2017-2018 MINORITY HEALTH INITIATIVE

Annual Report

December 1, 2018

In accordance with Nebraska State Statute 71-1628.07

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

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 (DHHS), Office of Health Disparities and Health Equity (OHDHE) for the Nebraska Legislature to highlight progress and outcomes of the Minority Health Initiative (MHI) funding for the 2017-2018 year. The 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 for the 2017-2019 award period. This report covers the first year progress and outcomes of the two-year project period. Also included in the appropriation is annual funding to be distributed equally among federally qualified health centers in the second Congressional District. These funds are not included in the competitive request for application. These 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 goal of the Minority Health Initiative grant program is to work collaboratively with stakeholders to assist in the elimination of health disparities which disproportionately impacts minority populations in Nebraska. Populations served include racial and ethnic minorities, American Indians, and refugees.

During the 2017-2018 project period, the Office of Health Disparities and Health Equity incorporated various elements into the grant program to improve program outcomes. These included the use of outcome based performance measures, evidence based programming, and alignment of strategies with those of the DHHS Chronic Disease Program. Based on health disparities and leading cause of death data, the OHDHE focused on evidence based strategies that assisted to control and/or prevent chronic diseases. The use of Community Health Workers continued to be supported during this project period to address social factors that influence health outcomes.

This report demonstrates positive changes occurring among the 2017-2018 MHI projects to improve the health of minority populations in Nebraska. Thousands of minority citizens across Nebraska were served, resulting in Increased knowledge and behavioral changes, achievements of blood pressure control, lowered diabetes A1C rates, and weight loss for many individuals during the first year the 2017-2018 MHI grant period. With the projects focusing on the use of various strategies to improve health outcomes, we have included on page 34 a definition of key terms used in this report.

On behalf of the Office of Health Disparities and Health Equity, MHI grantees, and the individuals served, we thank the Nebraska Legislature for providing the MHI funding to improve health outcomes for Nebraska's racial and ethnic populations. For additional information, please contact Josie Rodriguez, Administrator, Office of Health Disparities and Health Equity, at 402-471-0152 or minority.health@nebraska.gov.

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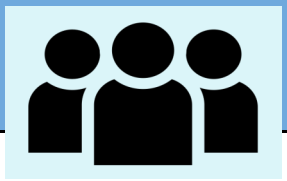
2017-2018

MINORITY HEALTH INITIATIVE

Activities and Outcomes

Total number of people served



4,638

Served by

23.48

Full-time public health staff

*Includes projects in Congressional Districts 1 & 3 only

HEALTH SCREENINGS

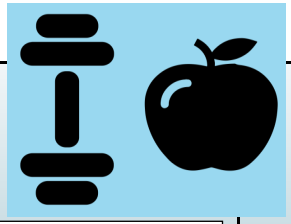
2,930

individuals were screened for hypertension, diabetes, obesity, or pre-diabetes

REFERRALS

1,967

people received referrals to additional services



HEALTH EDUCATION

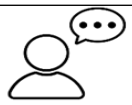
1,001

minorities participated in health education

471

enrollees demonstrated knowledge increase as a result of health education

"The meals made for the classes were inexpensive, easy to make and very healthy."



"The education I received from the community health worker was very helpful and useful. I am trying to not get diabetes like my father has." [Translated from Spanish]

- **Health Impact:**
  The Eating Smart Being Active curriculum has been shown to increase fruit and vegetable consumption by 0.3 servings 6 months post intervention[1].

2017-2018

MINORITY HEALTH INITIATIVE

Activities and Outcomes

Diabetes Prevention and Management Programs

189

individuals enrolled into a diabetes prevention program, chronic disease self-management program, or diabetes self-management education program

164

participants completed a diabetes prevention and management program

"Taking the diabetes prevention classes has helped me learn about the importance of healthy eating and exercise. I am very happy with what I learned because I get to share the information with my family."

"When I first came to you, I had not been taking my medication due to money and travel issues. I was always feeling ill. Now I feel more responsible and take my medication every day. I feel much better. I always have good interaction with [staff of the program] and you all are always very responsive."

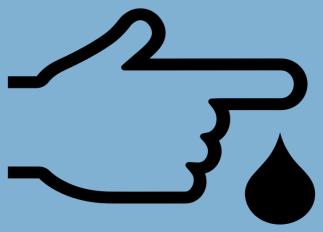
Health Impact:

- Those who participate in a diabetes prevention program and lose 5% to 7% of their body weight can reduce their risk of developing type 2 diabetes by 58%[2]. Even 10 years after completing the program, participants were one third less likely to develop type 2 diabetes[3].
- Diabetes management interventions involving community health workers have resulted in decreases in A1c among African American and Latino participants[4].
- Chronic disease management interventions involving community health workers combined with goal setting led to improvements in chronic diseases among participants in one study[5].
- A culturally relevant diabetes self-management education program resulted in a decrease in diabetes related anxiety as well as improvements in A1c, low-density lipoprotein cholesterol levels, and systolic blood pressure among black women with type 2 diabetes[6].
- Medicare beneficiaries who completed diabetes self-management education (DSME) were expected to reduce the number of hospitalizations by 29%, with men reducing the number of emergency room visits by 19% and hospital observation stays by 33%.[7].

2017-2018

MINORITY HEALTH INITIATIVE

Activities and Outcomes



Diabetes

108

participants improved their diabetes Hemoglobin A1c rate

"I have learned better ways to control my A1c."

Blood Pressure

199

participants have improved their blood pressure

"I found it beneficial to have blood work done through the group and have my blood pressure checked on a regular basis."

"I notice more about what we are going to eat. It has helped me change a lot of the purchases in my food plan. I have lost weight which makes me feel very good mentally and physically."

Weight Loss

114

participants reduced their weight

14

maintained their weight loss

MEDICAL HOME

307

people were linked to a medical home

"Because of your help with finding a doctor, my children were able to get their exams and begin school. It was helpful to have someone guide me in this transition."

People Served

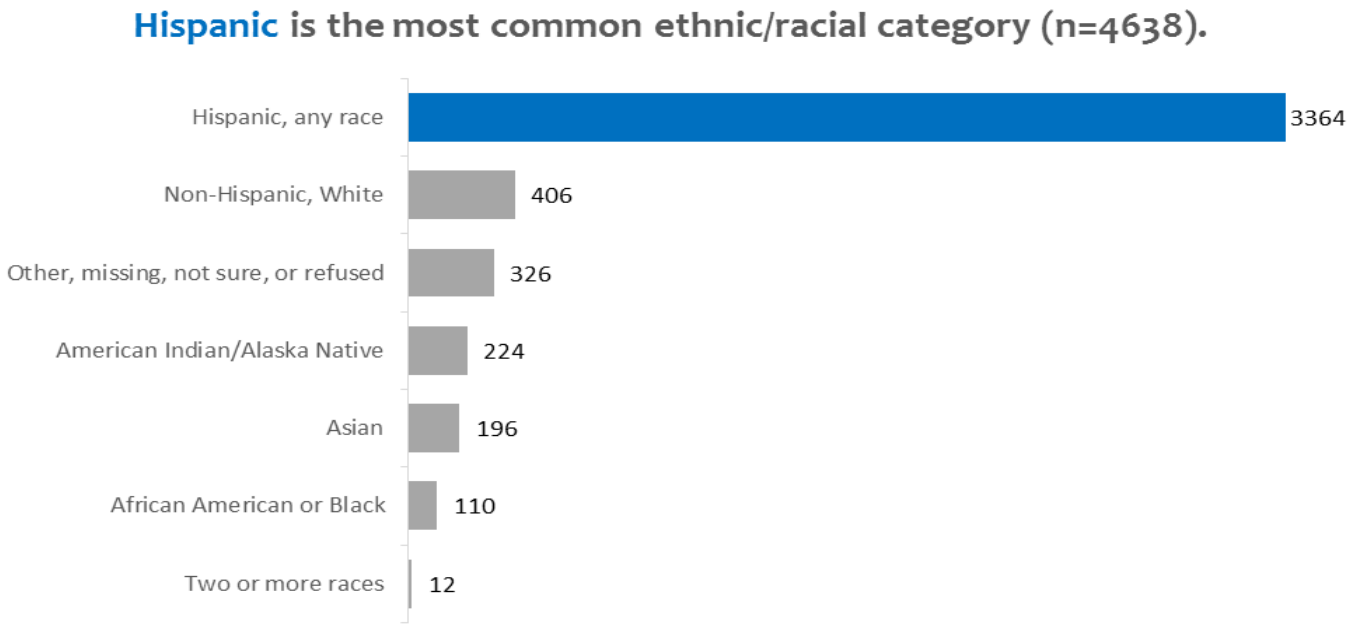
Summaries of the clients served by the Minority Health Initiative projects for the period July 1, 2017 through June 30, 2018 are shown below. These numbers represent the number of people provided services by the projects as a group. They also include the number of people who demonstrated changes in health 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.

Participant Demographics	
Total number served	4,638
Age	
0-17	397
18-24	288
25-64	3,502
65+	451
Total	4,638

Gender	
Female	3,063
Male	1,572
Total	4,635[A]

[A][Note: 3 individuals declined to identify gender].

Participants (Cont.)	
Race and Ethnicity	
African American or Black	110
American Indian/Alaska Native	224
Asian	196
Hispanic, any race	3,364
Non-Hispanic, White	406
Other, missing, not sure, or refused	326
Two or more races	12
Total	4,638

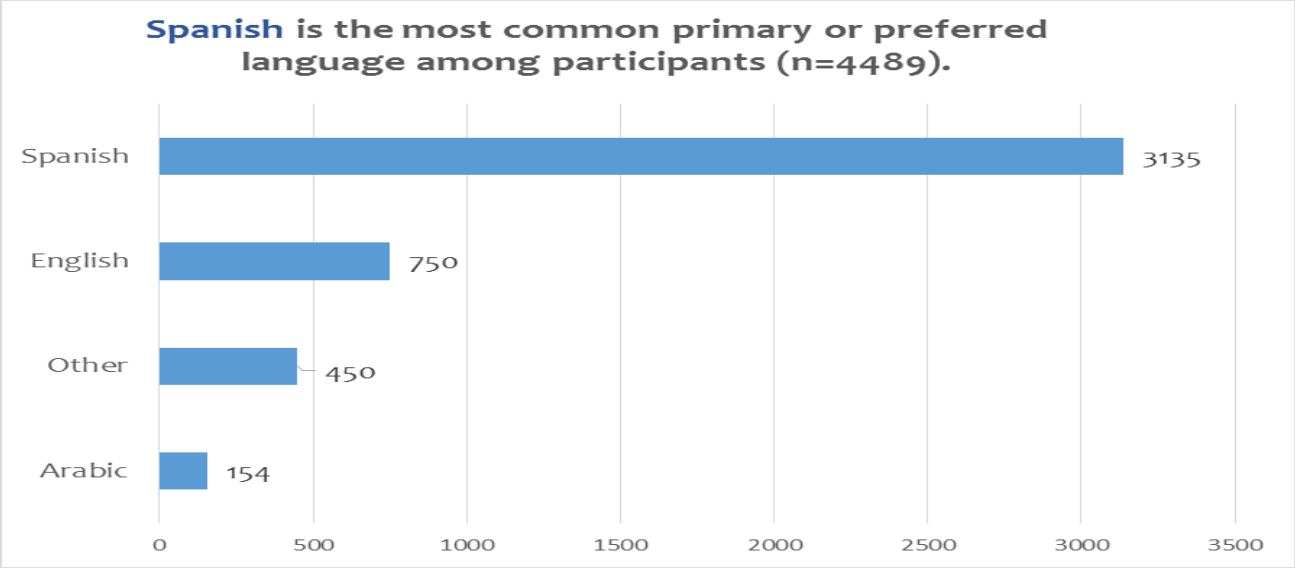


Refugee Status	
Refugee	273
Non-refugee	2,094
Total	2,367[B]

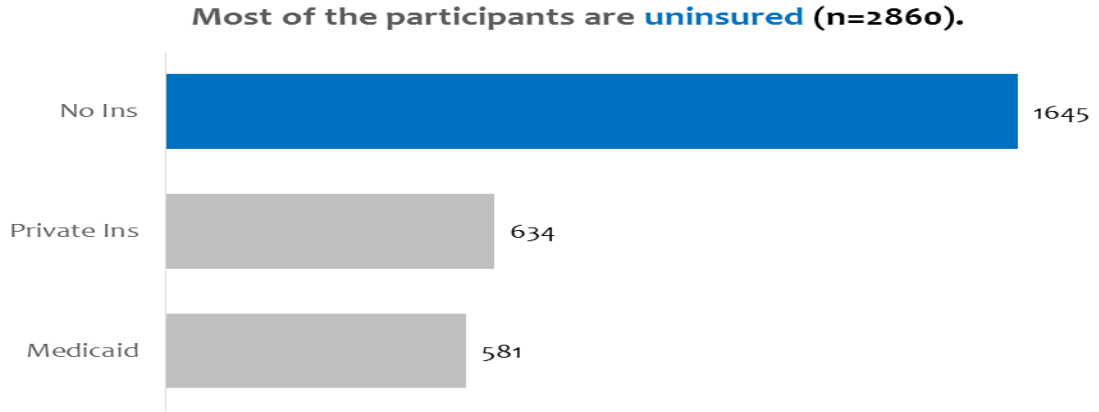
[B][Note: 2,271 individuals did not designate Refugee status].

Participants (Cont.)	
Preferred/Primary Language	
English	750
Spanish	3,135
Arabic	154
Other	450
Total	4.489[C]

[C][Note: 149 individuals declined to identify preferred /primary language].



Insurance Status	
Private Insurance	634
Medicaid	581
No Insurance	1,645
Total	2,860[D]



[D][Note: 1,778 individuals declined to identify insurance status].

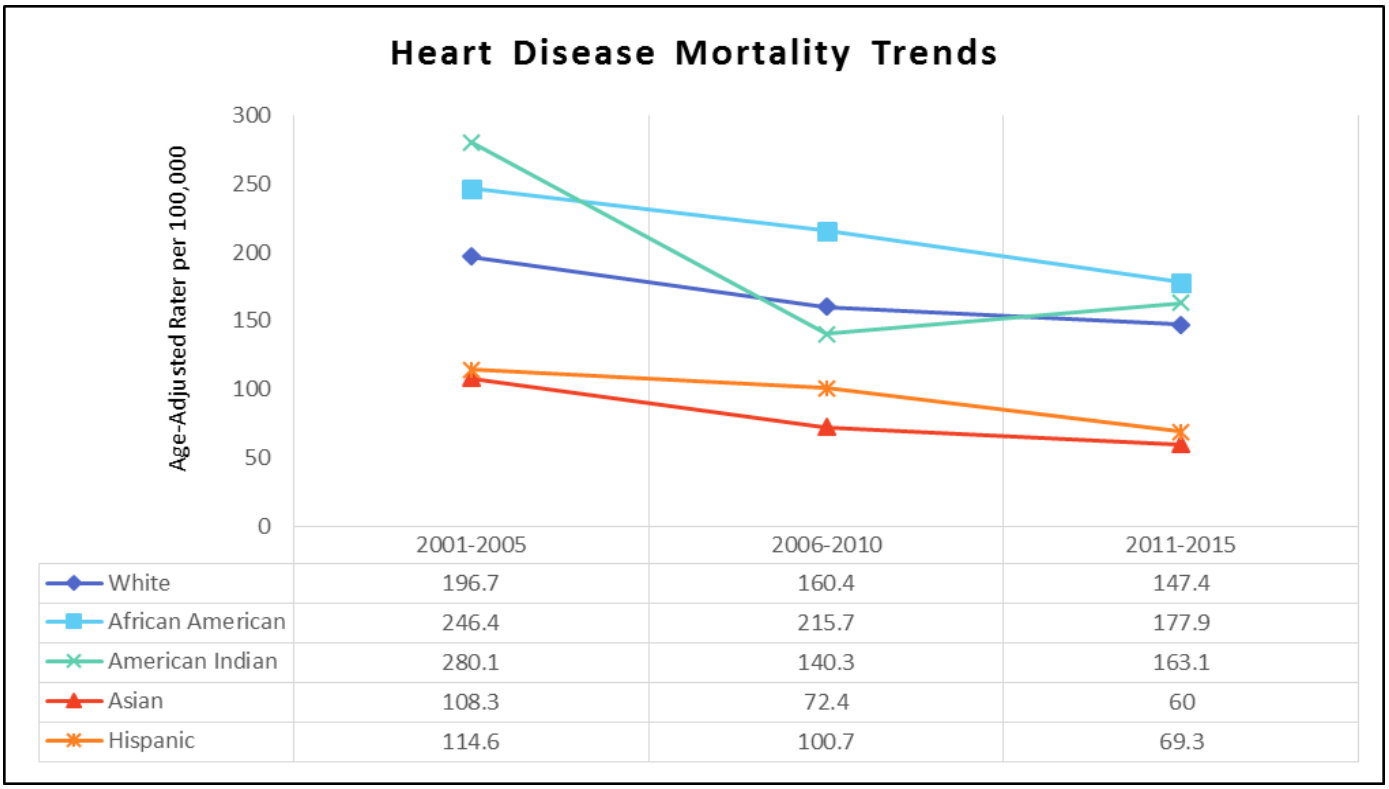
Risk Factors Related to Priority Issues, 2011-2015, Nebraska

Health Issue	Race/Ethnicity	Percent
Obesity * Prevalence among adults aged 18+	African American	36.5
	American Indian	43.3
	Asian	13.9
	Hispanic	33.0
	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

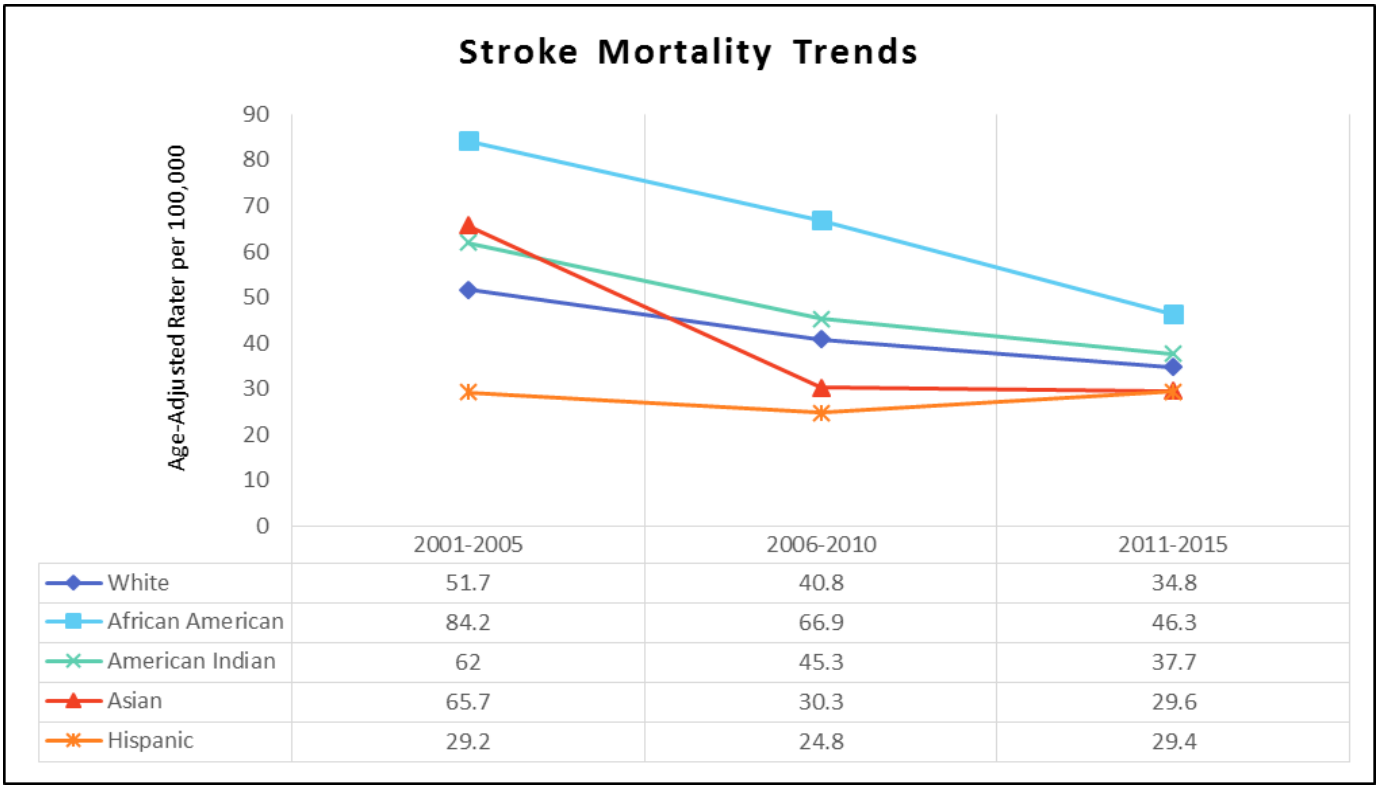
Notes and Data Source: * Nebraska Behavioral Risk Surveillance System (BRFSS) 2011-2015

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

Death Rates Related to Priority Issues, 2010-2015, Nebraska



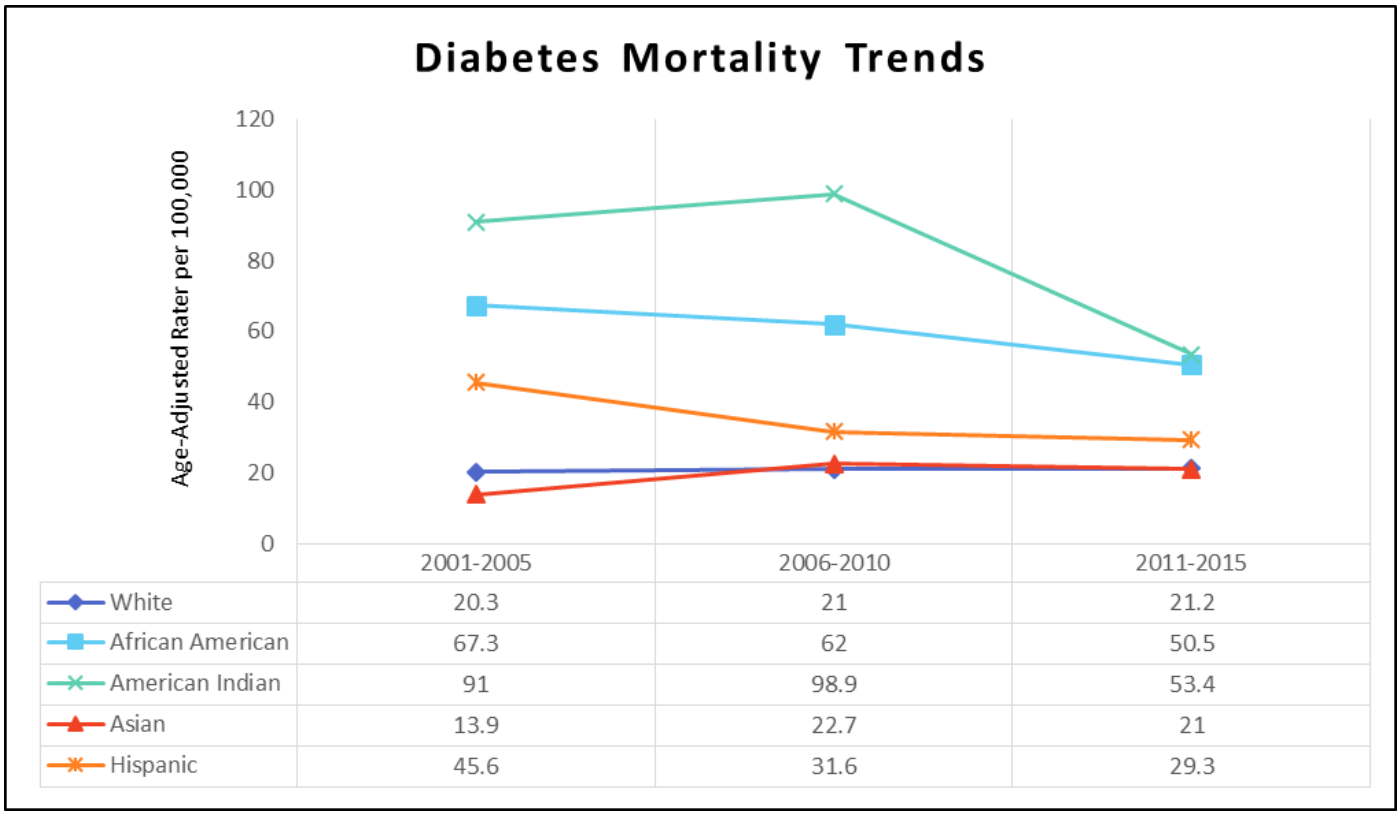
	2001-2005	2006-2010	2011-2015
White	196.7	160.4	147.4
African American	246.4	215.7	177.9
American Indian	280.1	140.3	163.1
Asian	108.3	72.4	60
Hispanic	114.6	100.7	69.3



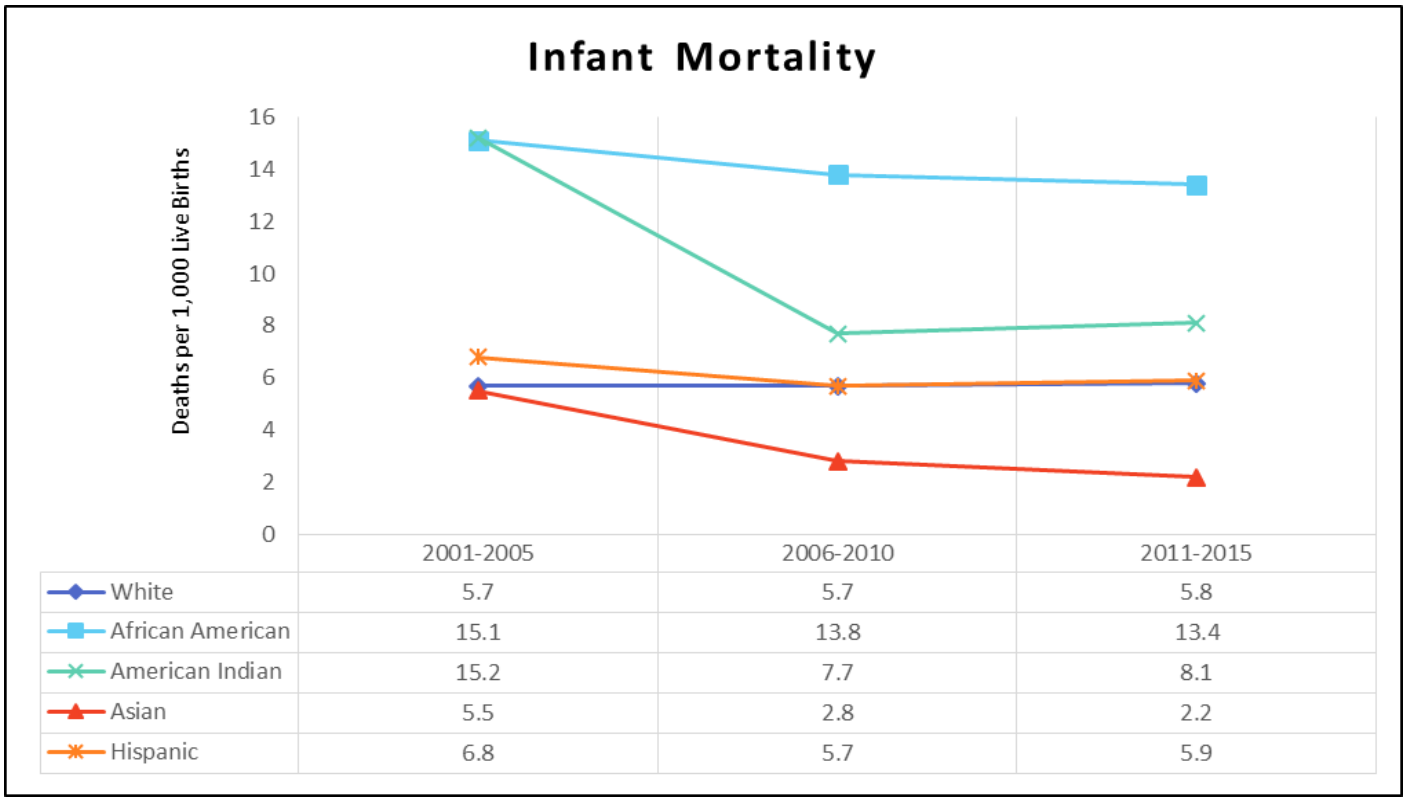
	2001-2005	2006-2010	2011-2015
White	51.7	40.8	34.8
African American	84.2	66.9	46.3
American Indian	62	45.3	37.7
Asian	65.7	30.3	29.6
Hispanic	29.2	24.8	29.4

Data Source: Nebraska DHHS Vital Statistics 2001-2015

Death Rates Related to Priority Issues, 2010-2015, 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



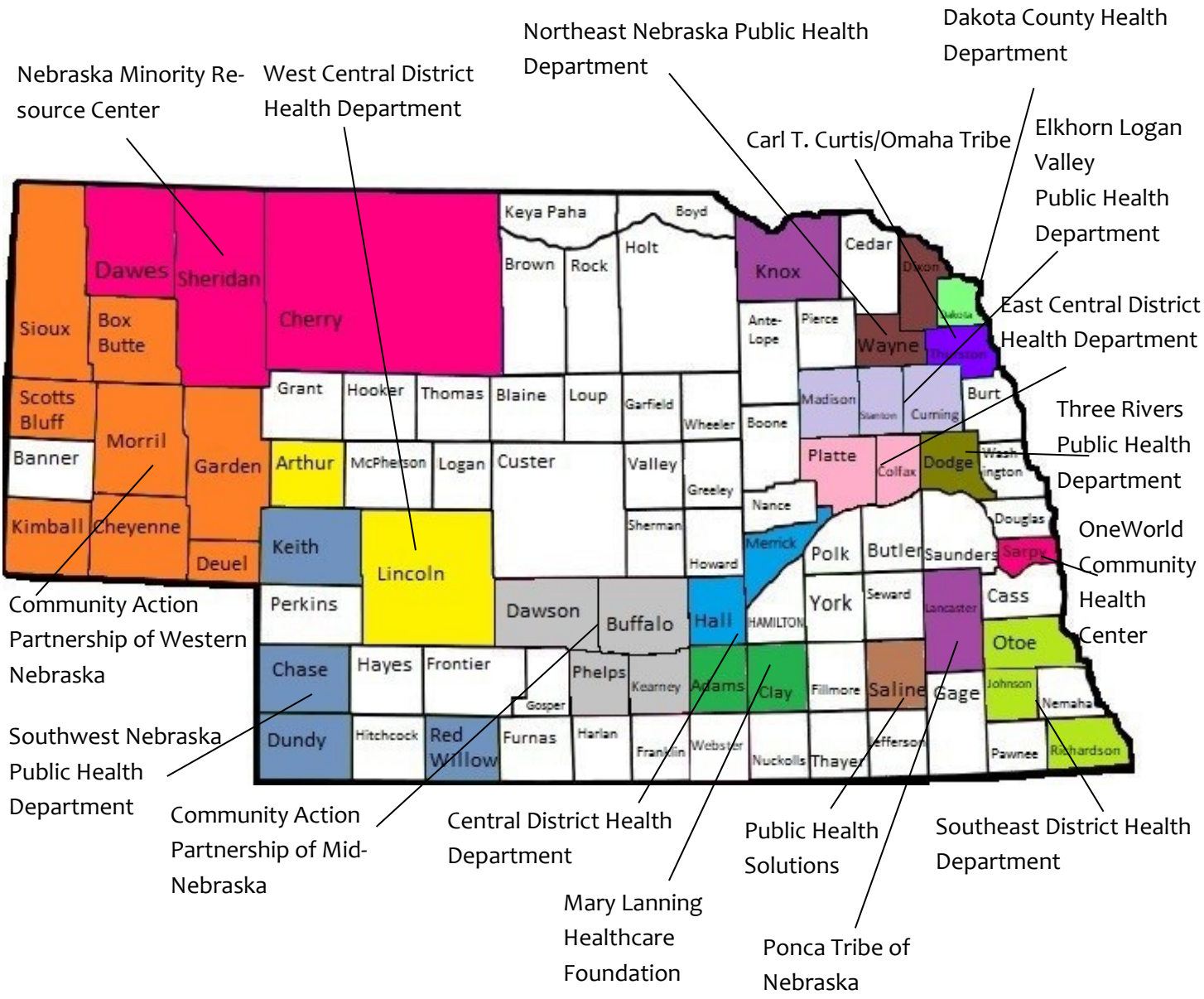
	2001-2005	2006-2010	2011-2015
White	5.7	5.7	5.8
African American	15.1	13.8	13.4
American Indian	15.2	7.7	8.1
Asian	5.5	2.8	2.2
Hispanic	6.8	5.7	5.9

Data Source: Nebraska DHHS Vital Statistics 2001-2015

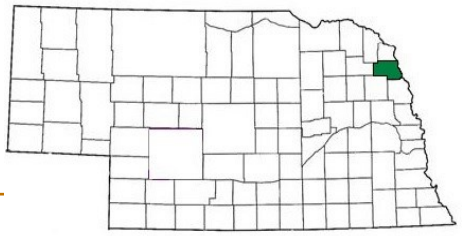
Minority Health Initiative two-year projects (7/2017—6/2019) were awarded to the following organizations:		
Projects (Congressional Districts 1 & 3)	**Amount**	**County(ies)**
Carl T. Curtis Health Center/Omaha Tribe	$81,012.07	Thurston
Central District Health Department	$318,378.78	Hall, Merrick
Community Action Partnership of Mid-Nebraska	$282,645.53	Buffalo, Dawson, Kearney, Phelps,
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
Mary Lanning Healthcare Foundation	$81,339.89	Adams, Clay
Nebraska Minority Resource Center	$50,254.10	Cherry, Dawes, Sheridan
Northeast Nebraska Public Health Department	$27,171.16	Dixon, Wayne
One World Community Health Center	$303,665.09	Sarpy
Ponca Tribe of Nebraska/Cultural Centers Coalition	$881,625.74	Knox, Lancaster
Public Health Solutions (contract)	$65,237.76	Saline
Southeast District Health Department	$50,832.61	Johnson, Otoe, Richardson
Southwest Nebraska Public Health Department	$38,201.64	Chase, Dundy, Keith, Red Willow
Three Rivers Public Health Department	$88,147.15	Dodge
West Central District Health Department	$68,882.43	Arthur, Lincoln
TOTAL	$3,092,979.48	
Federally qualified health centers (Congressional District 2) For a one-year period		
Charles Drew Health Center	$688,550.00	CD 2
One World Community Health Center	$688,550.00	CD 2

Grantee Reports

Summaries of the outcomes of the individual project grants in Congressional Districts 1 and 3 begin on Page 15. Funding allocated to the Federally Qualified Health Centers in Congressional District 2 appears on pages 32 and 33 . The reports are arranged alphabetically by grantee name, and include the county(ies) covered by the project, the funding awarded for the first year of the project period, the funding priority(ies) 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, 2017 through June 30, 2018.



Thurston County



Carl T. Curtis/Omaha Tribe

Target Health Issues
Diabetes

Dollars
$40,506.04 per year

Key Project Partners
Winnebago Diabetes Program
Four Hills of Life Wellness Center
Whirling Thunder Fitness Center
Dr. Sudah Shaheb, Specialist in Endocrinology/ Anthropology

People Served
43

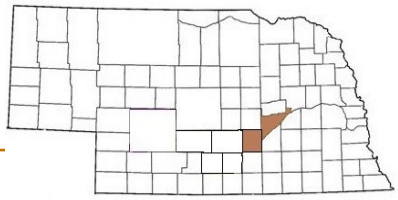
Utilizing the "Balancing Your Life With Diabetes" curriculum, the Carl T. Curtis Health Center is offering a series of Diabetes Self-Management Education (DSME) sessions to reduce the disease burden of diabetes mellitus (DM) and improve the quality of life for American Indians who have, or are at risk for Diabetes Mellitus by facilitating the participants' knowledge, skill, and ability necessary for diabetes self-care and equip clients with proficiency to make informed decisions, practice self-care, apply problem-solving abilities, and work with the health care team to improve their health status and quality of life.

Year 1 Progress and Outcomes

- 43 participants were enrolled into the Diabetes Self-Management Education (DSME) program.
- 43 participants received health education.
- Of the 43 enrolled into the DSME program, 29 (67%) of participants completed the program.
- 29 (67%) of participants demonstrated knowledge increase as a result of health education.
- 29 (67%) of enrollees indicated satisfaction with the health education.
- 26 participants have improved blood pressure.
- 22 participants improved their A1c levels
- 23 participants reduced their weight.

Hall & Merrick Counties

Central District Health Department



Target Health Issues
Cardiovascular disease, Diabetes/pre-diabetes, Obesity

Dollars
$159,189.39 per year

Key Project Partners
Heartland Health Center, Third City Community Clinic, The Central Nebraska Council on Alcoholism and Addictions, Inc., University of Nebraska - Lincoln, Hall County Community Collaborative

People Served
503

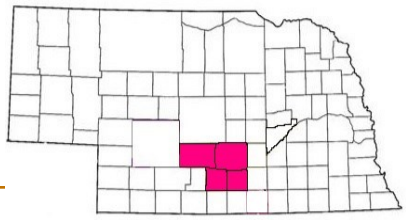
Central District Health Department is implementing the Diabetes Prevention Program (DPP), to strengthen the healthcare system targeting minority individuals at risk for obesity, diabetes and cardiovascular disease using the collective impact model and integration of Community Health Workers to offer outreach, education, referrals and health navigation services. The DPP program provides participants with educational materials and a specialty trained lifestyle coach to teach new skills and support reaching the identified goals. Facilitated discussions and a support group of peers allowing participants to share ideas, celebrate successes, and address obstacles together.

Year 1 Progress and Outcomes

- 503 individuals were screened for hypertension, diabetes, obesity, and/or pre-diabetes.
- 629 referrals were made to additional services.
- 19 participants were enrolled into the Diabetes Prevention Program (DPP).
- Of those enrolled into DPP, 18 (95%) completed the program.
- 56 individuals received health education.
- 17 participants indicated satisfaction with the health education.
- Of those receiving health education, 29 (52%) demonstrated knowledge increase as a result of the health education.
- 57 individuals reported satisfaction with program services.
- 194 individuals were linked to a medical home.
- 281 individuals were served in their primary language.
- 5 program participants have maintained weight loss.

Buffalo, Dawson, Kearney, & Phelps Counties

Community Action Partnership of Mid Nebraska



Target Health Issues
Obesity, Cardiovascular disease, Diabetes, and Pre-diabetes

Dollars
$141,322.77 per year

Key Project Partners
Orthman Community YMCA
Nebraska Extension Office (Buffalo & Dawson Counties)
HelpCare Clinic
Valley Pharmacy

People Served
125

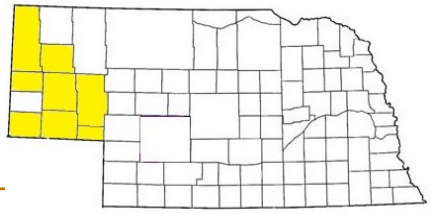
Community Action Partnership of Mid-Nebraska utilizes the "Prevent Diabetes STAT (Screen, Test, Act Today)" program to prevent the onset of diabetes by conducting pre-diabetic screenings, partnering with health care providers for healthy lifestyle instruction, and providing participants with education to promote physical exercise and healthy nutrition choices. The focus on making enduring lifestyle changes will serve to transition participants toward making healthy dietary choices and increasing their physical activity to achieve results.

Year 1 Progress and Outcomes

- 79 individuals have been screened for hypertension, diabetes, obesity, and/or pre-diabetes.
- 95 program participants have achieved lifestyle change goals.
- 63 participants have received health education.
- 80 individuals have received referrals to additional services.
- 97 respondents indicated satisfaction with health education.
- 16 participants report satisfaction with program services.
- 74 individuals have been linked to medical homes.
- 34 individuals have been served in their primary language.
- 4 participants have maintained weight loss.

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

Community Action Partnership of Western Nebraska (CAPWN)



Target Health Issues
Cardiovascular disease, Diabetes

Dollars
$126,657.29 per year

Key Project Partners
Schmeeckle Research, Lakota Lutheran Center, Guadalupe Center, UNMC

People Served
224

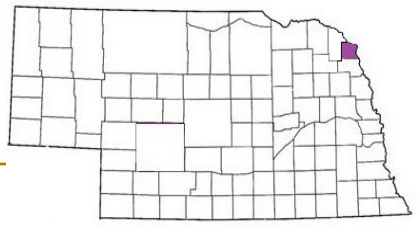
CAPWN supports clients through the use of Community Health Workers (CHWs) to improve health equity related to cardiovascular disease and diabetes. The CHWs provide the Diabetes Education Empowerment Program (DEEP) to assist participants in taking control of their disease and reduce the risk of complications. CHWs engage clients to be knowledgeable of their health in an effort to improve their overall health outcomes by adjusting eating habits, increasing physical activity, and developing self-care skills.

Year 1 Progress and Outcomes

- 12 individuals were screened for hypertension, pre-diabetes, diabetes, or obesity.
- 92 individuals achieved lifestyle change goals.
- 102 program participants demonstrated knowledge increase as a result of health education.
- 8 program participants indicated satisfaction with the health education.
- 119 individuals were satisfied with the program services.
- 22 program participants improved their blood pressure.
- 11 program participants have improved their A1c.

Dakota County

Dakota County Health Department



Target Health Issues
Obesity, Cardiovascular disease and Diabetes

Dollars
$90,731.20 per

Key Project Partners
YMCA, Local Churches, Local Clinics, Siouxland Community Health Center, WIC

People Served
91

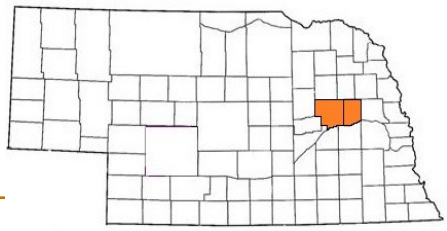
Dakota County Health Department collaborates with local agencies to provide comprehensive chronic disease self-management education following the Diabetes Prevention Program (DPP) which involves facilitated group education, provider referrals and access to community resources to ensure an impact driven model that centers on obesity, cardiovascular disease, (specifically hypertension and diabetes prevention), and increasing awareness to improve participants' quality of life by practicing self-care skills that include healthy eating habits and increased physical activity.

Year 1 Progress and Outcomes

- 41 screenings were conducted for hypertension, diabetes, pre-diabetes, and/or obesity.
- 26 individuals were enrolled in DPP.
- 9 participants have demonstrated knowledge increases as a result of health education.
- 25 individuals have received referrals to additional services.
- 4 participants have achieved lifestyle change goals.
- 5 participants have improved their blood pressure.
- 8 participants reduced their weight.
- 5 participants have maintained lifestyle changes at 6 or 12 months.

Colfax & Platte Counties

East Central District Health Department



Target Health Issues
Diabetes, Obesity and
Cardiovascular disease

Dollars
$92,119.65 per year

Key Project Partners
Good Neighbor Community Health Center
CHI Health Clinic
St. Bonaventure Catholic Church
Dr. Ryan Spohn, University of Nebraska Oma-

People Served
32

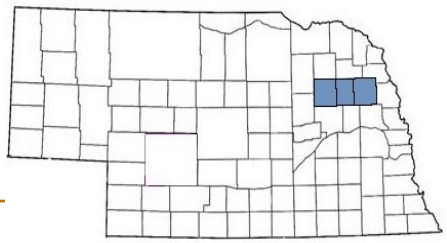
East Central District Health Department is implementing the "Eating Smart, Being Active" curriculum to reduce obesity for minority clients who have a BMI greater than ≥25. The program participants are referred from community partners Good Neighbor Community Health Center and CHI Health Clinic to participate in activities addressing physical activity, nutrition, healthy lifestyle choices, food preparation and safety, and food resource management.

Year 1 Progress and Outcomes

- 30 individuals have received health education.
- 10 program participants have demonstrated knowledge increase as a result of health education.
- 192 health education sessions have been administered.
- 32 individuals have been referred to the program by partner agencies.
- 3 program graduates have received follow-up support.
- 19 individuals diagnosed as diabetic are enrolled in case management.
- 10 participants indicated satisfaction with the case management services.
- 5 participants have improved their A1c levels.

Cuming, Madison, & Stanton Counties

Elkhorn Logan Valley Public Health Department



Target Health Issues
Obesity, Cardiovascular disease

Dollars
$68,284.63 per year

Key Project Partners
Midtown Health Center, Inc.

People Served
30

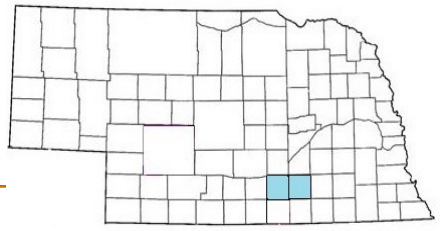
Elkhorn Logan Valley Public Health Department is implementing the "Eating Smart, Being Active" curriculum through Community Health Workers (CHWs) for participants who are overweight, obese, or have a chronic health condition and as such are enrolled into program activities addressing physical activity, nutrition, healthy lifestyle choices, food preparation and safety, and food resource management.

Year 1 Progress and Outcomes

- 29 individuals have been referred to the program by healthcare providers.
- 30 program participants have demonstrated knowledge increase as a result of health education.
- 20 individuals indicated satisfaction with program services.
- 30 individuals have been served in their primary language.
- 23 program participants have reduced their weight.
- 3 participants have maintained weight loss.
- 2 participants have maintained lifestyle changes at 6 or 12 months.

Adams & Clay Counties

Mary Lanning Healthcare Foundation



Target Health Issues
Obesity, Diabetes

Dollars
$40,669.95 per year

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

People Served
228

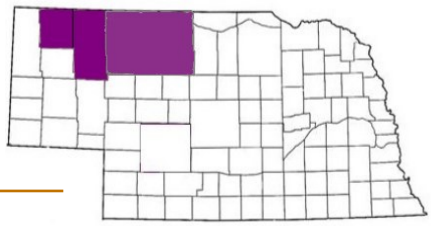
Mary Lanning Healthcare Foundation is providing individual diabetes self-management education program "*El Paquete Total*". *The program* offers supports for family members to address diabetes and obesity through disease management education and advocacy by facilitating the knowledge, skill, and ability necessary for diabetes self-care to improve health status and quality of life.

Year 1 Progress and Outcomes

- 83% of program participants indicate satisfaction with the (DSME) education.
- 72 individuals have received referrals to additional services.
- 148 individuals are adhering to their medication regimens.
- 46 program participants have improved blood pressure control.
- 66 program participants have improved A1c levels.
- 91 individuals have received referrals for other services.
- 92 program participants indicated knowledge increase as a result of health education.
- 4 program participants have improved nutrition practices.
- 42 program participants have reduced weight.

Cherry, Dawes & Sheridan Counties

Nebraska Minority Resource Center



Target Health Issues
Obesity, Diabetes

Dollars
$25,127.05 per year

Key Project Partners
Gordon-Valentine Hospitals
Valentine Public Library

People Served
46

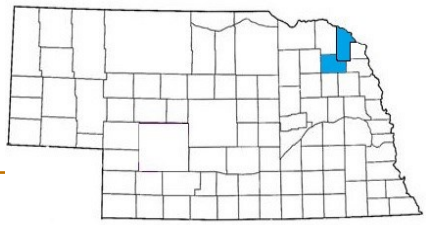
Nebraska Minority Resource Center is working to reduce consumption of sugary beverages among youth and adults through early intervention methods that offer beverage alternatives, and involve the youths' families, parents and/or guardians to participate in workshops and educational activities that provide nutrition education and recommendations for improving overall health while specifically targeting reduced intake of sugar-sweetened beverages.

Year 1 Progress and Outcomes

- 42 individuals have received program services.
- 57 health education activities have been implemented.
- 23 program participants have demonstrated knowledge increase as a result of health education.
- 25 individuals indicate satisfaction with health education activities.
- 25 program participants indicated satisfaction with program services.
- 18 program participants have achieved lifestyle change goals.
- 19 program participants have reduced their weight.

Dixon & Wayne Counties

Northeast Nebraska Public Health Department



Target Health Issues
Obesity, Cardiovascular disease, Pre-diabetes and Diabetes

Dollars
$13,585.58 per year

Key Project Partners
Salem Lutheran Church

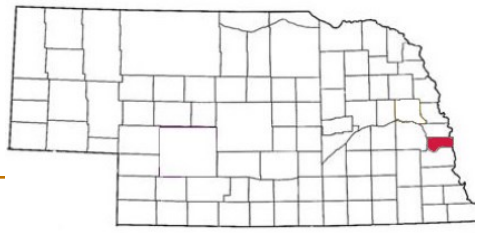
People Served
69

The Northeast Nebraska Public Health Department works to prevent prevalence of chronic disease by offering the Living Well with Diabetes program consisting of education sessions that provide insight into ways for living healthier, screenings to identify risk factors for development of chronic disease, assistance with setting personal goals to improve healthy living, and one-to-one support with a Community Health Worker to achieve those goals.

Year 1 Progress and Outcomes

- 56 screenings have been completed for hypertension, diabetes, obesity, or pre-diabetes.
- 21 individuals have received health education.
- 12 individuals have demonstrated knowledge increase as a result of health education.
- 7 participants indicated satisfaction with health education.
- 6 participants indicated satisfaction with program services.
- 6 participants have achieved lifestyle change goals.
- 26 participants have improved their blood pressure.
- 19 participants have reduced their weight.

One World Community Health Center



Target Health Issues
Obesity, Cardiovascular disease, and Diabetes (including pre-diabetes)

Dollars
$151,832.55 per year

Key Project Partners
Dr. Richard Stacy, UNO

People Served
291

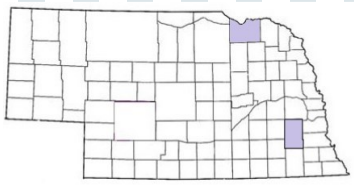
OneWorld Community Health Center trains Community Health Workers (CHWs/Promotores) to deliver the Diabetes Prevention Program (DPP) "Road to Health" to reduce risk factors, improve health outcomes and increase health care access for minorities identified as at risk for obesity, cardiovascular disease, diabetes, and pre-diabetes. Participants will receive education addressing healthy lifestyle choices, connection to a medical home, and provided with access to other community resources to manage and improve their health conditions.

Year 1 Progress and Outcomes

- 291 screenings were administered for hypertension, diabetes, obesity, and/or pre-diabetes.
- 291 individuals received health education.
- 125 participants demonstrated knowledge increase as a result of health education.
- 250 participants indicated satisfaction with program services.
- 17 individuals were linked to medical homes.
- 291 individuals were served in their primary language.
- 32 participants have improved their blood pressure.
- 21 participants have improved their A1c levels.
- 45 participants maintained lifestyle changes at 6 or 12 months.

Knox & Lancaster Counties

Ponca Tribe of Nebraska



Target Health Issues
Obesity, Cardiovascular disease, Diabetes, and Pre-Diabetes

Dollars
$ 440,812.87 per year

Key Project Partners
Asian Community and Cultural Center, El Centro de las Américas, Good Neighbor Community Center, Malone Community Center, People's Health Center, Lincoln/ Lancaster County Health Department, University of Nebraska-Lincoln Nutrition & Health Sciences Department

People Served
2,467

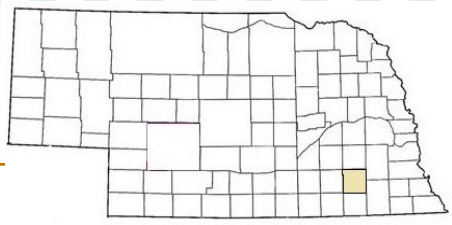
The Ponca Tribe of Nebraska works with key partners to implement the [adapted] St. Johnsbury Community Health Team (CHT) model, augmented by the [adapted] Diabetes Self-Management Education (DSME) program to prevent and/or improve management of obesity, diabetes, and cardiovascular disease through community health worker provided services and coordinated access to a comprehensive range of community resources and medical/dental services. The St. Johnsbury Community Health Team model involves the formation of a Community Connections Team consisting of Community Health Workers to implement the DSME program; an Extended Community Health Team, which is inclusive of a broad representation of community partners who provide diverse psychosocial and health services to the community; Advanced Primary Care Practices to link patients with medical homes; and, an Administrative Core to oversee integration of CHT components.

Year 1 Progress and Outcomes

- 1,068 screenings were administered for hypertension, diabetes, obesity, and/or pre-diabetes
- 157 individuals received health education.
- 627 individuals received referrals to additional services.
- 104 participants have completed the DSME program.
- 109 individuals improved their blood pressure.
- 10 participants have improved A1c levels.
- 55 participants have reduced their weight.
- 16 participants have maintained lifestyle changes at 6 or 12 months.
- 91 individuals have been referred to the program by healthcare providers/partner agencies.
- 104 participants complete4d the DSME program.
- 4 Memorandums of Understanding have been signed with community partners

Saline County

Public Health Solutions



Target Health Issues
Diabetes (including pre-diabetes) and Obesity

Dollars
$32,618.88 per year

Key Project Partners
Saline Medical Specialties, Crete Area Medical Center

People Served
98

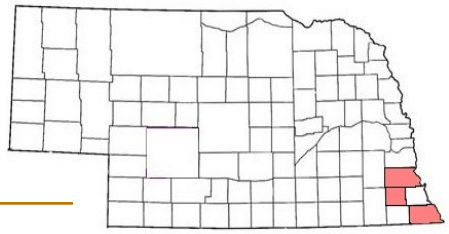
Public Health Solutions is utilizing a Community Health Worker (CHW) to provide health screenings to identify pre-diabetic and diabetic minority people to participate in the Diabetes Prevention Program (DPP) with the objectives of decreasing the risk of developing diabetes in pre-diabetics, reducing obesity, facilitating the ability to self-manage chronic disease in those with a diagnosis of diabetes, and increasing access to primary care by utilizing a network of referral options. The CHW consults with a public health nurse for clients identified as higher risk, and works to reduce barriers to screening, primary care services, and self-management practices.

Year 1 Progress and Outcomes

- 98 individuals have been screened for diabetes, pre-diabetes, and/or obesity.
- 11 individuals who have a diabetes diagnosis have developed a chronic disease self-management plan.
- 6 program participants have maintained adherence to their medication regimens.
- 52 individuals have received referrals to additional services.
- 42 individuals have been linked to medical homes.

Johnson, Otoe, & Richardson Counties

Southeast District Health Department



Target Health Issues
Obesity, Cardiovascular Disease, Diabetes (including pre-diabetes)

Dollars
$25,416.31 per year

Key Project Partners
Local employers
SEDHD Immunization Clinic

People Served
73

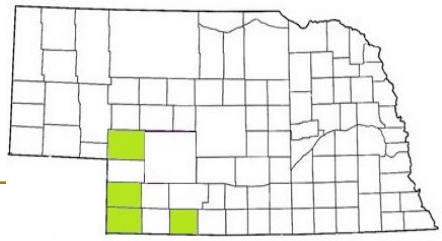
The Southeast Nebraska District Health Department (SEDHD) is utilizing the National Diabetes Prevention Program (NDPP) to serve participants at risk for hypertension, cholesterol and high blood glucose. Information regarding healthy living through diet, exercise, and regular monitoring of their health numbers is provided via one-to-one education supplemented with written materials. Referrals to medical homes ensures the consistent monitoring of participants' health along with helping clients to understand the importance of regular health care provider visits. SEDHD partners with local employers, the SEDHD immunization clinic, and other community partners to reach minority populations, maintain consistent contact, and offer regular screening clinics to enroll participants into the treatment program.

Year 1 Progress and Outcomes

- 86 individuals received health screenings for hypertension, diabetes, pre-diabetes and/or obesity.
- 86 health education services were conducted.
- 31 referrals were made to additional services.
- 39 participants indicated satisfaction with program services.
- 37 participants reported improvement in attitudes resulting from program education services.
- 16 individuals have been linked to medical homes.
- 2 participants have been recruited to the (NDPP) program.

Chase, Dundy, Keith, & Red Willow Counties

Southwest Nebraska Public Health Department



Target Health Issues
Cardiovascular disease, Diabetes preventive screening and Health education

Dollars
$19,100.82 per year

Key Project Partners
N/A

People Served
83

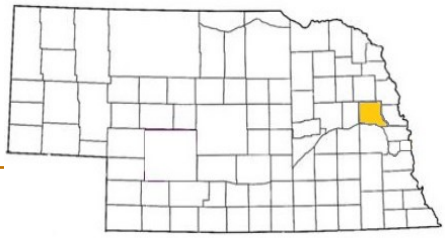
Southwest Nebraska Public Health Department (SWNPHD) implements the Eating Smart, Being Active (ESBA) program to provide health screenings and education to participants relevant to their health numbers, including blood pressure, cholesterol, and blood glucose results. Information about healthy living through diet, exercise, and regular monitoring of their health numbers is also provided using one-to-one education and supplemented with written educational materials. SWNPHD utilizes the ESBA program recommended information and practices to provide participants with accurate screenings and information regarding their health and health risks.

Year 1 Progress and Outcomes

- 83 participants have demonstrated knowledge increase as a result of health education.
- 83 participants have indicated satisfaction with health education.
- 1 individual received a referral to additional services.
- 83 individuals were served in their primary language.
- 6 participants have achieved lifestyle change goals.
- 1 participants has improved their blood pressure.
- 6 individuals have reduced their weight.
- 4 participants have maintained lifestyle changes at 6 or 12 months.

Dodge County

Three Rivers Public Health Department



Target Health Issues
Diabetes (including pre-diabetes)

Dollars
$44,073.58 per year

Key Project Partners
Good Neighbor Fremont (FQHC)
Fremont Health Medical Center

People Served
37

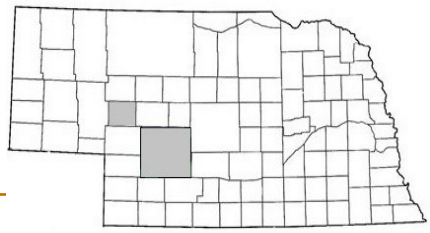
Three Rivers Public Health Department utilizes a Community Health Worker to deliver the National Diabetes Prevention Program (NDPP) to prevent type 2 diabetes with clients assessed as pre-diabetic by offering an educational curriculum with accompanying materials and other resources to promote healthy change, accompanied by a specially trained lifestyle coach to lead the program. Participants also have access to a support group comprised of individuals who have similar goals and challenges and can share ideas, celebrate successes, and work together to overcome obstacles as they meet long-term lifestyle change goals.

Year 1 Progress and Outcomes

- 37 individuals have been screened for hypertension, diabetes, obesity, and/or pre-diabetes.
- 13 participants have been enrolled in the NDPP program.
- 2 participants have demonstrated knowledge increase as a result of health education.
- 2 participants indicated satisfaction with the health education.
- 6 individuals reported satisfaction with program services.
- 5 participants achieved lifestyle change goals.
- 4 participants demonstrated improved A1c levels.
- 4 participants reduced their weight.

Arthur & Lincoln Counties

West Central District Health Department



Target Health Issues
Obesity, Cardiovascular disease, and Diabetes

Key Project Partners
West Central District Health Department Public Health Clinic, Health Services and Dental Clinic, Great Plains Health, Community Connections, Dr. Deb's Medical, WIC, People's Family Health, local medical providers, local service agencies

Dollars
$34,441.22 per year

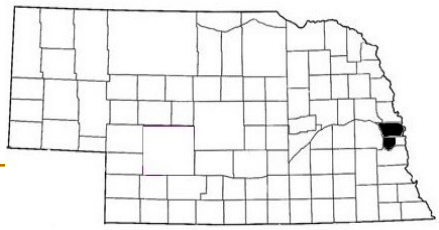
People Served
198

West Central District Health Department utilizes a Community Health Worker (CHW) to deliver the "Road to Health" (RTH) program for participants to learn and be supported as they incorporate information on obesity, cardiovascular disease, and diabetes into making healthy lifestyle choices. The CHW establishes access to medical providers and available services by providing interpretation assistance and health literate practices to support and advocate for clients as they navigate the health care system.

Year 1 Progress and Outcomes

- 162 screenings were administered for hypertension, diabetes, obesity, and/or pre-diabetes.
- 35 participants were enrolled into the Road to Health (RTH) program.
- 16 participants demonstrated knowledge increase as a result of health education.
- 246 referrals were made to additional services.
- 198 individuals were served in their primary language.
- 5 participants improved their blood pressure.

Douglas County



Charles Drew Health Center

Target Health Issues
Cardiovascular disease, Asthma, Diabetes, Obesity, Infant mortality

Dollars
$688,550.00 per year

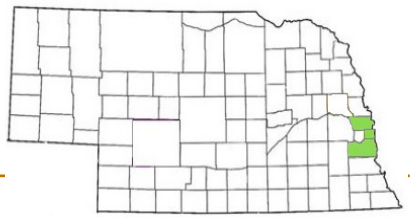
People Served
11,745

Also included in the appropriation is annual funding to be distributed equally among Federally Qualified Health Centers (FQHC) in the second Congressional District (Charles Drew Health Center, Inc. and One World 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.

Reach and Outcomes

- 94% of patients 12 years and over were screened for depression and had a follow-up plan documented if patient was considered depressed.
- 204 (86%) of asthma patients are being treated with an accepted Inhaled Corticosteroid or an accepted alternative medicine.
- 815 (54%) of adult patients (18-25 years) have achieved controlled hypertension (BP $\leq$ 140/90).
- The percent of adult patients with a diagnosis of Coronary Artery Disease (CAD) who were prescribed a lipid-lowering therapy was 88%.
- 208 women accessed prenatal care with 41% initiating their prenatal care during the first trimester.
- The percentage of patients aged 2-17 years with weight assessment and counseling for nutrition and physical activity increased from 85% to 86%.
- The percentage of adult patients with weight screening and follow-up was 63%.
- 88% of adult patients who were diagnosed with tobacco use, have had a cessation medication prescribed.
- 42% of patients were screened for substance use disorder; of those screened, 133 patients were diagnosed with a substance abuse disorder and are receiving treatment.
- The percentage of children were fully immunized by their 2nd birthday increased from 50% to 61%..
- Dental sealants were provided for 72.3% of children (ages 6-9 years).

Cass, Douglas, and Sarpy Counties



One World Community Health Center

Target Health Issues
Diabetes, Cardiovascular disease, Infant health, Depression, Pediatric oral health, Asthma, and Pediatric and adult weight management

Dollars
$688,550.00 per year

People Served
41,868

Also included in the appropriation is annual funding to be distributed equally among Federally Qualified Health Centers (FQHC) in the second Congressional District (Charles Drew Health Center, Inc. and One World 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.

Reach and Outcomes

- 158,899 visits were provided to 41,868 unique patients.
- 1,454 prenatal patients were provided services.
- 114,858 prescriptions were supplied.
- 20,543 uninsured people received medical services.
- 35% of minority patients were provided with interpretation for receiving medical services.
- 2,365 minority patients diagnosed with diabetes received medical services.
- 2,009 minority patients were treated for hypertension.
- 14,244 children received the appropriate immunizations before their second birthday.
- 97.7%of adult patients were screened and counseled for tobacco use.
- 3,018 patients diagnosed with depression and other mood disorders were provided with therapeutic supports.
- 4,820 patients received pediatric dental services.
- 96.9% of people with persistent asthma were placed on a pharmacological treatment plan.
- 78.5% adult patients (18+ years older) had their BMI documented and if determined to be under-/overweight were provided with a follow-up plan.
- 10,932 children and adolescents who scaled high on the relative BMI received counseling on nutrition and physical activity.
- 99% of prenatal patients delivered at/above the healthy birth weight indicator (greater than >2,500 grams).
- 1,370 minority patients brought their hypertension under control.
- 1,322 minority patients diagnosed with diabetes achieved A1c results below ≤9%.

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.

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.

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.

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

Evidence-Based Public Health: : the development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems, and appropriate use of behavioral science theory and program planning models.

Health disparity: differences in the health status of different groups of people. Some groups of people have higher rates of certain diseases, and more deaths and suffering from them, compared to others.

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

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.

Outcome: the statement of an intended result.

Results-Based Accountability (RBA): a disciplined way of thinking and taking action that can be used to improve the quality of life in communities, cities, counties, states and nations. RBA can also be used to improve the performance of programs, agencies and service systems.

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

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