NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

December 10, 2019

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

RE: 2018-2019 Annual Report on Minority Health Initiatives

Dear Mr. O'Donnell:

In accordance with Nebraska State Statute 71-1628.07, please find attached a copy of the 2018-2019 annual report on Minority Health Initiatives. This report covers the period July 1, 2018 – June 30, 2019, and highlights progress and outcomes of the Minority Health Initiative (MHI) funding.

Sincerely,

Dr. Gary J. Anthone, MD
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

2018-2019 MINORITY HEALTH INITIATIVE

Annual Report

December 1, 2019

In accordance with Nebraska State Statute 71-1628.07

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

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

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From the Administrator...

This report was created by the Nebraska Department of Health and Human Services (NDHHS), 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 2018-2019 grant year. The funding was 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 was 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 OHDHE used a competitive request for applications process for the 2017-2019 award period. This report illustrates the progress and outcomes for the 2018-2019 year. Also included in the appropriation is annual funding that is distributed equally among federally qualified health centers in the second Congressional District. These funds were not included in the competitive request for application. As directed by the Nebraska Legislature, these funds are also used to implement a minority health initiative which targeted, but were not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma. The goal of the Minority Health Initiative grant program was to work collaboratively with stakeholders to assist in the elimination of health disparities disproportionately impacting minority populations in Nebraska. Populations served included racial and ethnic minorities, American Indians, and refugees.

During the 2017-2019 project period, the OHDHE continued to incorporate various elements into the MHI grant program to improve program outcomes. These included the use of outcome-based performance measures and evidence-based programming. 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 (CHWs) continued to be supported during the project period to address social factors that influence health outcomes.

This report illustrates the progress and outcomes that were achieved by the MHI projects. Many individuals were served through screenings, health education, referrals, and various other activities. As a result of these activities, positive outcomes including reductions in diabetes hemoglobin A1c rates, improvements in blood pressure, reduction in weight loss, and linkages to medical homes were achieved during the 2018-2019 MHI grant year.

On behalf of the NDHHS, 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.

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.

2017-2019

MINORITY HEALTH INITIATIVE

Activities and Outcomes

Total number of people served

6,920

Served by

31

Full-time public health staff

*Includes projects in Congressional Districts 1 & 3 for Year 2 only

HEALTH SCREENINGS

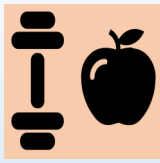
6,757

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

REFERRALS

5,587

people received referrals to additional services



"The education helped my family lower their cholesterol numbers. We each chose our own exercise activity and feel healthier all around." [Translated from Spanish].

HEALTH EDUCATION

1,646

minorities participated in health education

457

enrollees demonstrated knowledge increase as a result of health education

My life has transformed and I feel different with the help and what I've learned. Now I know that I can do a lot for my well-being and to be healthier. Thank you!".

2017-2019

MINORITY HEALTH INITIATIVE

Activities and Outcomes

Diabetes Prevention and Management Programs

630

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

501

participants completed a diabetes prevention and management program

"I really like the Living Well with Diabetes workshop because it helps me to better manage the problems of Diabetes and other chronic problems. The facilitators helped me to choose better foods , increase exercise and understand the importance of medications and my health care with this disease". [Translated from Spanish].

"The Diabetes Self-Management Education program helped me out when I didn't have health insurance and couldn't afford my diabetic testing supplies. With your help diagnosing my diabetes, high blood pressure, high cholesterol, and anemia I was able to learn new things to manage my diabetes and have lowered my A1c levels. [Translated from Spanish].

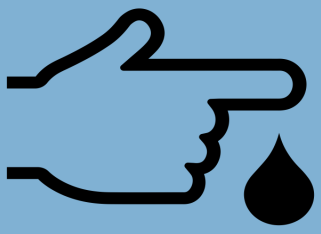
Health Impact:

- 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%[1]. Even 10 years after completing the program, participants were one third less likely to develop type 2 diabetes[2].
- Diabetes management interventions involving community health workers have resulted in decreases in A1c among African American and Latino participants[3].
- Chronic disease management interventions involving community health workers combined with goal setting led to improvements in chronic diseases among participants in one study[4].
- 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[5].
- Medicare beneficiaries who completed the 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%[6].

2017-2019

MINORITY HEALTH INITIATIVE

Activities and Outcomes



Diabetes

204

participants improved their diabetes Hemoglobin A1c rate

Blood Pressure

395

participants have improved their blood pressure

"When I drank more water as I was directed, my blood pressure changed [lowered] which had a big impact on my total health."

"I lost 15 pounds after I joined the Diabetes Prevention Program, and my knee problem got better so I kept working very hard to continue with the physical activity. My doctor congratulated me for maintaining healthy levels

Weight Loss

407

participants reduced their weight

156

maintained their weight loss

Medical Home

647

people were linked to a medical home

"The CHW helped me find a medical home doctor to control my diabetes. I followed the Dr. recommendations and my glucose improved a lot with the medicine; with the help my A1C (which was 16) lowered to 7 with my medication, diet and exercise."

People Served

Summaries of the clients served by the Minority Health Initiative projects for the period July 1, 2017 through June 30, 2019 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	6,920
Age	
0-17	536
18-24	488
25-64	5,199
65+	697
Total	6,920

Gender	
Female	4,552
Male	2,368
Total	6,920

Participants (Cont.)	
Race and Ethnicity	
African American or Black	282
American Indian/Alaska Native	497
Asian	368
Hispanic, any race	3,778
Non-Hispanic, White	96
Other, missing, not sure, or refused	1,877
Two or more races	23
Total	6,920

Refugee Status	
Refugee	477
Non-refugee	3,981
Total	4,458[A]

[A][Note: 2,462 individuals did not designate Refugee status].

Preferred/Primary Language	
English	1,403
Spanish	4,318
Arabic	273
Other	796
Total	6,790[B]

[B][Note: 130 individuals declined to identify preferred /primary language].

Insurance Status	
Private Insurance	1,297
Medicaid	1,066
No Insurance	3,354
Total	5,717[C]

[C][Note: 1,203 individuals declined to identify insurance status].

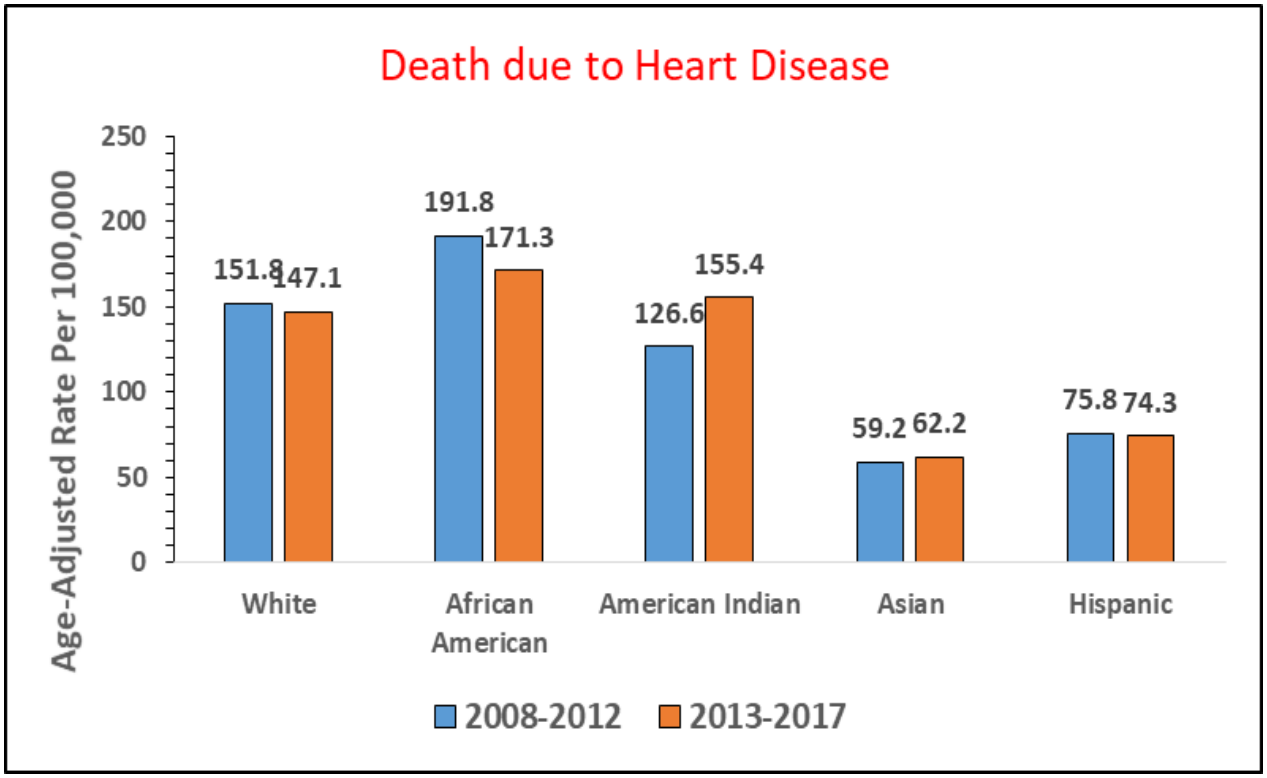
The charts on pages 9 through 11 are included in this report to identify the disparities between Nebraska's White population and other minority groups. The charts include key behavioral risk factors and health issues related to the 2018-2019 MHI project activities.

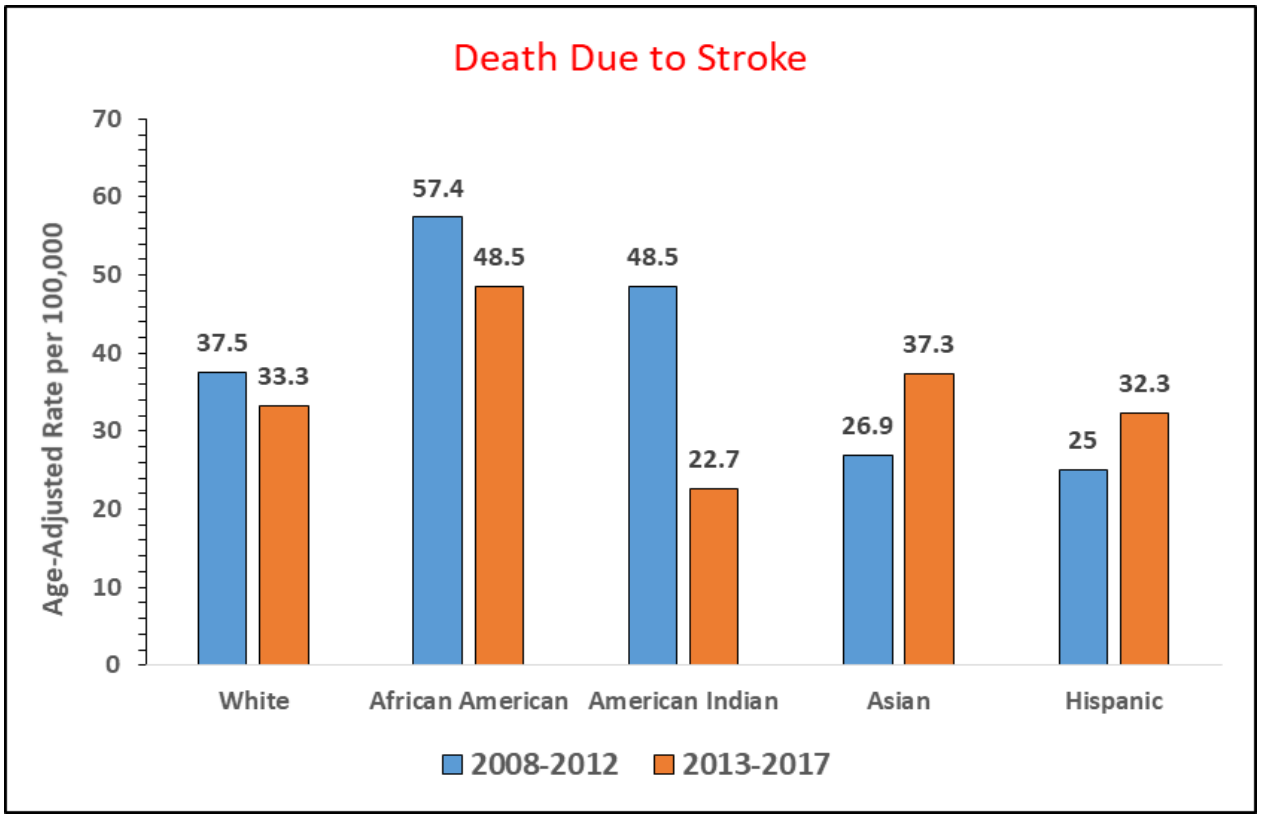
Risk Factors Related to Priority Issues, Nebraska

Health Issue	Race/Ethnicity	Percent
Obesity * Prevalence among adults aged 18+	African American	37.3
	American Indian	19.01
	Asian	27.9
	Hispanic	31.8
	White	30.8
High Blood Pressure * Prevalence among adults aged 18+	African American	42.8
	American Indian	16.3
	Asian	28.6
	Hispanic	23.3
	White	43.0
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
Physic Inactivity * Prevalence among adults aged 18+	African American	24.3
	American Indian	13.9
	Asian	29.1
	Hispanic	32.1
	White	21.8
Perceived Health Status: Fair or Poor * Prevalence among adults aged 18+	African American	19.4
	American Indian	28.5
	Asian	14.0
	Hispanic	25.9
	White	12.2

Notes and Data Source: * Nebraska Behavioral Risk Surveillance System (BRFSS) 2014-2016
**Nebraska Behavioral Risk Surveillance System (BRFSS) 2011&2013&2015

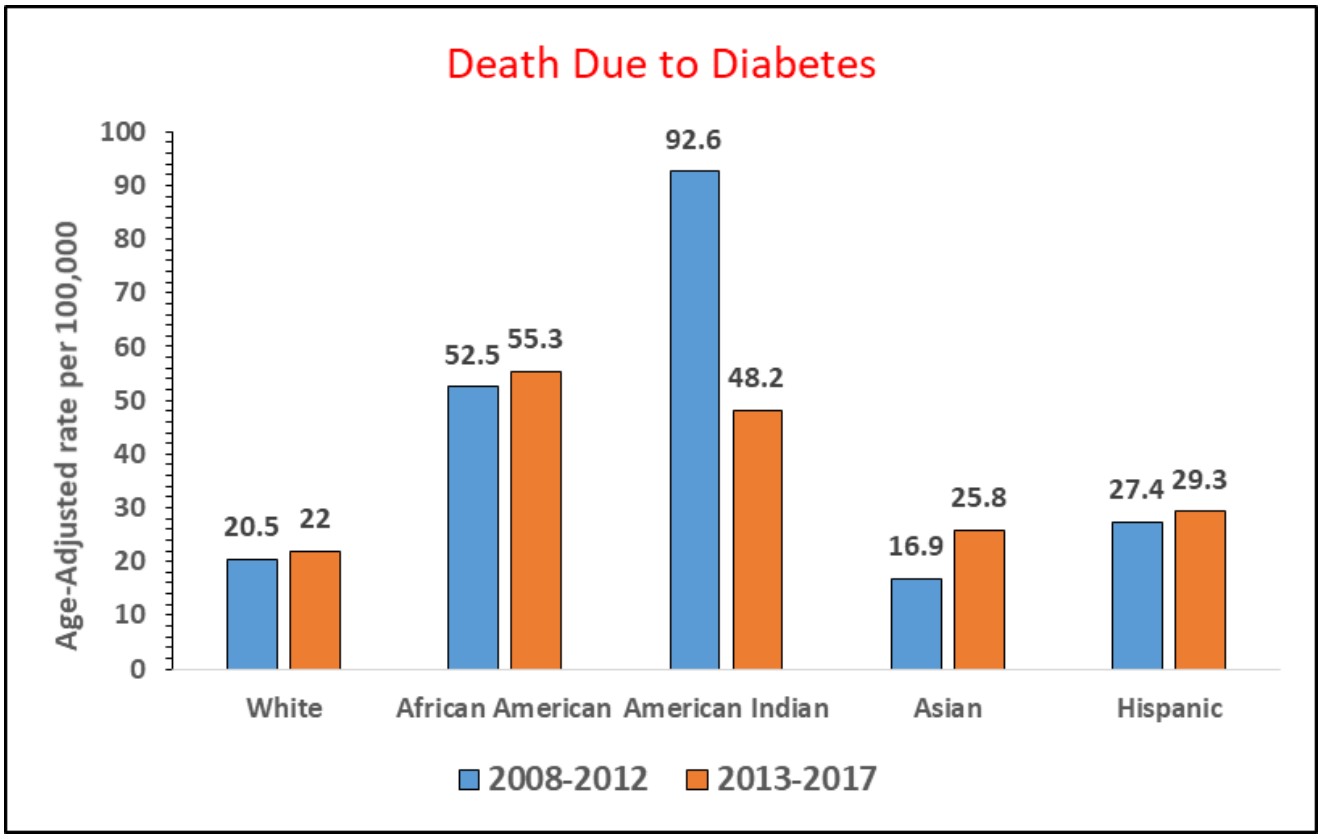
Death Rates Related to Priority Issues, Nebraska

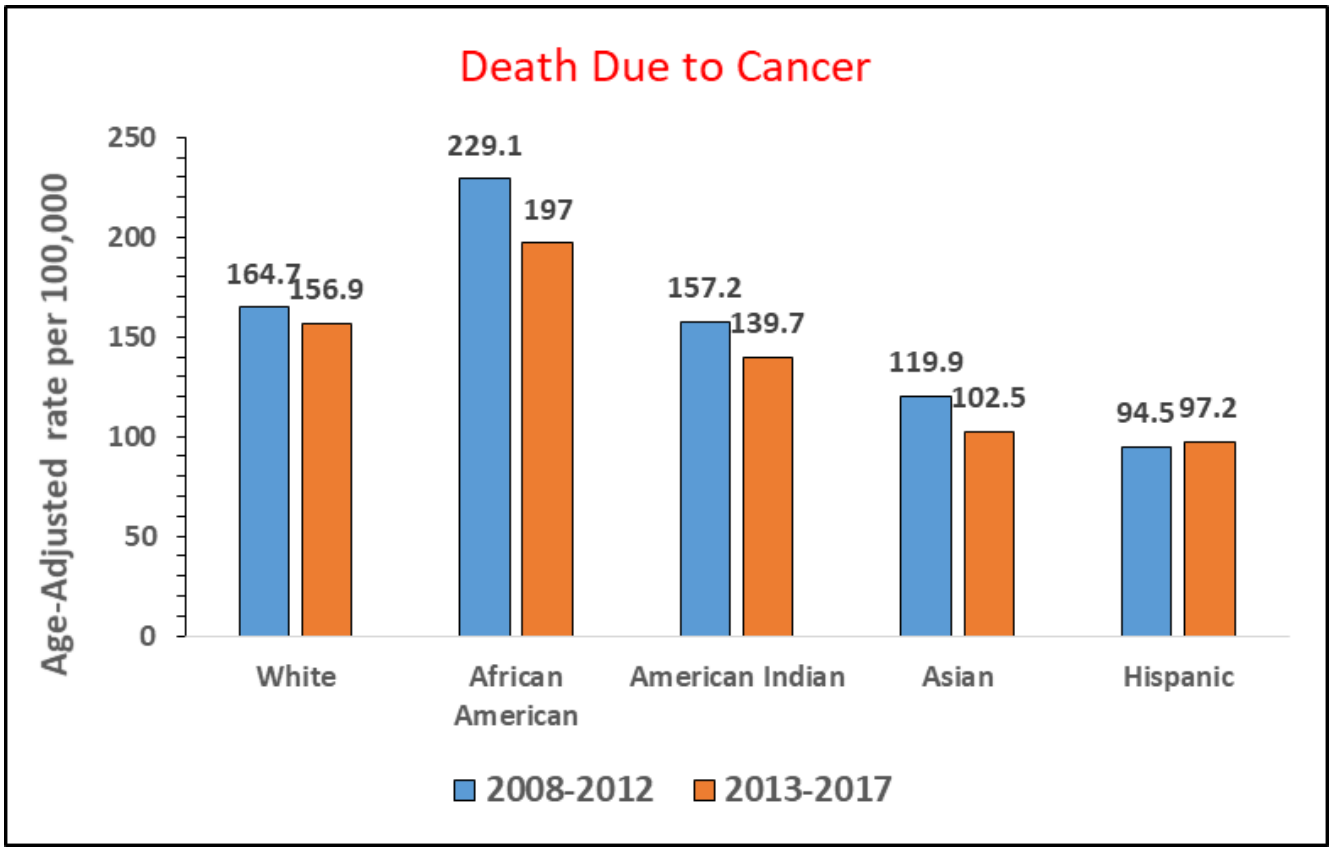




Data Source: Nebraska DHHS Vital Statistics 2008-2017

Death Rates Related to Priority Issues, Nebraska





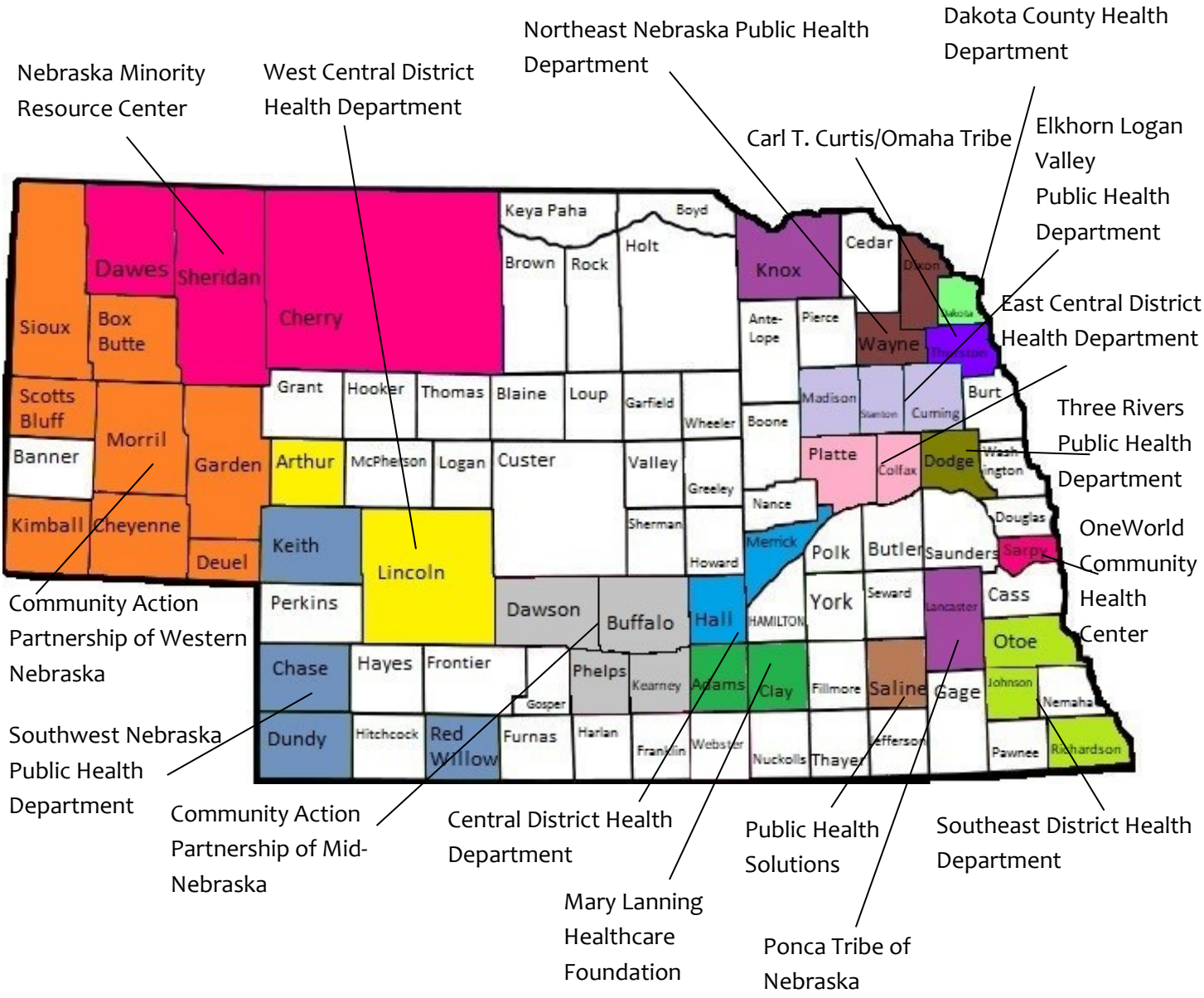
Data Source: Nebraska DHHS Vital Statistics 2008-2017

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	

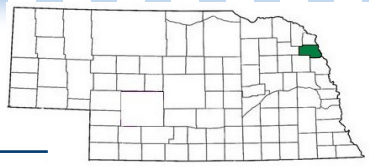
Federally qualified health centers (Congressional District 2) For a one-year period		
Charles Drew Health Center	$688,550.00	CD 2
One World Community Health Center	$688,550.00	CD 2

Grantee Reports

Summaries of the outcomes for the 2018-2019 year for the individual project grants in Congressional Districts 1 and 3 begin on Page 14. Summaries for the funding allocated to the Federally Qualified Health Centers in Congressional District 2 appear on pages 31 and 32. The reports are arranged alphabetically by grantee name, and include a brief description of each project, the county(ies) covered by the project, the funding amount awarded per year, targeted health issues addressed, project partners, the number of people served during the second year of the project, and outcomes achieved from July 1, 2018 through June 30, 2019,



Thurston County



Carl T. Curtis/Omaha Tribe

The Carl T. Curtis Health Center provided 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. The project will assist in increasing participants' knowledge, skill, and ability necessary for diabetes self-care and to 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.

Target health issues

Diabetes

Dollars

$40,506.04 per year

People served

66

Project partners

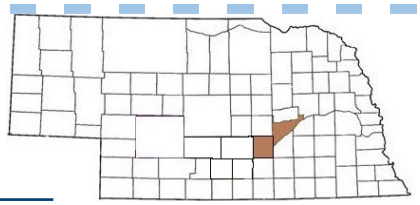
Winnebago Diabetes Program, Four Hills of Life Wellness Center, Whirling Thunder Fitness Center, Dr. Sudah Shaheb, Specialist in Endocrinology/ Anthropology

Year 2 Progress and Outcomes

- 66 individuals were enrolled into the Diabetes Self-Management Education (DSME) program.
  - Of the 66 enrolled into the DSME program, 27 participants completed the program.
  - 56 participants developed a self-management plan.
  - 27 participants who completed the DSME program demonstrated knowledge increase as a result of health education.
  - 27 of program graduates indicated satisfaction with the health education.
  - 25 participants improved their nutrition practices.
  - 9 participants have improved blood pressure.
  - 18 participants improved their A1c levels
  - 6 participants reduced their weight.

Hall & Merrick Counties

Central District Health Department



Central District Health Department implemented the Diabetes Prevention Program (DPP) and Living Well, 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 provided 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 allowed participants to share ideas, celebrate successes, and address obstacles together.

Target health issues

Cardiovascular disease, Diabetes/ Pre-diabetes, Obesity

Dollars

$159,189.39 per year

People served

367

Project partners

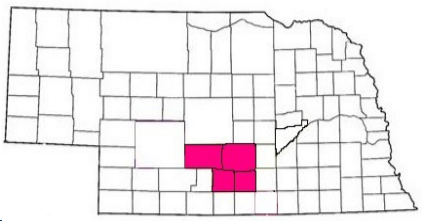
Heartland Health Center, Third City Community Clinic, Hall County Community Collaborative

Year 2 Progress and Outcomes

- 442 screenings for hypertension, diabetes, obesity, and/or pre-diabetes were conducted.
- 1,019 linkages were made between clients and additional resources.
- 125 individuals who did not have a medical home were assisted to establish one.
- 32 individuals enrolled into the Diabetes Prevention Program (DPP).
  - 19 participants completed the DPP program.
  - 19 participants improved nutrition.
  - 19 participants increased their physical activity.
  - 19 participants reduced their BMI, and 17 maintained that reduction of 6-12 months.
  - 19 participants maintained lifestyle changes adopted during DPP.
- 7 individuals completed Living Well.
  - 7 participants increased knowledge.
  - 7 participants improved nutrition.
  - 7 participants improved physical activity.

Buffalo, Dawson, Kearney, & Phelps Counties

Community Action Partnership of Mid Nebraska



Community Action Partnership of Mid-Nebraska utilized 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 served to transition participants toward making healthy dietary choices and increase their physical activity to achieve results.

Target health issues

Obesity, Cardiovascular disease, Diabetes, and Pre-diabetes

Dollars

$141,322.76 per year

People served

165

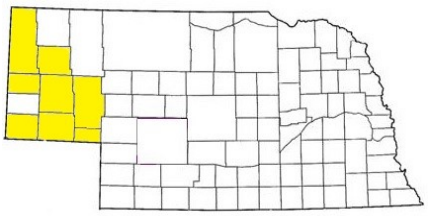
Project partners

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

Year 2 Progress and Outcomes

- 165 screening for hypertension, diabetes, obesity, and/or pre-diabetes were conducted.
- 107 individuals participated in a health education program
  - 35 participants improved their nutrition practices.
  - 42 participated in a healthy lifestyle walking program.
  - 93 participants were linked to a medical home.
  - 65 participants achieved lifestyle change goals.
  - 39 participants reduced their weight.
  - 15 participants have maintained weight loss.
- 4 individuals were enrolled in the Living Well CDSMP (Chronic Disease Self-Management Program).
  - 4 participants completed the Living Well CDSMP program.

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



Community Action Partnership of Western Nebraska (CAPWN)

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

Target health issues

Cardiovascular disease, Diabetes

Dollars

$126,657.28 per year

People served

423

Project partners

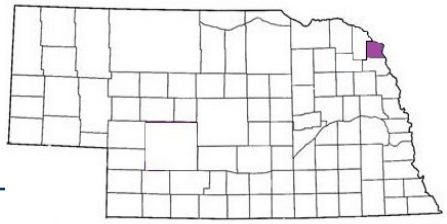
Lakota Lutheran Center, Guadalupe Center, UNMC

Year 2 Progress and Outcomes

- 165 screenings for hypertension, pre-diabetes, diabetes, or obesity were conducted.
- 93 individuals were linked to a medical home.
- 97 Individuals who enrolled in case management for hypertension.
  - 5 participants improved their blood pressure as a result of case management .
  - At least 5 participants maintained improved blood pressure at 6 and 12 months as a result of case management.
- 96 Individuals who enrolled in case management for diabetes
  - 7 participants improved their HbA1c as a result of case management .
  - At least 3 participants maintained improved HbA1c at 6 and 12 months as a result of case management .
- 4 individuals were enrolled into the DEEP program.
  - 1 participant improved their HbA1c.
  - 2 participant adhered to medication regimen.

Dakota County

Dakota County Health Department



Dakota County Health Department collaborated with local agencies to provide a Diabetes Self Management Education. The program involves facilitated group education, provider referrals and access to community resources to ensure an impact driven model centered on obesity, cardiovascular disease, (specifically hypertension and diabetes prevention), and increased awareness to improve participants' quality of life .

Target health issues

Obesity, Cardiovascular disease and Diabetes

Dollars

$90,731.20 per year

People served

134

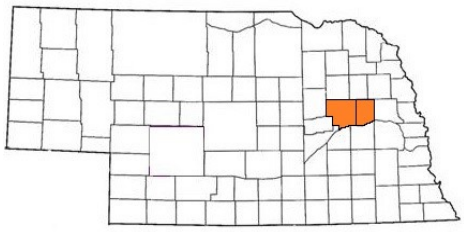
Project partners

YMCA, Local Churches, Local Clinics, Siouxland Community Health Center, WIC

Year 2 Progress and Outcomes

- 112 screenings were conducted for hypertension, diabetes, pre-diabetes, and/or obesity.
- 81 individuals have received referrals to additional services.
- 45 individuals were enrolled in DPP.
  - 15 participants have demonstrated knowledge increases as a result of health education.
  - 44 participants successfully completed a self-management plan.
  - 18 participants achieved their lifestyle change goals and maintained the change at 6 or 12 months.
  - 23 participants improved their blood pressure.
  - 17 participants reduced their weight, and 13 have maintained their weight loss.

Colfax & Platte Counties



East Central District Health Department

East Central District Health Department is implemented the "Eating Smart, Being Active" curriculum to reduce obesity for minority clients who have a BMI greater than ≥25. The program participants were 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.

Target health issues

Diabetes, Obesity and Cardiovascular disease

Dollars

$92,119.65 per year

People served

86

Project partners

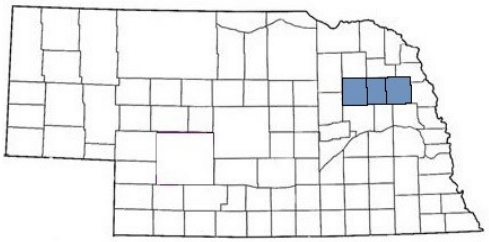
Good Neighbor Community Health Center,
CHI Health Clinic ,
St. Bonaventure Catholic Church

Year 2 Progress and Outcomes

- 31 individuals participated in Eating Smart, Being Active.
  - All participants received a series of 7 health education sessions.
  - 12 participants demonstrated knowledge increase as a result of the health education sessions.
  - 9 participants reduced their BMI.
  - 11 participants improved their nutrition practices.
  - 6 participants have maintained lifestyle changes at 6 or 12 months.
- 30 newly diagnosed diabetic patients were enrolled into case management.
  - 15 participants reported satisfaction with program services.
  - 11 participants improved their A1c levels.

Cuming, Madison, & Stanton Counties

Elkhorn Logan Valley Public Health Department



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

Target health issues

Obesity, Cardiovascular disease

Dollars

$68,284.63 per year

People served

34

Project partners

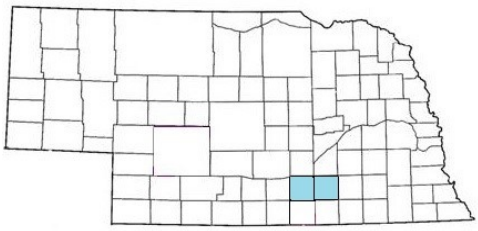
Midtown Health Center, Inc.

Year 2 Progress and Outcomes

- 24 individuals were screened for hypertension, diabetes, obesity, or pre-diabetes and enrolled in the Eating Smart Being Active program (ESBA).
  - 24 participants were provided a series of 6 sessions of ESBA.
  - 22 participants demonstrated knowledge increase as a result of health education.
  - 24 participants were satisfied with health education.
  - 18 participants improved their nutrition.
  - 16 increased their physical activity.
  - 22 participants reduced their weight.
  - 2 participants their BMI.
  - At least 22 participants have maintained weight loss at 6 or 12 months.
  - 24 participants have maintained lifestyle changes at 6 or 12 months.

Adams & Clay Counties

Mary Lanning Healthcare Foundation



Mary Lanning Healthcare Foundation provided the individual diabetes self-management education program "*El Paquete Total*". The program offered 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.

Target health issues

Obesity, Diabetes

Dollars

$40,669.95 per year

People served

267

Project partners

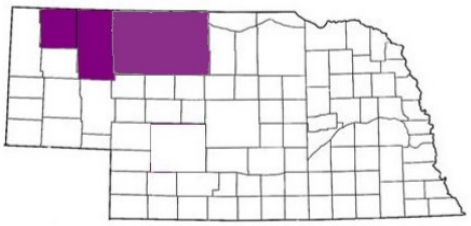
South Heartland District Health Department, Hastings Family YMCA, Community Health Clinic

Year 2 Progress and Outcomes

- 168 individuals participated in health education.
  - 64 participants indicated knowledge increase as a result of health education.
  - 146 participants indicate satisfaction with the health education.
- 141 individuals participated in diabetes case management.
  - 108 participants in diabetes case management developed a chronic disease self-management plan.
  - 46 participants reduced their weight.
  - 46 participants reduced blood pressure.
  - 17 participants have improved A1c levels.

Cherry, Dawes & Sheridan Counties

Nebraska Minority Resource Center



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

Target health issues

Obesity, Diabetes

Dollars

$25,127.05 per year

People served

63

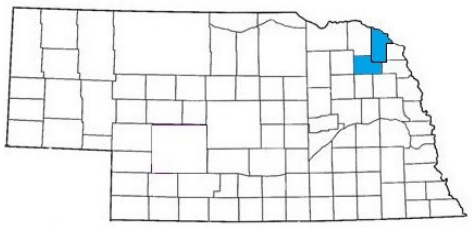
Project partners

Gordon-Valentine Hospitals, Valentine Public Library

Year 2 Progress and Outcomes

- 63 individuals received health education.
- 19 participants indicated satisfaction with health education.
- 19 participants demonstrated knowledge increase as a result of health education.
- 19 participants indicated satisfaction with program services.
- 7 participants achieved lifestyle change goals.
- 12 participants improved their blood pressure.
- 12 participants reduced their weight.
- 7 participants maintained lifestyle changes at 6 or 12 months.

Dixon & Wayne Counties



Northeast Nebraska Public Health Department

The Northeast Nebraska Public Health Department worked to prevent prevalence of chronic disease by offering the Living Well with Diabetes program consisting of education sessions that provided 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.

Target health issues

Obesity, Cardiovascular disease, Pre-diabetes and Diabetes

Dollars

$13,585.58 per year

People served

26

Project partners

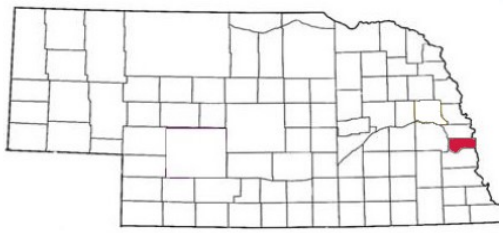
Salem Lutheran Church

Year 2 Progress and Outcomes

- 35 screenings for hypertension, diabetes, obesity, or pre-diabetes were completed.
- 9 individuals received health education through the Living Well With Diabetes program.
  - 1 participant demonstrated knowledge increase as a result of health education.
  - 7 participants indicated satisfaction with health education.
  - 2 participants indicated satisfaction with program services.
  - 2 participants achieved lifestyle change goals.
  - 10 participants improved their blood pressure.
  - 8 participants reduced their weight.

Sarpy County

OneWorld Community Health Center



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.

Target health issues

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

Dollars

$151,832.54 per year

People served

249

Project partners

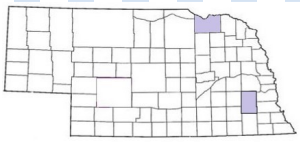
Dr. Richard Stacy, UNO

Year 2 Progress and Outcomes

- 220 screenings were conducted or hypertension, diabetes, obesity, and/or pre-diabetes.
- 27 people received referrals to additional services.
- 58 people were linked to medical homes.
- 93 participants demonstrated knowledge increase as a result of health education.
- 80 people improved their nutrition practices.
- 80 participants increased their physical activity.
- 18 participants reduced their BMI.
- 20 participants have improved their blood pressure.
- 9 participants have improved their A1c levels.
- 10 pre-diabetic participants either reduced their risk or are no longer at
- 29 participants maintained lifestyle changes at 6 or 12 months.

Knox & Lancaster Counties

Ponca Tribe of Nebraska



The Ponca Tribe of Nebraska worked with key partners to implemented a program adopted from the St. Johnsbury Community Health Team (CHT) model. The St. Johnsbury Community Health Team model involved the formation of a Community Connections Team consisting of Community Health Workers who implemented the DSME program; an Extended Community Health Team, included a broad representation of community partners who provide diverse psychosocial and health services to the community.

Target health issues

Obesity, Cardiovascular disease, Diabetes, and Pre-diabetes

Dollars

$440,812.87 per year

People served

838

Project partners

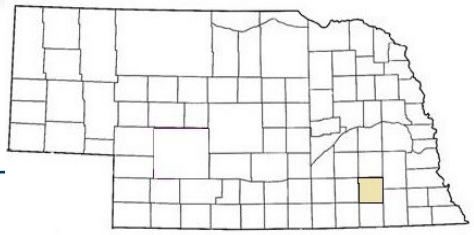
Asian Community and Cultural Center, El Centro de las Americas, Good Neighbor Community Center, Malone Community Center, Bluestem Health, Lincoln/Lancaster County Health Department, University of Nebraska-Lincoln Nutrition & Health Sciences Department

Year 2 Progress and Outcomes

- 1,897 screenings were conducted.
- 373 referrals were made from healthcare providers to CHWs.
- 168 individuals were linked to additional services.
- 575 individuals received health education.
- 230 individuals made lifestyle changes to improve health.
- 174 individuals increased physical activity.
- 241 individuals participated in healthy lifestyle support groups.
- 290 individuals attended physical activity support groups.
- 331 individuals received case management for high blood pressure; 165 of those improved blood pressure, and 151 maintained the improvement.
- 122 individuals increased knowledge as a result of health education.
- 182 individuals received case management for diabetes; 65 of those improved their A1c, and 17 maintained A1c improvement,
    - 109 participants reduced weight, and 85 maintained the weight loss at 6-12 months.
- 336 individuals completed the DSME (Diabetes Self Management) program:
    - 96 participants improved their blood pressure and 52 improved their A1c l levels as a result of completing DSME.
    - 114 participants reduced weight as a result of completing DSME,
- 278 individuals received free or reduced-cost dental services; of those 142 received specialty dental services to address chronic disease risk factors.

Saline County

Public Health Solutions



Public Health Solutions utilized 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 consulted with a public health nurse for clients identified as higher risk, and worked to reduce barriers to screening, primary care services, and self-management practices.

Target health issues

Diabetes (including pre-diabetes) and Obesity

Dollars

$32,618.88 per year

People served

101

Project partners

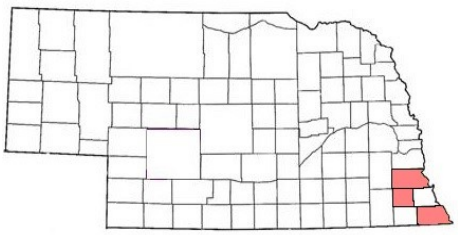
Saline Medical Specialties, Crete Area Medical Center

Year 2 Progress and Outcomes

- 101 screenings were conducted for diabetes, pre-diabetes, and/or obesity.
- 50 referrals were made to additional services.
- 60 individuals were linked to medical homes.
- 11 individuals were enrolled into the Diabetes Prevention Program (DPP).
  - 3 participants completed the Diabetes Prevention Program (DPP).
  - 2 participants reduced their risk and are no longer considered pre-diabetic.
  - 3 participants achieved lifestyle change goals.
  - 8 participants were adherent to their medication regimens.
- 23 participants with a diabetes diagnosis developed a chronic disease self-management plan as result of case management.
  - 5 individuals successfully completed a self-management plan.

Johnson, Otoe, & Richardson Counties

Southeast District Health Department



The Southeast Nebraska District Health Department (SEDHD) utilized the "Eat Healthy, Be Active" strategy to offer community workshops directed at reducing the risk for onset of hypertension, cholesterol and high blood glucose. Information addressing healthy living through diet, exercise, and regular monitoring of their health numbers was provided via one-to-one education and supplemented with written materials. Referrals to medical homes ensured the consistent monitoring of participants' health together with helping clients to understand the importance of regular health care provider visits. SEDHD partnered 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.

Target health issues

Obesity, Cardiovascular Disease, Diabetes (including Pre-diabetes)

Dollars

$25,416.31 per year

People served

148

Project partners

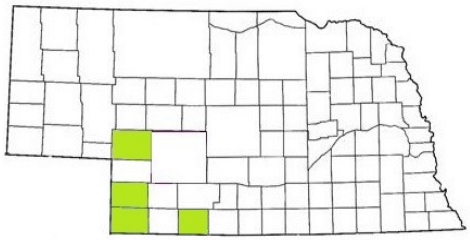
Local employers, SEDHD Immunization Clinic

Year 2 Progress and Outcomes

- 70 individuals participated in health screenings and health education sessions regarding hypertension, diabetes, pre-diabetes and/or obesity.
- 11 participants completed the "Eat Healthy, Be Active" program.
- 28 individuals were linked to medical homes
- 46 individuals received additional services.

Chase, Dundy, Keith, & Red Willow Counties

Southwest Nebraska Public Health Department



Southwest Nebraska Public Health Department (SWNPHD) implemented 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 testing results. Information about healthy living through diet, exercise, and regular monitoring of their health numbers was provided via one-to-one education and supplemented with written educational materials. Referrals to medical homes ensured consistent monitoring of participant's health to reinforce participants' understanding the importance of regular visits with the same health care provider.

Target health issues

Cardiovascular disease, Diabetes preventive screening, and Health education

Dollars

$19,100.82 per year

People served

47

Project partners

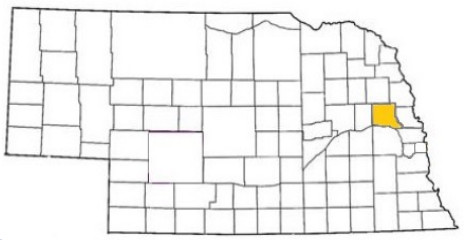
N/A

Year 2 Progress and Outcomes

- 46 screenings for hypertension, diabetes, obesity, or pre-diabetes were completed.
- 33 health education sessions were provided.
- 47 individuals received health education
  - 47 participants who received health education demonstrated increased knowledge.
- 22 referrals were made to additional services.

Dodge County

Three Rivers Public Health Department



Three Rivers Public Health Department utilized 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 had access to a support group comprised of individuals with similar goals and challenges and to share ideas, celebrate successes, and work together to overcome obstacles as they meet long-term lifestyle change goals.

Target health issues

Diabetes (including pre-diabetes)

Dollars

$44,073.58 per year

People served

27

Project partners

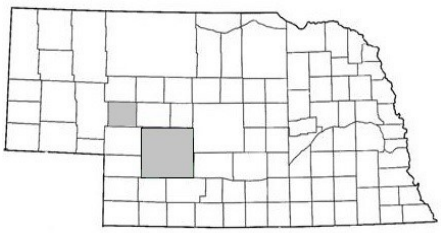
Good Neighbor Fremont (FQHC), Fremont Health Medical Center

Year 2 Progress and Outcomes

- 7 individuals were enrolled into the NDPP program.
  - 39 DPP health education sessions were completed.
  - 7 participants completed the NDPP program.
  - 2 participants achieved lifestyle change goals.
  - 4 participants reduced their weight.
  - 4 participants maintained their weight loss.
  - 3 participants pre-diabetic participants reduced their risk and are no longer considered pre-diabetic.
  - 3 participants maintained improved A1c levels at 6 or 12 months.
  - 6 participants maintained lifestyle changes at 6 or 12 months.

Arthur & Lincoln Counties

West Central District Health Department



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

Target health issues

Obesity, Cardiovascular disease, and Diabetes

Dollars

$34,441.22 per year

People served

180

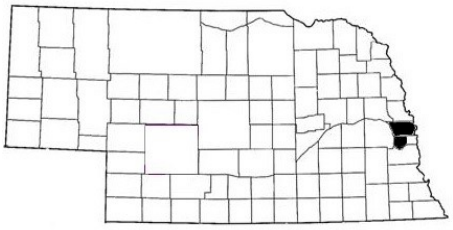
Project partners

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

Year 2 Progress and Outcomes

- 163 screenings were administered for hypertension, diabetes, obesity, and/or pre-diabetes.
- 47 individuals were enrolled in case management
  - As a result of case management, 39 participants maintained improved blood pressure at 6 or 12 months.
- 43 participants were enrolled into the Road to Health (RTH) program.
  - 24 health education sessions were provided to Road to Health participants
  - 28 participants demonstrated knowledge increase as a result of health education.
  - 3 participants reduced their Body Mass Index (BMI).
  - 9 participants improved their blood pressure.

Douglas County



Charles Drew Health Center
Federally Qualified Health Care Funding

Also included in the appropriation was annual funding distributed equally among Federally Qualified Health Centers (FQHCs) in the second Congressional District. Charles Drew Health Center utilized the funding to implement a minority health initiative which targeted, but was not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma. The information below is for all people served by the organization.

Target health issues

Cardiovascular disease, Asthma, Diabetes, Obesity, Infant mortality

Dollars

$688,550.00 per year

People served

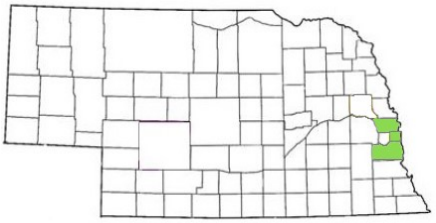
11,745

Activities & Outcomes July 1, 2018—June 30, 2019

- 93% of patients ages 12 years and over were screened for depression and had a documented follow-up plan if patient was considered depressed.
- A total of 655 adult patients, aged 18 years and over, with a diagnosis of Type I or Type II diabetes reached a A1c level of less than <9%.
- *199 (84%)* of patients 5-40 years of age with a diagnosis of mild, moderate or severe persistent asthma were treated with an accepted Inhaled corticosteroid or an accepted alternative medicine.
- *770 (51%) of* adult patients, aged 52 -85 years, with a diagnosis of hypertension continued to maintain control of their hypertension (BP less than 140/90).
- 155 women accessed prenatal care with 55% initiating their prenatal care during the first trimester; the percentage of births less than <2500 grams was 4.9%.
- The percentage of patients 3-17 years of age with weight assessment and counseling for nutrition and physical activity was 84.4%.
- The percentage of adult patients with weight screening and follow-up increased from 64% to 65%.
- 69% of adult patients diagnosed with tobacco use were prescribed cessation medication.
- 90% of children between 6 and 9 years old were provided with dental sealants.
- The percentage of children who were fully immunized by their 2nd birthday increased from 61% to 71%.

Cass, Douglas, and Sarpy Counties

OneWorld Community Health Center
Federally Qualified Health Care Funding



Also included in the appropriation was annual funding distributed equally among Federally Qualified Health Centers (FQHCs) in the second Congressional District. OneWorld Community Health Center utilized the funding to implement a minority health initiative which targeted, but was not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma. The information below is for all people served by the organization.

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

46,292

Activities & Outcomes July 1, 2018—June 30, 2019

- 1,586 prenatal patients were provided services with 80.5% accessing care in the first trimester; the percentage of births less than <2,500 grams was 9.5%.
- 1,760 minority patients had their hypertension in control.
- 1,845 minority patients diagnosed with diabetes achieved A1c results below ≤9%.
- 14,244 children received the appropriate immunizations before their second birthday.
- 97.6% of adult patients were screened and counseled for tobacco use.
- 3,613 patients diagnosed with depression and other mood disorders were provided with therapeutic supports.
- 93.7% of patients aged 12 and older were screened for depression and a follow-up plan was provided as appropriate.
- 5,941 patients received pediatric dental services.
- 98.2% of people with persistent asthma were placed on a pharmacological treatment plan.
- 80.5% of adult patients (18 years and older) had a documented BMI percentile and if determined to be under-/overweight were provided with a follow-up plan.
- 91.7% of patients aged 3 to 17 years were documented on the Body Mass Index (BMI) percentile and received counseling on nutrition and physical activity.

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