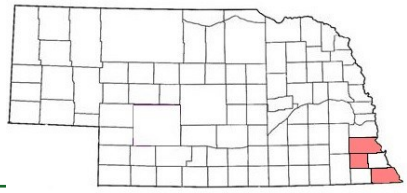


Knox County (continued)



Johnson, Otoe, & Richardson Counties

Southeast District Health Department



Target Health Issues
Obesity, diabetes, and cardiovascular disease

Dollars
$25,416.31 per year
$50,832.61 for two years

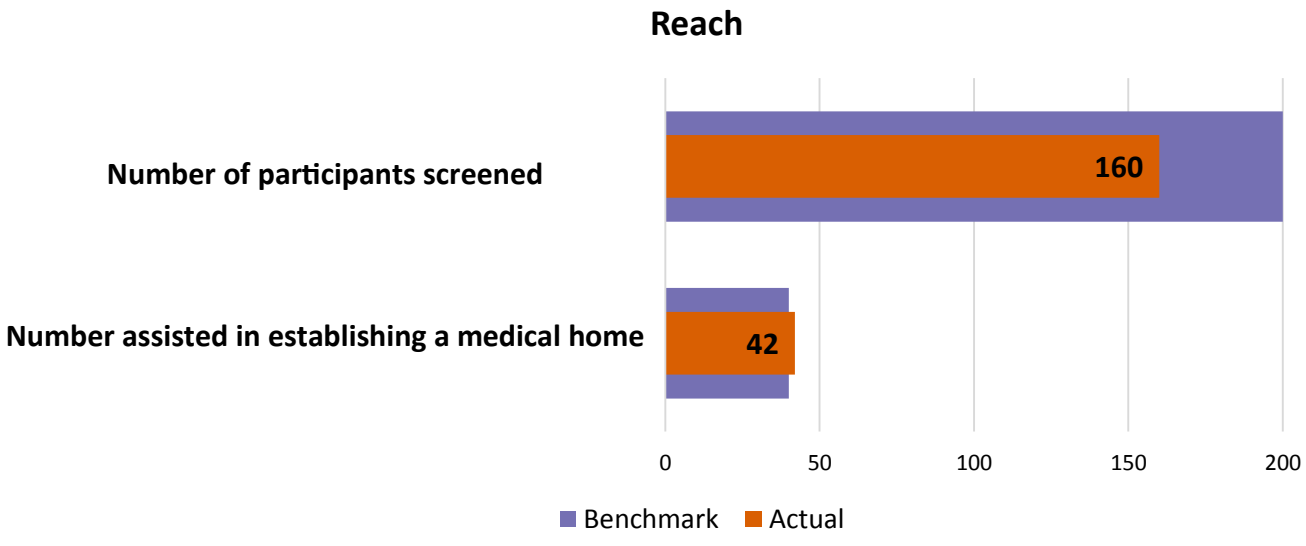
Key Project Partners
N/A

People Served
132

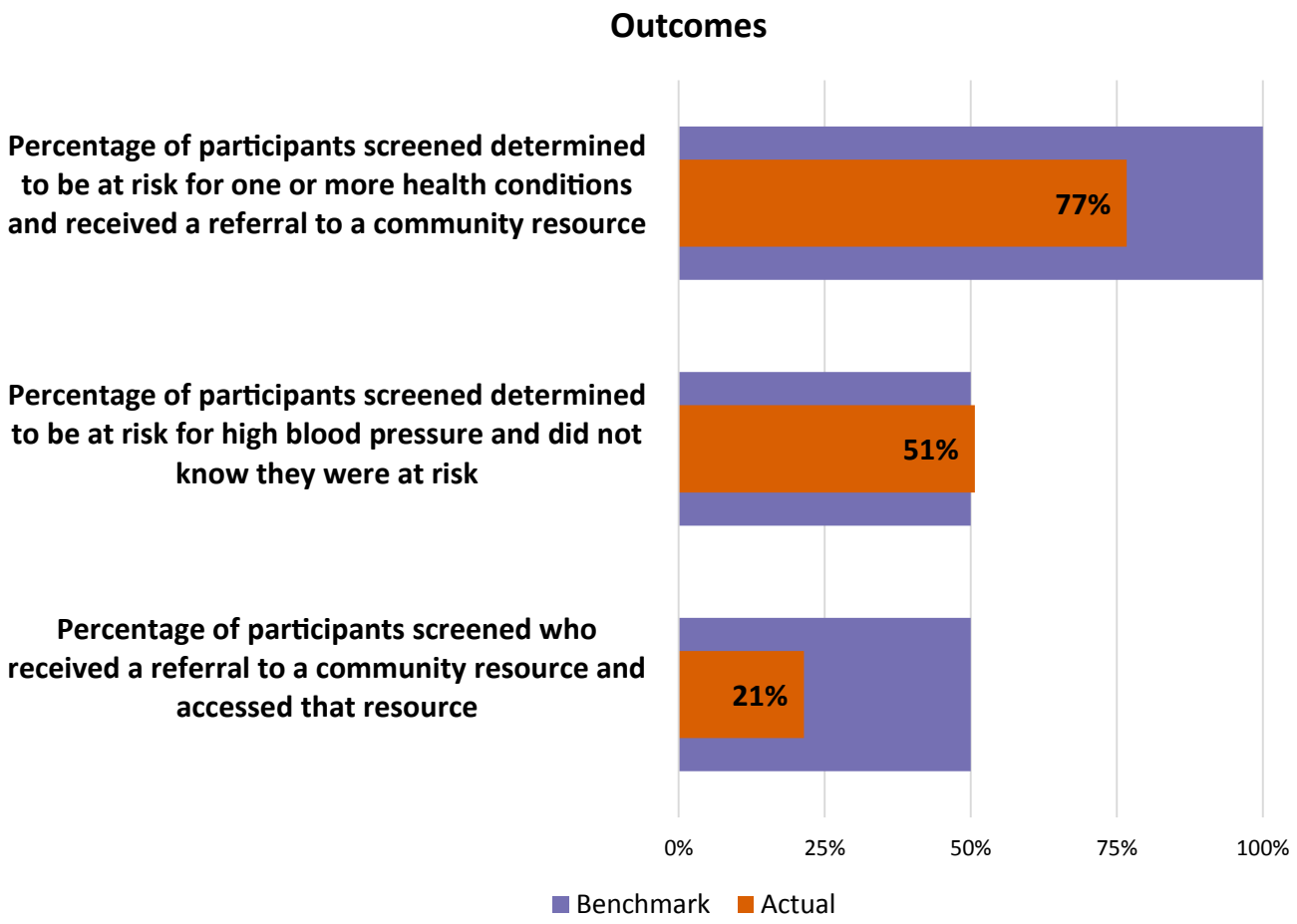
The Southeast Nebraska District Health Department concentrated on increasing and/or promoting linkages between health systems and community resources for minorities by engaging community partners and utilizing evidence-based interventions to achieve positive impact in their service community.

Strategies

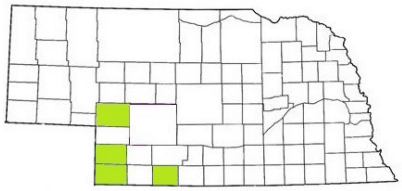
∝ Increase and/or promote linkages between health systems and community resources for minorities.



Johnson, Otoe, & Richardson Counties (Continued)



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
$38,201.64 for two years

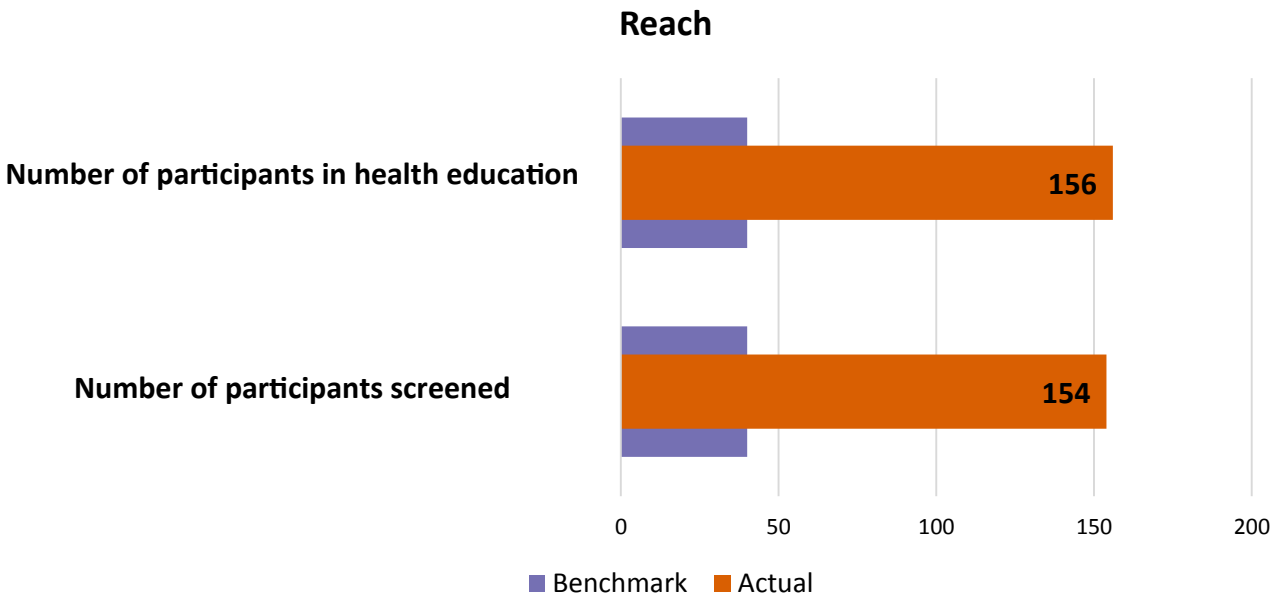
Key Project Partners
WIC clinics; local physicians

People Served
156

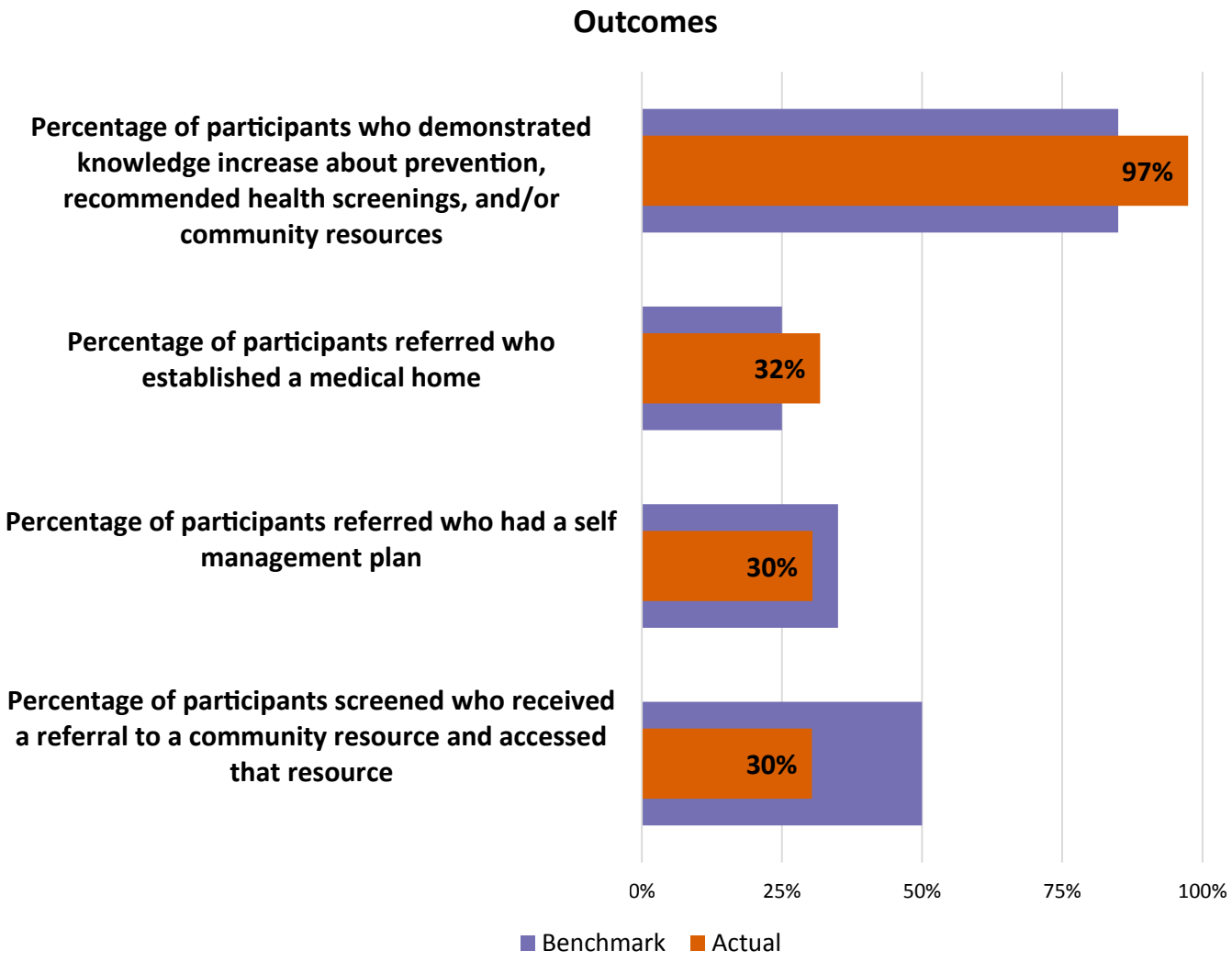
Southwest Nebraska Public Health Department provided health screenings for cardiovascular disease, diabetes, and obesity and delivered health education for prevention and management of chronic disease. In addition, they referred at-risk individuals to community resources and followed-up with referred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

Strategies

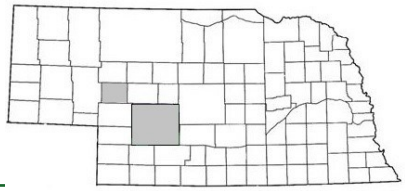
- Increase and/or promote linkages between health systems and community resources for minorities.



Chase, Dundy, Keith, & Red Willow Counties (Continued)



Arthur & Lincoln Counties



West Central District Health

Target Health Issues
Obesity, cardiovascular disease, and diabetes

Dollars
$34,441.22 per year
$68,882.43 for two years

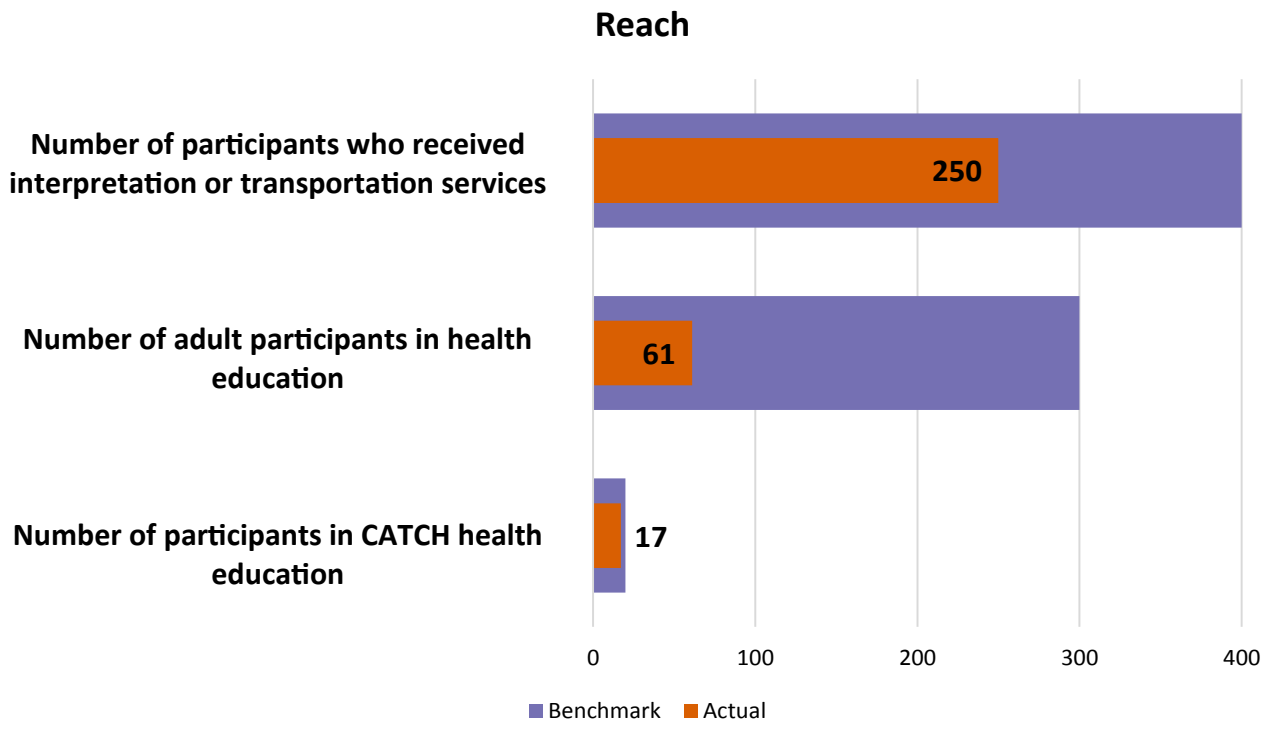
Key Project Partners
North Platte Public Schools
University of Nebraska Extension Service
Community Connections , Great Plains Health
West Central District Health Department

People Served
298

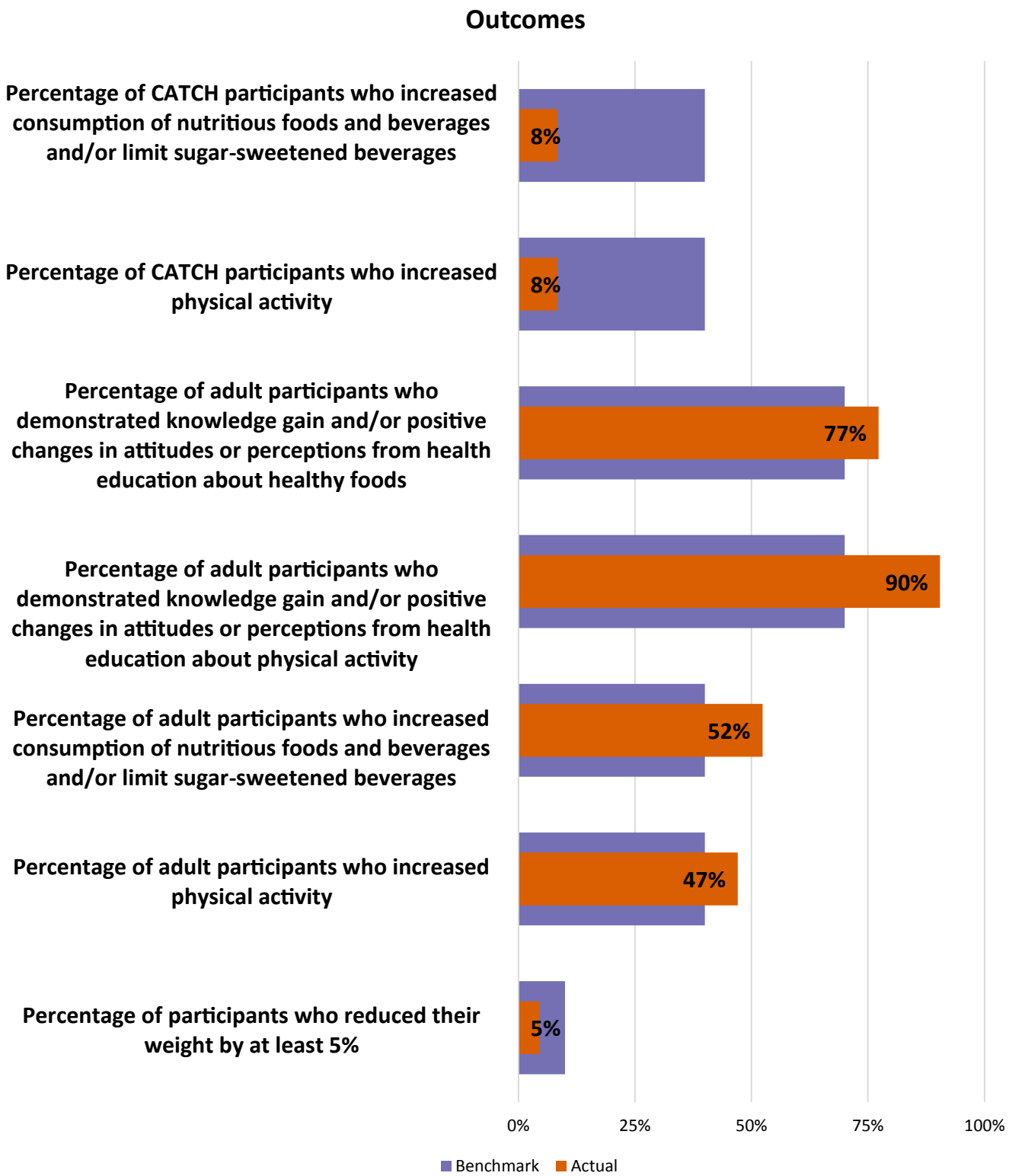
West Central District Health Department served as members of the care delivery team by advocating for clients. The Community Health Worker (CHW) collaborated with a team consisting of a physician, nurse or allied health worker to deliver health education or basic screening services while the providers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



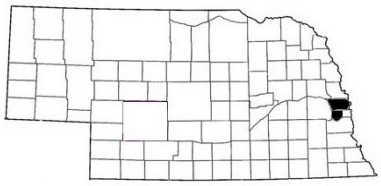
Arthur & Lincoln Counties (Continued)



Douglas County

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
11,671

Also included in the appropriation was annual funding distributed equally among Federally Qualified Health Centers (FQHC) in the second Congressional District including Charles Drew Health Center. Funding was used to implement a minority health initiative which may target, but was not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma.

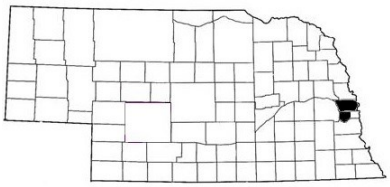
Activities and Outcomes July 1, 2016—June 30, 2017

- 92% of patients 12 years and over were screened for depression and had a follow-up plan documented if patient was considered depressed .
- 397 adult patients with a diagnosis of Type I or Type II diabetes achieved a HbA1c less than 9%.
- 89% of asthma patients are being treated with an accepted Inhaled Corticosteroid or accepted alternative medicine.
- 731 cardiovascular patients, (aged 18 -85 years) have sustained controlled hypertension.
- The percent of adult patients with a diagnosis of Coronary Artery Disease (CAD) who were prescribed a lipid-lowering therapy was 88%. 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 increased from 83% to 88%.
- 208 women accessed prenatal care with 41% initiating their prenatal care during the first trimester; the percentage of births less than <2500 grams was 8.3%.
- The percentage of patients 2-17 years with weight assessment and counseling for nutrition and physical activity increased from 82% to 85%.
- The percentage of adult patients with weight screening and follow-up was 64%.
- 88% of adult patients who were diagnosed with tobacco use were prescribed cessation medication.

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

73,328

Also included in the appropriation was annual funding distributed equally among Federally Qualified Health Centers (FQHC) in the second Congressional District including OneWorld Community Health Center. Funding was used to implement a minority health initiative which may target, but was not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma.

Activities and Outcomes July 1, 2016—June 30, 2017

- 96.8% of adult patients were screened and counseled for tobacco use.
- 1,131 minority patients had their hypertension in control.
- 969 diabetic minority patients had HbA1c results less than 8%.
- 1,509 expectant mothers received prenatal care.
- 84.5% of prenatal patients began their care in the first trimester.
- 572 minority individuals received health screenings from promotoras (Hispanic community health workers).
- 157 individuals who were found to be at risk for diabetes were referred to a medical home.
- 412 individuals increased their knowledge of hypertension and diabetes.
- 357 individuals who received screenings reported changes in behavior to improve their health.
- 35 individuals completed the training and practicum to become promotoras.
- 2,460 patients with a primary diagnosis of depression and other mood disorders were cared for.
- 4,487 pediatric dental patients were reached.
- 98.3% of patients aged 5 through 64 with persistent asthma had an acceptable pharmacological treatment plan.
- 90.3% of the 10,191 patients aged 3 to 17 had a documented Body Mass Index (BMI) percentile and received counseling on nutrition and physical activity.
- 15,393 patients aged 18 and older had a documented BMI percentile and follow-up plan if patients are underweight or overweight.

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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