2019-2020 MINORITY HEALTH INITIATIVE

Annual Report

December 1, 2020

In accordance with Nebraska State Statute 71-1628.07

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Office of Health Disparities and Health Equity

Division of Public Health

From the Administrator...

This report was produced by the Nebraska Department of Health and Human Services (DHHS) Office of Health Disparities and Health Equity (OHDHE) to highlight progress and outcomes of the Minority Health Initiative (MHI) funding for the 2019-2020 period. The Nebraska Legislature allocated funding for Minority Health Initiatives 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 goal of the Minority Health Initiative programs is to work collaboratively with stakeholders to assist in the elimination of health disparities disproportionately impacting minority populations in Nebraska. Populations served include racial and ethnic minorities, American Indians, and refugees. The OHDHE uses a competitive process to award funding.

To enhance the reporting of health outcomes of the MHI program, the OHDHE changed the program and created a new request for proposal (RFP) for the funding period of January 1, 2020- June 30, 2020 to focus on diabetes management for minorities. This decision was made because data continues to demonstrate that diabetes is one of the leading causes of death for minorities in Nebraska (DHHS, Vital Statistics 2008-2007). In addition, large disparities exist in the prevalence of diabetes between non-Hispanic Whites and minorities in Nebraska. With the intent of improving health outcomes for minorities in Nebraska, the OHDHE also included the integration of public health and primary care, which supports the integrated health system priority in the 2017-2021 Nebraska State Health Improvement Plan. As changes to the new RFP were being made, it was determined additional time was needed to issue the RFP, therefore OHDHE extended the previous year (2018-2019) grants through December 2019. The new Diabetes Care Management for Minorities RFP was issued in October 2109 and due to unforeseen delays, contracts with the awarded agencies did not begin until March 2020.

This report includes the two separate methodologies applied during the 2020 state fiscal year: the six month extension period for grantees from the previous award period, and the first six months of the new diabetes management for minorities contracts. Also included in the appropriation is annual funding distributed equally among community health centers funded by Federal program 330 in the second Congressional District, to implement a minority health initiative. These funds were not included in the competitive request for proposals, therefore the reports included for this funding are for the full 2019 - 2020 year. This report illustrates the outcomes achieved and work completed for the July 1, 2019 - June 30, 2020 funding year.

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

Table of Contents

List of Minority Health Initiative Grants, Contracts, and Community Health Centers 4
People Served 6
Summaries of Activities and Outcomes 8
Minority Health Initiative Grants Map 13
Project Summaries (Congressional Districts 1 & 3)
- Carl T. Curtis Health Center/Omaha Tribe 14
- Central District Health Department 15
- Community Action Partnership of Mid-Nebraska 16
- Community Action Partnership of Western Nebraska 17
- Dakota County Health Department 18
- East Central District Health Department 19
- Elkhorn Logan Valley Public Health Department 20
- Mary Lanning Healthcare Foundation 21
- Nebraska Minority Resource Center 22
- Northeast Nebraska Public Health Department 23
- OneWorld Community Health Center 24
- Ponca Tribe of Nebraska/Cultural Centers Coalition 25
- Public Health Solutions District Health Department 26
- Southeast District Health Department 27
- Southwest Nebraska Public Health Department 28
- Three Rivers Public Health Department 29
- West Central District Health Department 30

Diabetes Care Management for Minorities Minority Health Initiative Contracts Map 31
Diabetes Care Management for Minorities Contract Summaries (Congressional Districts 1 & 3)
- Central District Health Department 32
- Dakota County Health Department 33
- MyVitalz East 34
- MyVitalz East 35
- OneWorld Community Health Center 36
- West Central District Health Department 37

Community Health Centers funded by Federal Program 330 in Congressional District 2
- Charles Drew Health Center 38
- One World Community Health Center 39

Risk Factors Related to Priority Issues 40
Death Rates Related to Priority Issues 41
Definitions of Key Terms 43
Reference Section 44

Minority Health Initiative Six-month Extension Projects (7/2019—12/2019)

Projects (Congressional Districts 1 & 3)	Amount	County(ies)
Carl T. Curtis Health Center/Omaha Tribe	$20,253.02	Thurston
Central District Health Department	$77,473.46	Hall, Merrick
Community Action Partnership of Mid-Nebraska	$70,661.40	Buffalo, Dawson, Kearney, Phelps,
Community Action Partnership of Western Nebraska	$63,328.64	Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sioux
Dakota County Health Department	$45,365.60	Dakota
East Central District Health Department	$46,059.83	Colfax, Platte
Elkhorn Logan Valley Public Health Department	$34,142.31	Cuming, Madison, Stanton
Mary Lanning Healthcare Foundation	$20,334.97	Adams, Clay
Nebraska Minority Resource Center	$12,563.53	Cherry, Dawes, Sheridan
Northeast Nebraska Public Health Department	$6,792.79	Dixon, Wayne
One World Community Health Center	$75,916.27	Sarpy (in CD1)
Ponca Tribe of Nebraska/Cultural Centers Coalition	$220,406.44	Knox, Lancaster
Public Health Solutions (contract)	$16,309.44	Saline
Southeast District Health Department	$12,708.15	Johnson, Otoe, Richardson
Southwest Nebraska Public Health Department	$9,550.41	Chase, Dundy, Keith, Red Willow
Three Rivers Public Health Department	$22,036.79	Dodge
West Central District Health Department	$17,220.60	Arthur, Lincoln
TOTAL	$771,123.65	

Diabetes Care Management for Minorities - Minority Health Initiative Contracts

January 1, 2020 - June 30, 2021 period

Contracts are for 18 months—6 month progress is included in this report period

Contracts (Congressional Districts 1 & 3)	18 Months Period	Region and Counties
Central District Health Department	$324,355.50	**East Central Region** - Adams, Clay, Hall, Merrick, and York Counties
Dakota County Health Department	$231,678.00	**Northeast Region** - Dakota, Dixon, Knox, Wayne, and Thurston Counties
MyVitalz East	$306,750.00	**Eastern Region** - Dodge, Madison, Stanton, Cuming, Platte, and Colfax Counties
MyVitalz West	$227,750.00	**Western Region** - Sioux, Dawes, Sheridan, Cherry, Deuel, Box Butte, Scotts Bluff, Morrill, Garden, Kimball, and Cheyenne Counties
OneWorld Community Health Center	$227,746.80	**Metro Region** - Sarpy County (Congressional District 1 portion only)
West Central District Health Department	$292,320.00	**West Central Region** - Phelps, Kearney, Dundy, and Red Willow Counties
Contractor withdrew from funding	$733,644.80	**Southeast Region** - Lancaster, Saline, Otoe, Johnson , and Richardson Counties
TOTAL	**$2,344,245.10**	

Community Health Centers funded by Federal Program 330 in Congressional District 2

July 1, 2019 - June 30, 2020

Community Health Center	Amount
Charles Drew Health Center	$688,550.00
One World Community Health Center	$688,550.00
TOTAL	**$1,377,160.00**

People Served

Demographic information of the clients served by the Minority Health Initiative projects for the period July 1, 2019 through December 31, 2019 time period are shown below. These numbers represent all individuals served by the projects.

Participant Demographics	
Total number served	1,133
Age	
0-17	133
18-24	58
25-64	882
65+	60
Total	1,133
Gender	
Female	784
Male	349
Total	1,133
Race and Ethnicity	
African American or Black	57
American Indian/Alaska Native	114
Asian	73
Hispanic, any race	725
Non-Hispanic, White	70
Other, missing, not sure, or refused	74
Two or more races	20
Total	1,133
Refugee Status	
Refugee	73
Non-refugee	892
Total	965[A]
Preferred/Primary Language	
English	337
Spanish	625
Arabic	40
Other	131
Total	1,133
Insurance Status	
Private Insurance	320
Medicaid	339
No Insurance	474
Total	1,133

[A] 168 individuals did not designate Refugee status.

People Served

***Demographic information for clients served by the Diabetes Care Management for Minorities Minority Health Initiative for the January 1, 2020 through June 31st, 2020 time period are shown below.* These numbers represent all individuals served by the projects.**

Participant Demographics	
Total number served	290
Race and Ethnicity	
African American or Black	10
American Indian/Alaska Native	13
Asian	7
White, Hispanic	220
Other	10
Total	256
Ethnicity	
Hispanic	240
Non-Hispanic	47
Total	287
Insurance Status	
Medicare	3
Medicaid	66
Private Insurance	137
No Insurance	84
Total	290

MINORITY HEALTH INITIATIVE GRANTS

Six Month Extension

Summary of Activities and Outcomes

Total number of people served

1,133

Served by

31.63

Full-time public health staff

Includes projects in
Congressional Districts 1 & 3 Extension only

HEALTH SCREENINGS

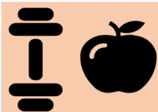
1,297

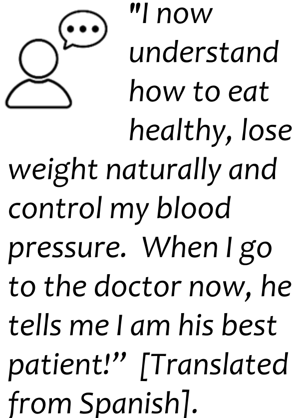
individuals were screened for hypertension, diabetes, obesity, or pre-diabetes

REFERRALS

462

people received referrals to additional services





HEALTH EDUCATION

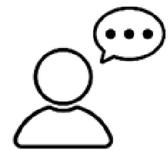
631

minorities received at least one or more health education tutorial

673

participants demonstrated knowledge increase as a result of health education

- **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].



"I don't want to think about what could have happened without the health classes. I am motivated and feel great from following the life changes and am sharing what I learned with my family!"

MINORITY HEALTH INITIATIVE GRANTS

Six Month Extension

Summary of Activities and Outcomes

Diabetes Prevention and Management Programs

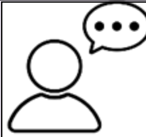
175

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

248*

participants completed a diabetes prevention and management program

*some graduates had been enrolled in a prior session, and completed the course during this reporting period



"This [DSME] program brings me back to life. My A1C was 12.3 and I had given up. Now it is 7.4—how amazing that is! I have peer support now to tell someone how I feel and how hard I am trying so I feel more connected. My family has made it a routine to go to the gym together, and I feel happier and motivated. Thank you for caring about my health and me."

"My doctor referred me to the Living Well with Diabetes program. I had a heart attack and my health care provider told me I would never be the same, and could no longer do the same things as before. After taking Living Well I made the changes I thought were impossible to achieve, but found that I am able to do those things again and my whole life has improved."

"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]."

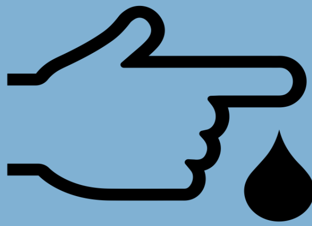
Health Impact:

- 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%[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 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%.[7]

MINORITY HEALTH INITIATIVE GRANTS

Six Month Extension

Summary of Activities and Outcomes



Diabetes

133

participants improved their diabetes Hemoglobin A1C rate

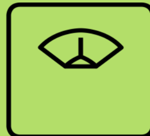
Blood Pressure

29

participants have improved their blood pressure

"Now I understand the proper care and have the right medication to control my high blood pressure. I am grateful for your help."

"I have lost over 50 pounds since starting the program. I did not know how much sugar was in one drink! Now I can better help and monitor my granddaughter who has Type 2 diabetes. At the grocery store, I have the constant voice of the CHW about what to buy to eat!



Weight Loss

300

participants reduced their weight

326*

maintained their weight loss

*measures were taken after 6 or 12 months for some participants in a prior session

Medical Home

249

people were linked to a medical home

"I knew I needed to change my lifestyle because of my medical struggles. The CHW helped me find a medical home doctor. After making the changes recommended by my doctor my blood pressure and glucose levels have gone down and I take my condition seriously."

DIABETES CARE MANAGEMENT FOR MINORITIES

Minority Health Initiative Contracts (6 month period)

Summary of Activities Outcomes

A total of **290** patients were served within this period

A total of **667** encounters were made between a Community Health Worker (CHW) and each patient

CHWs met with primary health care team **570** times to talk about each patient

OUTREACH EFFORTS

- Patients were issued a diabetic kit and test strips and trained on its use.
- Outreach efforts with patients were conducted by phone.
- Clinics are taking all possible efforts to keep the facilities clean and safe.
- Informational letters and program flyers were provided to clinics

8 CHWs completed the **Living Well** Training.

8 CHWs completed the **CLAS** Training

DIABETES CARE MANAGEMENT FOR MINORITIES

Minority Health Initiative Contracts (6 month period)

Summary of Activities and Outcomes

120 patients were issued a diabetic kit and trained on its use

16 Patients

Received information on healthy eating and physical activity

12 Patients

Received education on diabetes, blood pressure, and cholesterol

6 Patients

Received assistance with interpretation services

4 Patients

Assisted in obtaining/ restocking medication

12 Patients

Referred to finance department to receive financial assistance

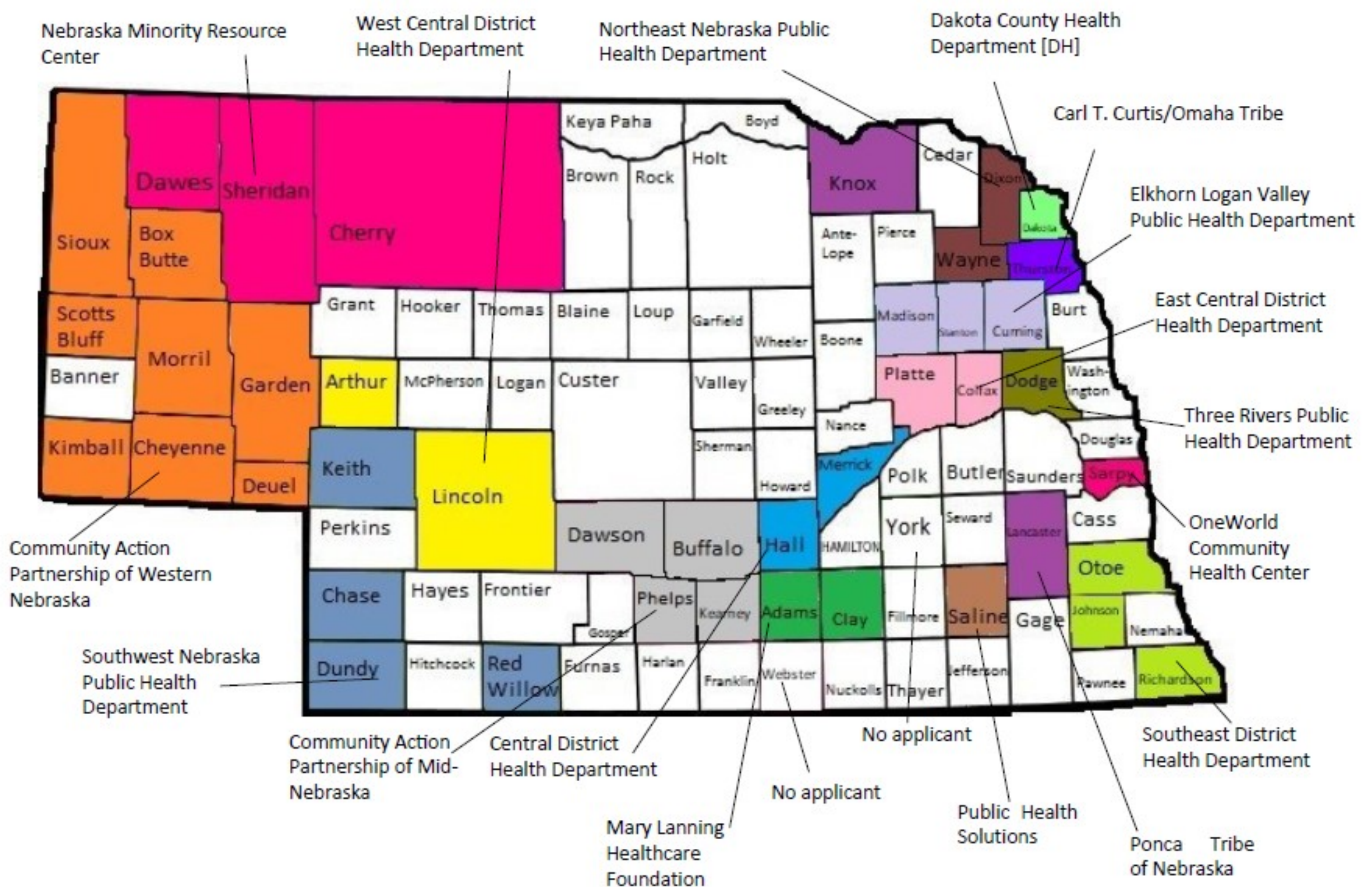
8 Patients

Received assistance in scheduling doctor appointments

A total of **213** patients showed improvement on their blood glucose level

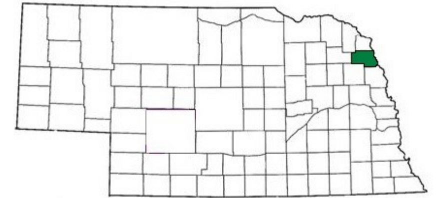
Grantee Reports

Summaries of the project outcomes for the six-month extension period for the 2017-2019 Minority Health Initiative grants begin on page 13. 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 for the half-year, the targeted health issues addressed, the project partners, the number of people served for the extension period, and outcomes achieved from July 1, 2019 through December 31, 2019. A map of the 2017 - 2019 MHI projects during the extension period is shown below.



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 and improve the quality of life for American Indians who have, or are at risk. The project increased participants' knowledge, skill, and ability necessary for diabetes self-care and equipped 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. Improve their health status and quality of life.

Target health issue
Diabetes

Dollars
$20,253.02
[six month extension period]

People served
30

Project partners
Winnebago Health Department,
Four Hills of Life Wellness Center

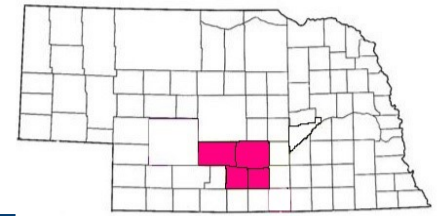
Six month Progress and Outcomes

30 new individuals were enrolled into the DSME program.

- Of the 30 enrolled into the DSME program, 10 participants completed the program.
- 30 participants developed a self-management plan.
- 10 participants who completed the DSME program demonstrated knowledge increase as a result of health education.
- 10 of program graduates indicated satisfaction with the health education.
- 5 participants have improved blood pressure.
- 9 participants improved their A1C levels.
- 3 participants reduced their weight.
- 3 participants reduced their BMI.

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
$70,661.40 [six month extension period]

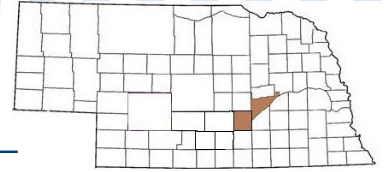
People served
40

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

Six month Progress and Outcomes

- 22 screening for hypertension, diabetes, obesity, and/or pre-diabetes were completed.
- 36 people were newly diagnosed with diabetes or high blood pressure.
- 34 people received referrals to additional services.
- 40 individuals participated in at least one or more health education sessions.
- 17 participants indicated satisfaction with a health education session.
- 21 participants were enrolled into the Living Well CDSMP (Chronic Disease Self-Management Program).
    - 9 enrollees graduated the Living Well CDSMP program.
    - 9 participants reduced their A1C levels to within normal range.

Hall & Merrick Counties



Central District Health Department

Central District Health Department continued 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. Living Well is a chronic disease self-management program, which helped people with diagnoses of diabetes and other chronic conditions and learn how to be as healthy as they can be.

Target health issues
Cardiovascular disease, Diabetes/ Pre-diabetes, Obesity

Dollars
$77,473.46
[six month extension period]

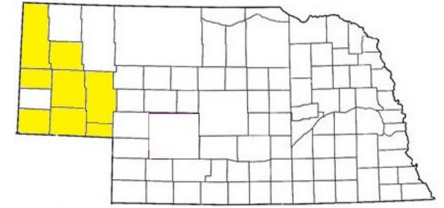
People served
70

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

Six month Progress and Outcomes

- CHWs provided education, outreach, and referral services to 70 individuals
- 62 participants were provided with outreach, education, networking, and other services to assisting with overcoming barriers in attending community classes or diabetes management plans
- 52 linkages were made between clients and additional resources.
- 12 individual were enrolled into the Living Well with Diabetes Program
  - 5 individuals completed the program
  - 5 individuals completed a self-management plan
  - 5 participants reduced weight
- 5 individuals were enrolled in the Diabetes Prevention Program*
  - 5 participants completed the DPP program.
  - 5 participants improved nutrition.
  - 5 participants increased their physical activity.
  - 5 participants reduced their BMI.

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
$63,328.64
[six month extension period]

People served
93

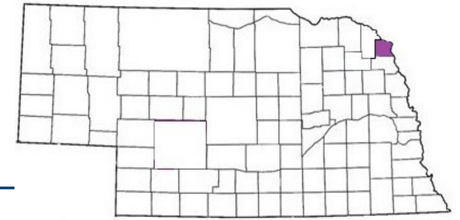
Project partners
Lakota Lutheran Center, Guadalupe Center, UNMC

Six month Progress and Outcomes

- 62 people were newly diagnosed with diabetes or high blood pressure.
- 93 individuals were linked to a medical home.
- 93 transportation services were provided.
- 93 participants demonstrated knowledge increase as a result of one or more health education sessions.
- 57 visits were completed by a case manager.
- 51 participants diagnosed with hypertension developed a chronic disease self-management plan.
- 4 participants improved their blood pressure.
- 3 participants maintained improved blood pressure at 6 or 12 months .

Dakota County

Dakota County Health Department



Dakota County Health Department collaborated with local agencies to provide 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
$45,365.60
[six month extension period]

People served
49

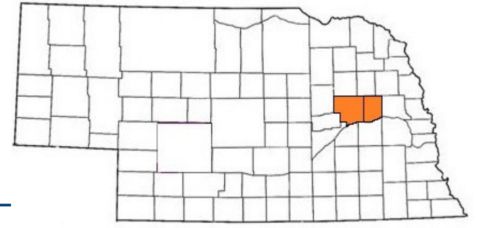
Project partners
YMCA, Local Churches, Local Clinics, Siouxland Community Health Center, WIC

Six month Progress and Outcomes

- 49 people were newly diagnosed with diabetes or high blood pressure.
- 49 individuals received referrals to additional services.
- 49 people received one or more visits with a case manager/community health worker (CHW).
- 49 people indicated satisfaction with one or more program services.
- 16 new beginners were enrolled in diabetes self education program.
    - 17 learners demonstrated knowledge increases as a result of one or more health education sessions.
    - 4 participants achieved their lifestyle change goals and all 4 of those maintained the changes at 6 or 12 months.
    - 11 participants improved their blood pressure.

Colfax & Platte Counties

East Central District Health Department



East Central District Health Department 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 $46,059.83

$46,059.83 [six month extension period]

People served
29

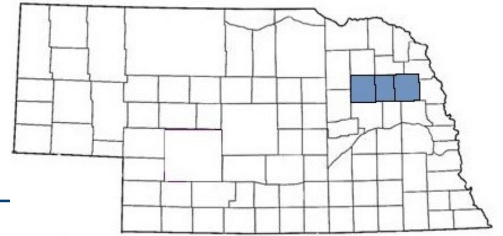
Project partners
Good Neighbor Community Health Center,
CHI Health Clinic ,
St. Bonaventure Catholic Church

Six month Progress and Outcomes

- 29 people received a series of 7 health education sessions.
    - 12 participants demonstrated knowledge increase as a result of the health education sessions.
    - 3 participants reduced their BMI.
    - 4 participants improved their nutrition practices.
    - 6 participants have maintained lifestyle changes at 6 and/or 12 months.
- 17 newly diagnosed diabetic patients were enrolled into case management.
    - 3 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 management.

Target health issues
Obesity, Cardiovascular disease

Dollars
$34,142.31
[six month extension period]

People served
8

Project partners
Midtown Health Center, Inc.

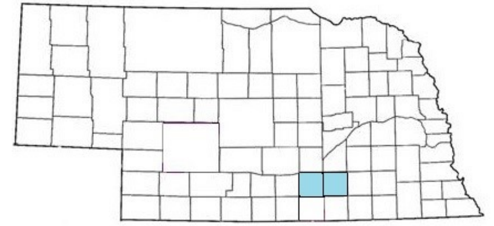
Six month Progress and Outcomes

- 8 people were provided with a (8-session series) of health education services.
- 8 learners demonstrated knowledge increase as a result of health education.
- 8 participants indicated satisfaction with health education.
- 10 people improved their nutrition.*
- 8 persons reported increasing their physical activity.
- 8 participants reduced their weight.
- 3 participants reduced their BMI.
- At least 20 participants have maintained weight loss at 6 or 12 months.*
- 23 clients have maintained lifestyle changes at 6 or 12 months. *

**Numbers counted include participants enrolled in prior program services.*

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 to improve health status and quality of life.

Target health issues
Obesity, Diabetes

Dollars
$20,334.97
[six month extension period]

People served
7

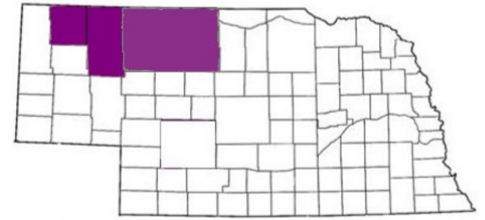
Project partners
South Heartland District Health Department,
Hastings Family YMCA,
Community Health Clinic

Six month Progress and Outcomes

- 123 individuals participated in health education.*
    - 256 post-tests indicated knowledge increase as a result of at least one or more health education tutorials.
    - 146 participants indicate satisfaction with the health education.
- 303 case management encounters were completed.*
    - 207 clients in on-going diabetes case management developed a chronic disease self-management plan.
    - 30 participants reduced their weight.
    - 31 participants have improved A1C levels.

**Numbers counted include participants enrolled in prior program services.*

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. Youth and families, parents and/or guardians were involved 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 $12,563.53

$12,563.53
[six month extension period]

People served
31

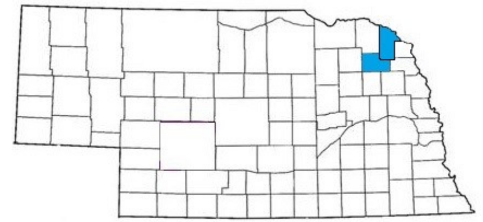
Project partners
Gordon-Valentine Hospitals, Valentine Public Library

Six month Progress and Outcomes

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

Dixon & Wayne Counties

Northeast Nebraska Public Health Department



The Northeast Nebraska Public Health Department worked to reduce 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
$6,792.79
[six month extension period]

People served
3

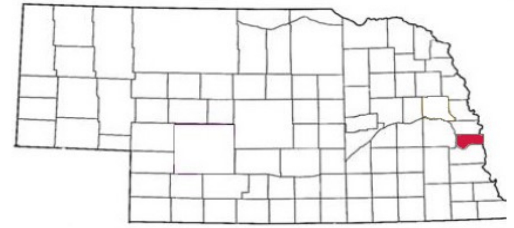
Project partners
Salem Lutheran Church

Six month Progress and Outcomes

- 3 individuals received health education through the Living Well With Diabetes program.
    - 1 participant demonstrated knowledge increase as a result of health education.
    - 1 participant indicated satisfaction with health education.
    - 1 participant indicated satisfaction with program services.
    - 1 participant achieved lifestyle change goals.
    - 1 participant improved their blood pressure.
    - 1 participant reduced their weight.

Sarpy County (in CD1)

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 received education addressing healthy lifestyle choices, connection to a medical home, and access to other community resources to manage and improve their health conditions.

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

Dollars
$75,916.27

[six month extension period]

People served
107

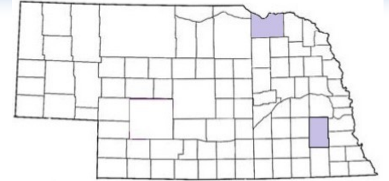
Project partners
Dr. Richard Stacy, UNO

Six month Progress and Outcomes

- 107 screenings were conducted or hypertension, diabetes, obesity, and/or pre-diabetes.
- 45 people received referrals to additional services.
- 20 people were linked to medical homes.
- 107 participants demonstrated knowledge increase as a result of health education.
- 94 people improved their nutrition practices.
- 94 participants increased their physical activity.
- 40 participants reduced their BMI.
- 12 participants have improved their blood pressure.
- 10 participants have improved their A1C levels.
- 5 pre-diabetic participants either reduced their risk or are no longer at risk.
- 94 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 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 involved the formation of a Community Connections Team where CHWs implemented the DSME program; an Extended Community Health Team, with a broad representation of community partners who provide diverse psychosocial and health services to the community; Advanced Primary Care Practices linked patients with medical homes; and an Administrative Core managed integration of CHT components.

Target health issues
Obesity, Cardiovascular disease, Diabetes, and Pre-diabetes

Dollars
$220,406.44 [six month extension period]

People served
437

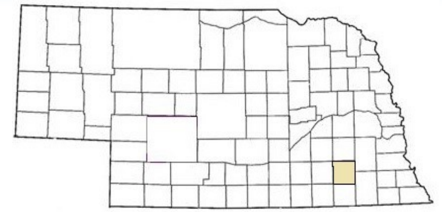
Project partners
Asian Community and Cultural Center, El Centro de las Americas, Good Neighbor Community Center, Malone Community Center, Bluestem Health, Lincoln/Lancaster County Health Department, University of Nebraska-Lincoln Nutrition & Health Sciences

Six month Progress and Outcomes

- 398 screenings were conducted.
- 298 referrals were made from healthcare providers to CHWs.
- 180 individuals were linked to additional services.
- 387 people received health education.
- 425 individuals made lifestyle changes to improve health, and 197 of those maintained their lifestyle changes at 6 or 12 months.
- 174 individuals increased physical activity.
- 352 learners increased knowledge as a result of at least one or more health education classes.
- 163 participants improved their blood pressure.
- 250 participants reduced weight, and 306 maintained the weight loss at 6-12 months.
- 129 new enrollees completed the DSME program.
- 51 participants reduced weight as a result of completing DSME.
- 87 DSME graduates improved their A1C levels, and 84 maintained A1C improvement at 6 or 12 months.

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
$16,309.44
[six month extension period]

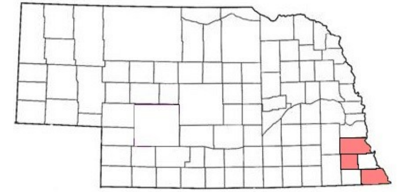
People served
30

Project partners
Saline Medical Specialties,
Crete Area Medical Center

Six month Progress and Outcomes

- 15 people indicated satisfaction with program services.
- 15 participants indicate improvements in attitudes resulting from health
- 30 participants received one or more visits with a case manager/Community Healthy Worker (CHW).
- 5 people improved their A1C levels.

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 which helped clients 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
$12,708.15
[six month extension period]

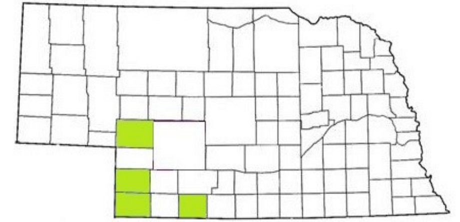
People served
11

Project partners
Local employers, SEDHD Immunization Clinic

Six month Progress and Outcomes

- 11 individuals participated in health screenings and health education sessions regarding hypertension, diabetes, pre-diabetes and/or obesity.
- 11 people were linked to medical homes .

Chase, Dundy, Keith, & Red Willow Counties



Southwest Nebraska Public Health Department

Southwest Nebraska Public Health Department (SWNPHD) implemented the "Eating Smart, Being Active" program to provide health screenings and education to participants' relevant 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
$9,550.41
[six month extension period]

People served
36

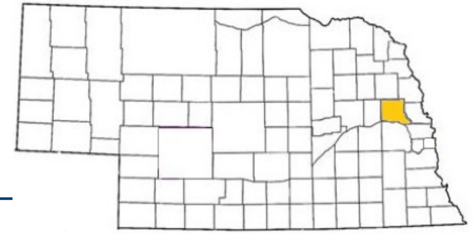
Project partners

Six month Progress and Outcomes

- 36 screenings for hypertension, diabetes, obesity, or pre-diabetes were completed.
- 21 health education sessions were provided.
- 21 individuals received health education:
    - 21 participants who received health education demonstrated increased knowledge.
    - 21 participants indicated satisfaction with the health education.
- 21 referrals were made to additional services.
- 21 follow-ups by a Community Health Worker were made.

Dodge County

Three Rivers Public Health Department



A Community Health Worker delivered the national Diabetes Prevention Program (DPP) to prevent Type 2 diabetes in clients assessed as pre-diabetic. An educational curriculum with accompanying materials and other resources to promote healthy change, were offered, 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
$22,036.79
[six month extension period]

People served
38

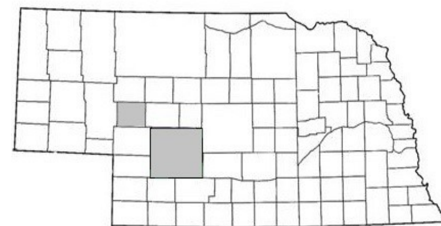
Project partners
Good Neighbor Fremont (FQHC), Fremont Health Medical Center

Six month Progress and Outcomes

- 38 people were screened for hypertension, diabetes, obesity, or pre-diabetes.
- 6 people were referred to the program by healthcare providers.
- 11 people received at least one or more case management sessions for diabetes with a total of 44 case management visits completed overall.
  - 7 participants reported knowledge increase as a result of case management activities.
  - 6 participants improved their nutrition practices.
  - 9 people increased their physical activity.
  - 5 participants have maintained their weight loss.
  - 2 pre-diabetic participants reduced their risk and are no longer considered pre-diabetic.
  - 2 participants maintained improved A1C levels at 6 or 12 months.
  - 12 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" 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
$17,220.60 [six month extension period]

People served
41

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

Six month Progress and Outcomes

- 132 screenings were administered for hypertension, diabetes, obesity, and/or pre-diabetes.
- 41 people were newly diagnosed with diabetes or high blood pressure.
- 17 case management visits were completed.
- 9 people received a health education session.
- 15 participants have maintained the reduction in their Body Mass Index (BMI) at 6 or 12 months.
- 25 people lowered their blood pressure.
- 2 participants improved their A1C measures.

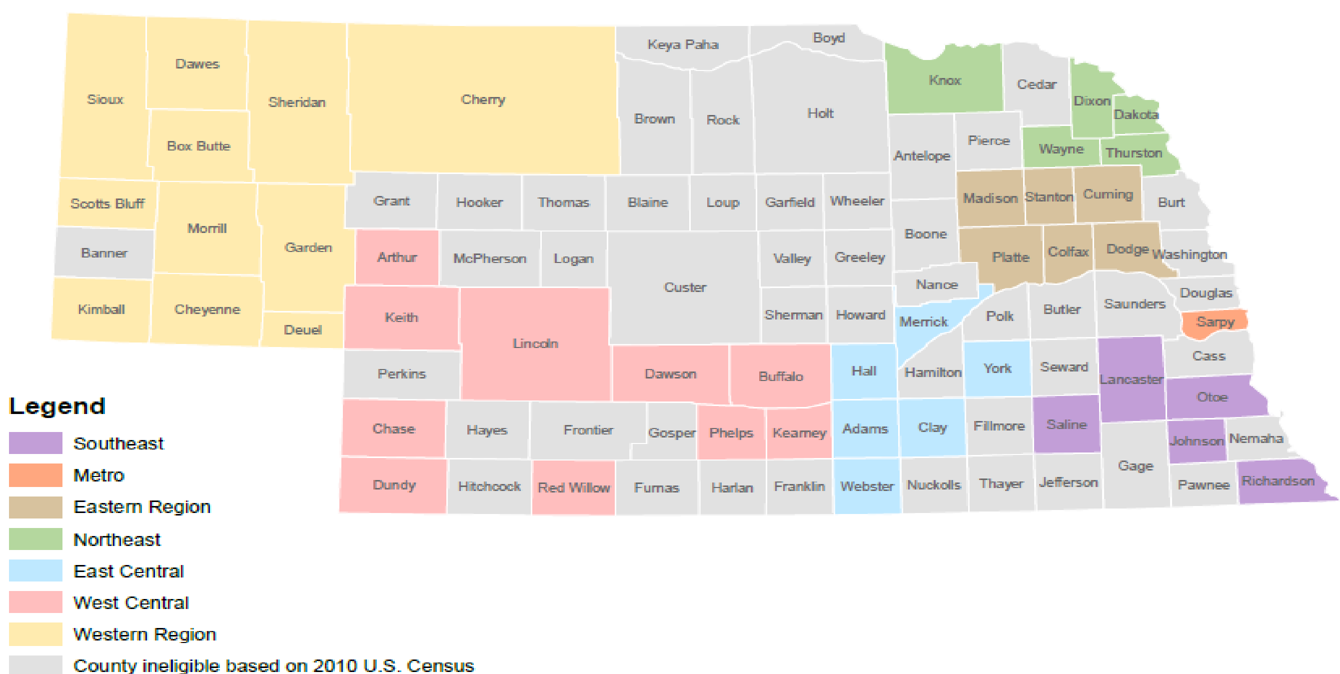
Diabetes Care Management for Minorities - Minority Health Initiative Contracts

The Office of Health Disparities and Health Equity (OHDHE) awarded six contracts to qualified bidders. The MHI diabetes care management for minorities goal is to improve health outcomes for minority populations diagnosed with diabetes in Nebraska's first and third Congressional Districts through referrals from physicians for the services of Community Health Workers (CHW). The intent of MHI projects is to promote community and clinical linkages to lower diabetes hemoglobin A1C (HbA1C) rates for minority populations through referral systems that use bidirectional linkages that include a Community Health Worker. The A1C reading is an average measurement of glucose levels over three or more months. Progress towards reduced A1C readings will be seen in the next reporting period.

A summary of progress towards achieving the reduction of diabetes hemoglobin A1C rates for patients served by each contractor between January 1, 2020 - June 30, 2020 are included on pages 32 through 38. The summaries are arranged alphabetically by grantee name, and include a brief description of each project, the total amount of funding received (18 months), the region and counties covered by the project, and a summary of work completed for the six month time period that this report covers. The COVID-19 pandemic has had a major impact on the start of projects. Local response and mitigation by organizations has necessitated a redirected focus on immediate public health concerns rather than diabetes management. A map of the regions eligible for the Diabetes Care Management for Minorities is shown below.

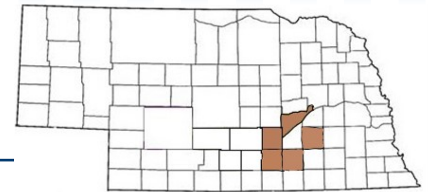
Also included in the appropriation is minority health initiative funding through the Federal 330 Program, which is distributed equally among community health centers in the second Congressional District. These funds are not included in the competitive request for proposals, therefore the reports included are for the full 2019 - 2020 reporting year. Reports for the community health centers are displayed on pages 39 and 40. The total funding awarded for the contracts and the funding issued to the Community Health Centers in the second Congressional District are included on page 31.

Minority Health Initiative Regions



Adams, Clay, Hall, Merrick, and York Counties

Central District Health Department



Central District Health Department (CDHD) provides diabetes care management via a Community Health Worker (CHW) who partners with Family Practice P.C. to access medical records of patients diagnosed with diabetes. CDHD is expanding into CHI Health system for medical providers. CDHD applies the Diabetes Management Interventions Engaging CHWs framework to improve knowledge, attitudes, and skills for diabetes self-management. The CHW interacts with patients to review provider recommendations, track patient progress, navigate services, and assist with identifying and reducing barriers to better health.

Target health issues
Diabetes

Dollars
$324,355.50
[18 month period]

People served
0

Project partners
Family Practice, P.C., CHI Health

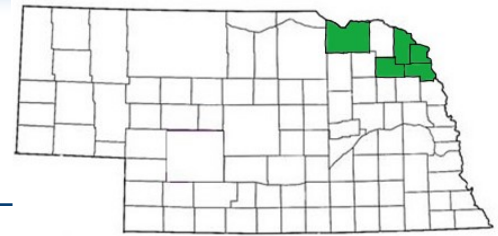
Progress and Outcomes July 1, 2019—June 30, 2020

The project experienced significant challenges due to COVID-19. Minority populations in these counties are currently experiencing job loss, lack of access to healthcare and social supports due to the pandemic, displacing diabetes/self-care as a primary concern.

An adapted work plan proposal approval is in progress, and includes CHWs assisting with the following:

- Informing minority populations on where to access COVID-19 testing, health services, and associated supports.
- Conducting remote check-ins to maintain continuity of support services for patients with chronic conditions who participate in group/individual disease management coaching for DPP, Living Well and/or Health Coaching.
- Translating written materials, and providing interpreter services for scheduled remote medical appointments and translating the information offered during that process.
- Assisting with unemployment applications and other qualified benefits, and expanding the capacity of those supports (e.g., homeless shelters, food pantries, and local agencies).

Dakota, Dixon, Knox, Wayne, and Thurston Counties



Dakota County Health Department

The Dakota County Health Department partners with Siouxland Community Health Center to serve diabetic patients. Siouxland provides referrals to DCHD Community Health Workers (CHW) to assist patients with their diabetic case management which includes education, A1C, blood glucose level monitoring and reduction of barriers to achieving health outcomes. The CHW communicates monthly progress to the partner agency to provide the best possible care for the patients along the continuity of care spectrum they have developed.

Target health issues
Diabetes

Dollars
$231,678.00
[18 month period]

People served
8

Project partners

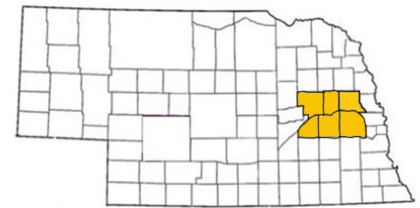
Progress and Outcomes July 1, 2019—June 30, 2020

The project experienced significant challenges due to COVID-19. Minority populations in the counties are currently experiencing job loss, lack of access to healthcare and social supports due to the pandemic, displacing diabetes/self-care as a primary concern.

- Baseline A1C was collected from patients during this period.
- 2 CHWs were assigned to provide services to patients.
- CHWs conducted 21 encounters with patient.
- CHWs worked to assist:
  - 2 patients in receiving diabetes, blood pressure, and cholesterol education
  - 4 patients with financial assistance application
  - 4 patients with transportation issues
  - 2 patients with food pantry referrals
- CHW and primary health care team met 25 times to discuss patient progress and needs.
- 3 CHWs completed the Living Well Training.
- 2 CHWs completed the CLAS assessment.

Dodge, Madison, Stanton, Cuming, Platte, and Colfax Counties

MyVitalz - East Region



MyVitalz is working with a team of health providers from the Nebraska Hospital Association, in the Eastern Region and has established relationships with critical access hospitals, and 25 urban hospitals. A pre-identified partner recruits patients and acts as a bidirectional linkage, providing the patient referral, pre-/post A1Cs as per HIPAA guidelines. Diabetes Education Center of the Midlands (DECM) will act as the CHW in a modified role by utilizing the technology to monitor patients. This allows for daily readings to be taken by the patient who is provided with their own equipment (e.g., glucose kit and communication apparatus). Patients are monitored on-line (Internet) by DECM and MyVitalz to assure the patient is in compliance. Interaction and intervention with the patient occur based on necessity and best practices. This technology-based model of patient care coordinates on-going communications and availability of data and information across the continuum of care. DECM/MyVitalz will have CHWs assist with this process.

Target health issue
Diabetes

Dollars
$306,750.00
[18 month period]

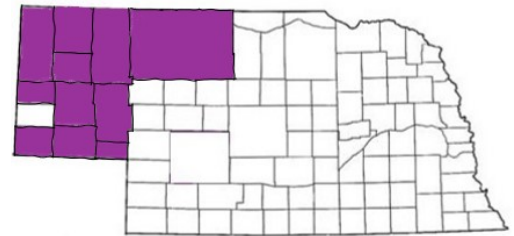
People served
240

Project partners
Nebraska Hospital Association, Diabetes Education Center of the Midlands

Progress and Outcomes July 1, 2019—June 30, 2020

- Baseline A1C was collected from patients during this period.
- 1 CHW was assigned to provide services to patients.
- 240 encounters were completed between a patient and CHW within this period.
- 99 out of 120 patients showed improvement in the blood glucose level by the 2nd quarter.
- 120 patients were issued a diabetic kit, and trained on its use.
- CHW and primary health care team met 240 times within this period to discuss patients progress and needs.
- 2 CHWs completed the Living Well Training.
- 1 CHW completed the CLAS assessment.

Sioux, Dawes, Sheridan, Cherry, Deuel, Box Butte, Scotts Bluff, Morrill, Garden, Kimball, and Cheyenne Counties



MyVitalz - West Region

MyVitalz is working with a team of health providers from the Nebraska Hospital Association, in the Western Region and has established relationships with the 65 Critical Access Hospitals, and the 25 urban hospitals. A pre-identified partner recruits patients and acts as a bidirectional linkage, providing the patient referral, pre-/post A1Cs as per HIPAA guidelines. Diabetes Education Center of the Midlands (DECM) will act as the CHW in a modified role by utilizing the technology to monitor patients. This allows for daily readings to be taken by the patient who is provided with their own equipment (e.g., glucose kit and communication apparatus). Patients are monitored on-line (Internet) by DECM and MyVitalz to assure the patient is in compliance. Interaction and intervention with the patient occur based on necessity and best practices. This technology-based model of patient care better coordinates on-going communications and availability of data and information across the continuum of care. DECM/MyVitalz will have CHWs assist with this process.

Target health issues
Diabetes

Dollars
$227,750.00
[18 month period]

People served
262

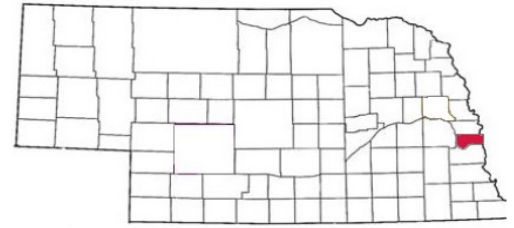
Project partners
National Hospital Association, Diabetes Education Center of the Midlands

Progress and Outcomes July 1, 2019—June 30, 2020

- Baseline A1C was collected from patients during this period.
- 1 CHW was assigned to perform services to these patients.
- CHW conducted 262 encounters with patients.
- 131 patients were issued a diabetic kit and trained on its use.
- 114 out of 131 patients showed improvement in the blood glucose level by the 2nd quarter.
- CHW and primary health care team met 262 times to discuss patient progress and needs.
- 1 CHW completed the Living Well Training.
- 1 CHW completed the CLAS assessment.

Sarpy County (in CD1)

OneWorld Community Health Center



OneWorld's medical clinicians direct minority patients with A1C of 6.5 or higher to the CHWs/ promotoras for diabetes care management. Promotoras enroll diabetic patients into OneWorld's certified diabetes classes, coach diabetic patients on nutrition and wellness, measure patients' progress in reducing their A1C rates, track their blood pressure, blood sugar and Body Mass Index (BMI) to identify whether they continue to be at risk for obesity, cardiovascular health and diabetes. CHWs/promotoras assist diabetic minority patients in scheduling appointments with the medical clinicians and visit patients regularly in their homes or at OneWorld. Promotoras/CHWs use a technology-based case management system in English, Spanish and other languages to connect by phone, text, and e-mail with patients.

Target health issues
Diabetes

Dollars
$227,746.80
[18 month period]

People served
27

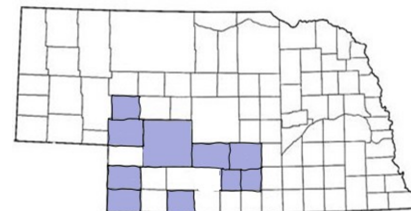
Project partners
UNMC, Creighton University, Consulate of Mexico, Sarpy/Cass Health Dept., Douglas County Health Dept., Lutheran Family Services, CHI Health

Progress and Outcomes July 1, 2019—June 30, 2020

The project experienced significant challenges due to COVID-19. Minority populations in the counties are currently experiencing job loss, lack of access to healthcare and social supports due to the pandemic, displacing diabetes/self-care as a primary concern.

- Baseline A1C was collected from patients during this period.
- 1 CHW was assigned to perform services to patients.
- CHW conducted 114 encounters with patients.
- CHW worked to assist:
  - 11 patients in receiving exercise and nutrition guidance from CHW
  - 10 patients in informing about the importance of checking blood glucose level at home and following provider's instructions
  - 4 patients in obtaining medication
  - 4 patients in referred to finance department for financial assistance
  - 8 patients in scheduling doctor's appointment.
- CHW and primary health care team met 32 times in total within this period discussing each patient.

Arthur, Keith, Lincoln, Dawson, Buffalo, Chase, Phelps, Kearney, Dundy, and Red Willow Counties



West Central District Health Department

WCDHD serves as the lead for the MHI program together with the Southwest District and Two Rivers Health Departments, to screen and identify minorities at risk (A1C levels above 6.5), and refer them to a primary care provider. The patients diagnosed with Type 2 diabetes are enrolled into the Living Well program and services that include data collection, monthly clinical team case management meetings, health coaching, and continued monitoring of glucose and A1C levels. Services also include addressing social determinant of health issues that impact diabetes management, and referrals to supportive services.

Target health issue
Diabetes

Dollars
$292,320.00
[18 month period]

People served
9

Project partners
Two Rivers District Health Department, Southwest District Health Department

Progress and Outcomes July 1, 2019—June 30, 2020

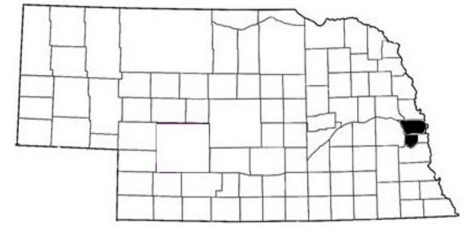
The project experienced significant challenges due to COVID-19. Minority populations in the counties are currently experiencing job loss, lack of access to healthcare and social supports due to the pandemic, displacing diabetes/self-care as a primary concern.

- Baseline A1C was collected from patients during this period.
- 3 CHWs were assigned to work with patients.
- CHWs conducted 30 encounters with patients.
- CHWs worked to assist:
    - 8 patients in completing a health assessment
    - 6 patients with medical terms interpretation
    - 5 patients in receiving guidance on healthy eating and exercise
    - 4 patients in receiving diabetes, blood pressure, and cholesterol education
    - 4 patients with financial assistance application.
- CHW and primary health care team met 11 times to discuss patient progress and needs.
- 2 CHWs completed the Living Well Training.
- 3 CHWs completed the CLAS assessment.

Douglas County

Charles Drew Health Center

Community Health Centers funded by Federal Program 330 in CD2



As previously indicated on page 30, the appropriation includes annual funding distributed equally among community health centers funded by Federal Program 330 in the second Congressional District. Charles Drew Health Center utilized the funding to implement a minority health initiative which is targeted, but was not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma. The information below incorporates data 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
15,587

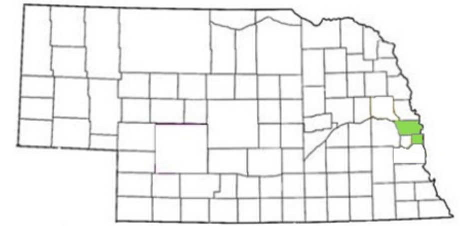
Activities & Outcomes July 1, 2019—June 30, 2020

- 82% 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 299 (39%) of 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%.
- 1,101 (53%) *of* adult patients, aged 52 -85 years, with a diagnosis of hypertension continued to maintain control of their hypertension (BP less than 140/90).
- 77% of women initiated their prenatal care during the first trimester; the percentage of births less than <2500 grams increased from 4.9% to 6%.
- 51.5% percent of patients 3-17 years of age received weight assessment and counseling for nutrition and physical activity.
- The percentage of adult patients with weight screening and follow-up is 45%.
- 77.7% of adult patients diagnosed with tobacco use were prescribed cessation medication.
- 81% 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 71% to 73%

Douglas and Sarpy (in CD2) Counties

OneWorld Community Health Center

Community Health Centers funded by Federal Program 330 in CD2



As previously indicated on page 30, the annual funding appropriated is distributed equally among Community Health Centers funded by Federal program 330 in the second Congressional District. OneWorld Community Health Center utilized the funding to implement a minority health initiative which is 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
50,182

Activities & Outcomes July 1, 2019—June 30, 2020

- 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 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.

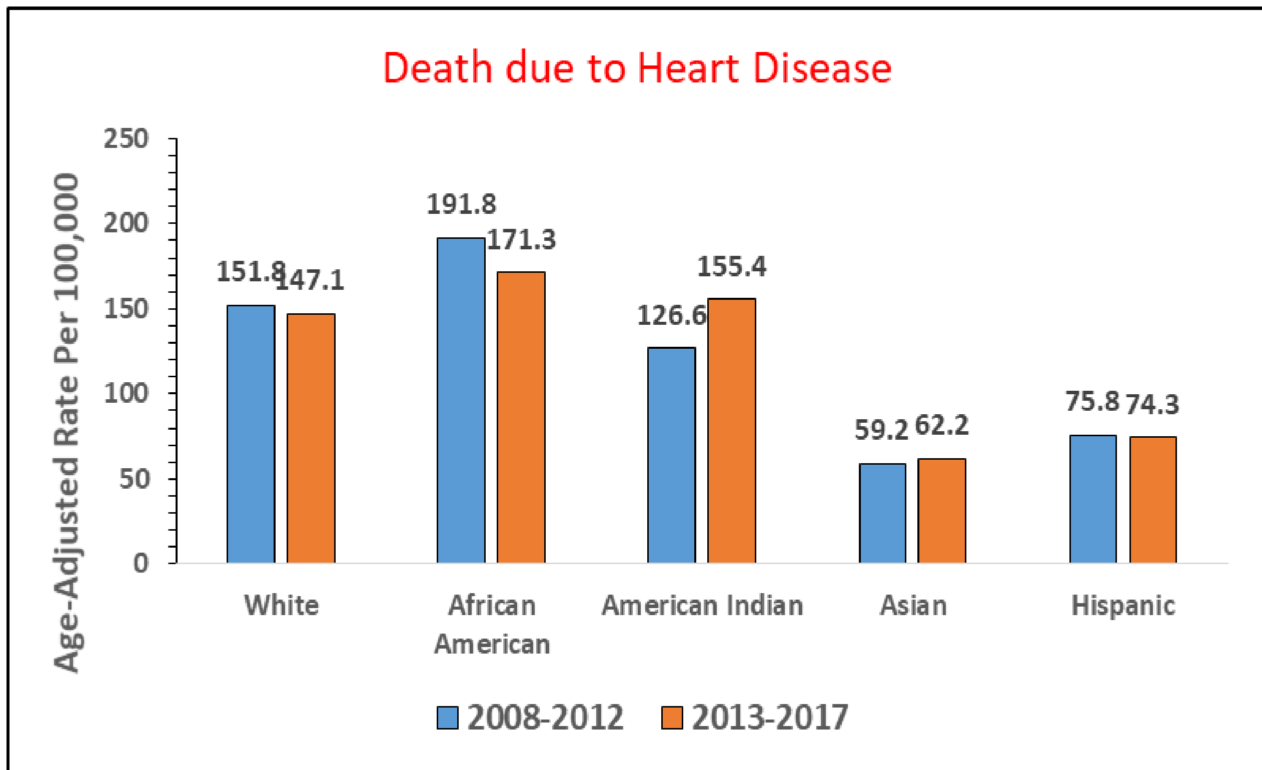
Risk Factors Related to Priority Issues, Nebraska

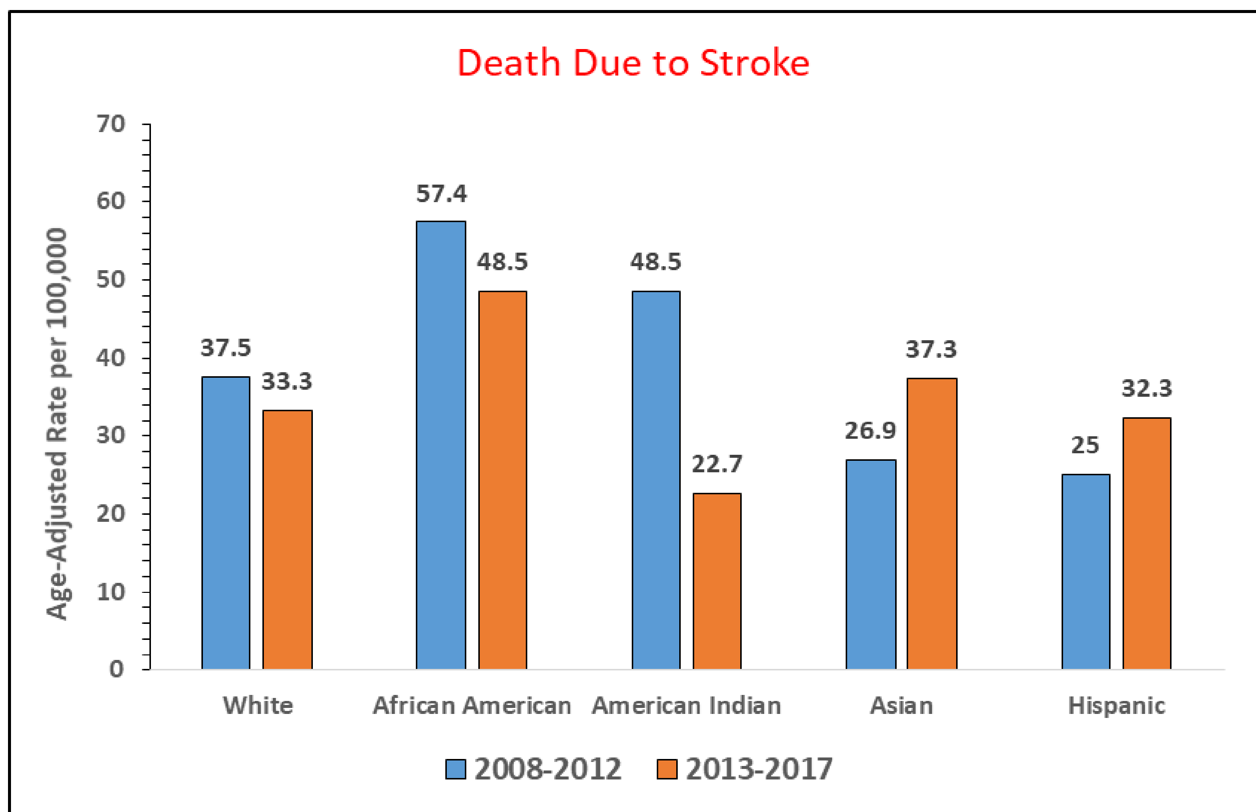
Health Issue	Race/Ethnicity	Percent
Diabetes Prevalence among adults aged 18+	African American	14.8%
	American Indian	20.3%
	Asian	*
	Hispanic	9.3%
	White	10.0%
Obesity Prevalence among adults aged 18+	African American	44.6%
	American Indian	33.2%
	Asian	*
	Hispanic	34.6%
	White	32.2%
High Blood Pressure Prevalence among adults aged 18+	African American	44.8%
	American Indian	34.8%
	Asian	*
	Hispanic	20.8%
	White	31.2%
Consumed Vegetables Less than 1 time per day Prevalence among adults aged 18+	African American	32.5%
	American Indian	25.7%
	Asian	*
	Hispanic	39.2%
	White	17.6%
Physic Inactivity Prevalence among adults aged 18+	African American	30.9%
	American Indian	24.0%
	Asian	*
	Hispanic	35.7%
	White	24.0%

* Prevalence estimate not available if the unweighted sample size for the denominator was < 50 or the Relative Standard Error (RSE) is > 0.3 or if the state did not collect data for that calendar year.

Data Source: CDC Behavioral Risk Surveillance System (BRFSS) 2017

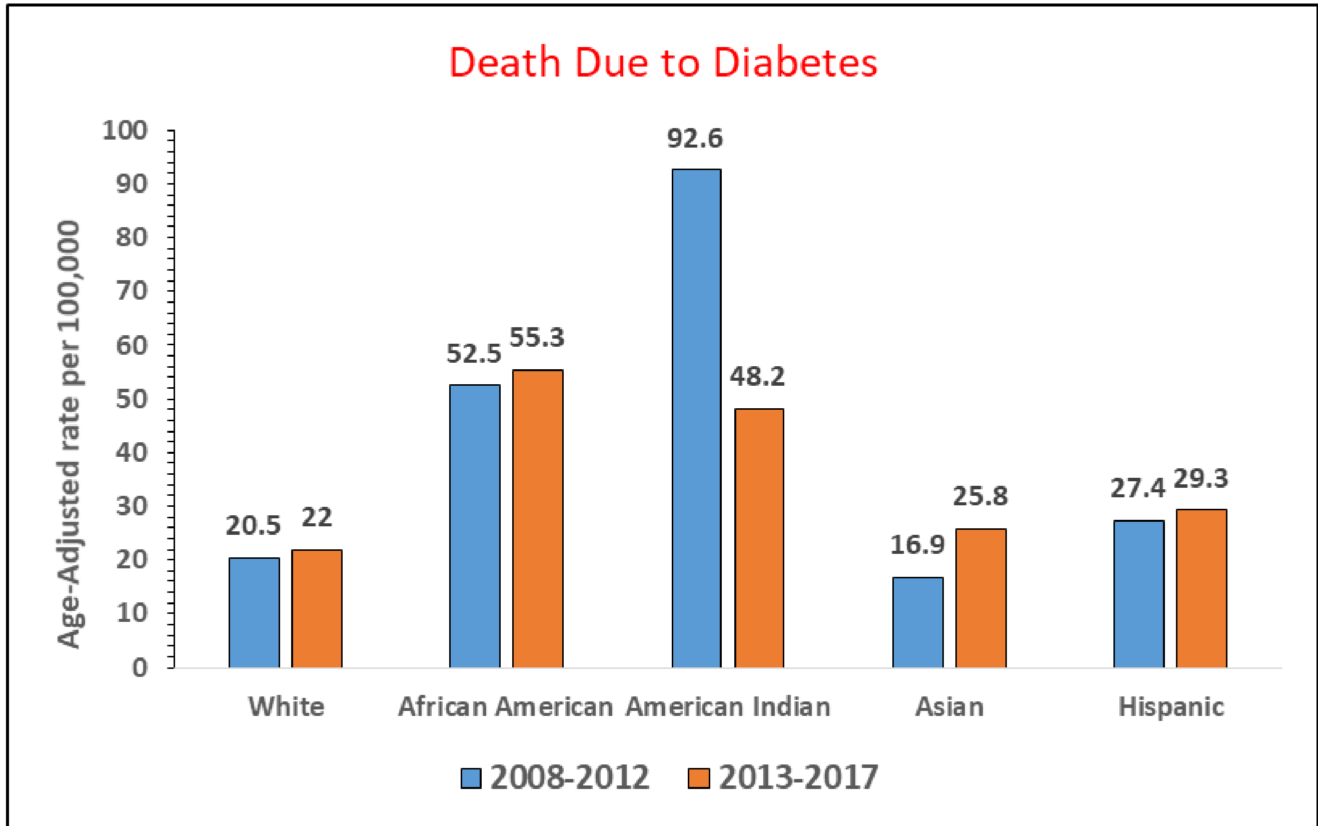
Death Rates Related to Priority Issues, Nebraska

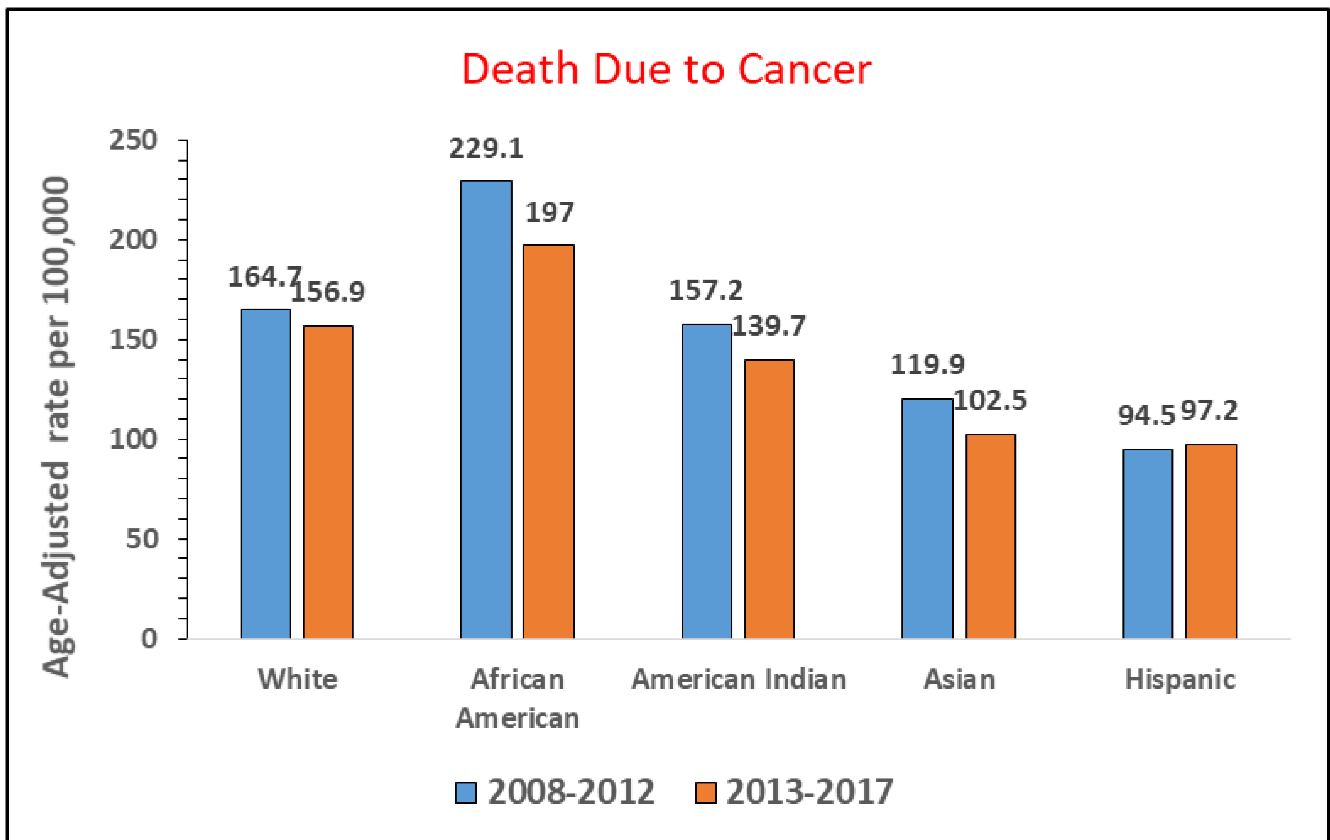




Data Source: Nebraska DHHS Vital Statistics 2008-2017

Death Rates Related to Priority Issues, Nebraska





Data Source: Nebraska DHHS Vital Statistics 2008-2017

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.

Chronic disease: illness that lasts three months or longer, generally cannot be prevented by vaccines or cured by medications, and does not disappear over time.

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.

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

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.

Health system: the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations.

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.

Project: the total scheme, program, or method worked out for the accomplishment of an objective, including documentation and services to be provided under an agreement.

Social Determinants of Health: conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risks.

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

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