2020-2021 MINORITY HEALTH INITIATIVE Annual Report

December 1, 2021

In accordance with Nebraska State Statute 71-1628.07

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Office of Health Disparities and Health Equity
Division of Public Health

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 2020-2021 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 or differences disproportionately impacting minority populations in Nebraska. Populations served include racial and ethnic minorities, American Indians, and refugees. The OHDHE used 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, 2021, to focus on diabetes management for minorities. The underlying rationale for this decision was based on data that continue~~s~~ to validate diabetes as one of the leading causes of death for minorities in Nebraska (DHHS, Vital Statistics 2011-2014**)**. In addition, significant disparities or differences 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 has incorporated public health and primary care, which supports the integrated health system priority in the 2017-2021 Nebraska State Health Improvement Plan.

OHDHE administered five contracts during this reporting period. The MHI program goal was to improve the health of minority populations diagnosed with diabetes in Nebraska's first and third Congressional Districts through referrals from physicians for the services of Community Health Workers (CHWs). 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 to include a Community Health Worker.

This report demonstrates the work implemented under the Diabetes Care Management for Minorities contracts that were awarded to agencies for the (18-month) period from January 1, 2020 through June 30, 2021. Also included in the appropriation is annual funding distributed equally among community health centers funded through Federal Program 330, Public Law 104-299, the federal Health Centers Consolidation Act of 1996 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 for that funding are for the full 2020 - 2021 year. This report illustrates the outcomes achieved and work completed for the January 1, 2020 - June 30, 2021 funding year. During this MHI program year, COVID-19 conditions necessitated widespread reallocation of resources across the public health system. Some of the MHI diabetes care management projects required reallocation of staff to respond to the immediate health and social needs related to the COVID-19 pandemic. Unfortunately, this resulted in a lower number of minority populations decreasing their A1C rates the program.

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 dhhs.minorityhealth@nebraska.gov.

Table of Contents

Diabetes Care Management for Minorities - Minority Health Initiative Contracts
January 1, 2020 - June 30, 2021 period
Progress for the 18-month contract period is covered in this report

Contracts (Congressional Districts 1 & 3)	Contract Amount for 18-Month 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
January 1, 2020 - June 30, 2021

Community Health Center	Amount
Charles Drew Health Center	$688,550.00
One World Community Health Center	$688,550.00
TOTAL	**$1,377,110.00**

People Served

Race and ethnicity for the clients served by the Minority Health Initiative projects during the January 1, 2020 through June 30, 2021 time period is shown below. These numbers represent individuals served by the projects.

Race and Ethnicity of Participants	
African American or Black	23
American Indian/Alaska Native	15
Asian	21
Two or more races	5
Other, missing, not sure, or refused	5
Hispanic	918
Total	987

2020-2021
MINORITY HEALTH INITIATIVE
Activities and Outcomes

Total number of people served

987

HEALTH ASSESSMENTS/SCREENINGS

229

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

CASE MANAGEMENT

501

people received case management services

99 Clients reduced A1Cs

HEALTH EDUCATION

668

minorities participated in health education
(Blood Pressure, Diabetes, Nutrition, Exercise, COVID-19)

SOCIAL SUPPORTS ADDRESSED

1,140

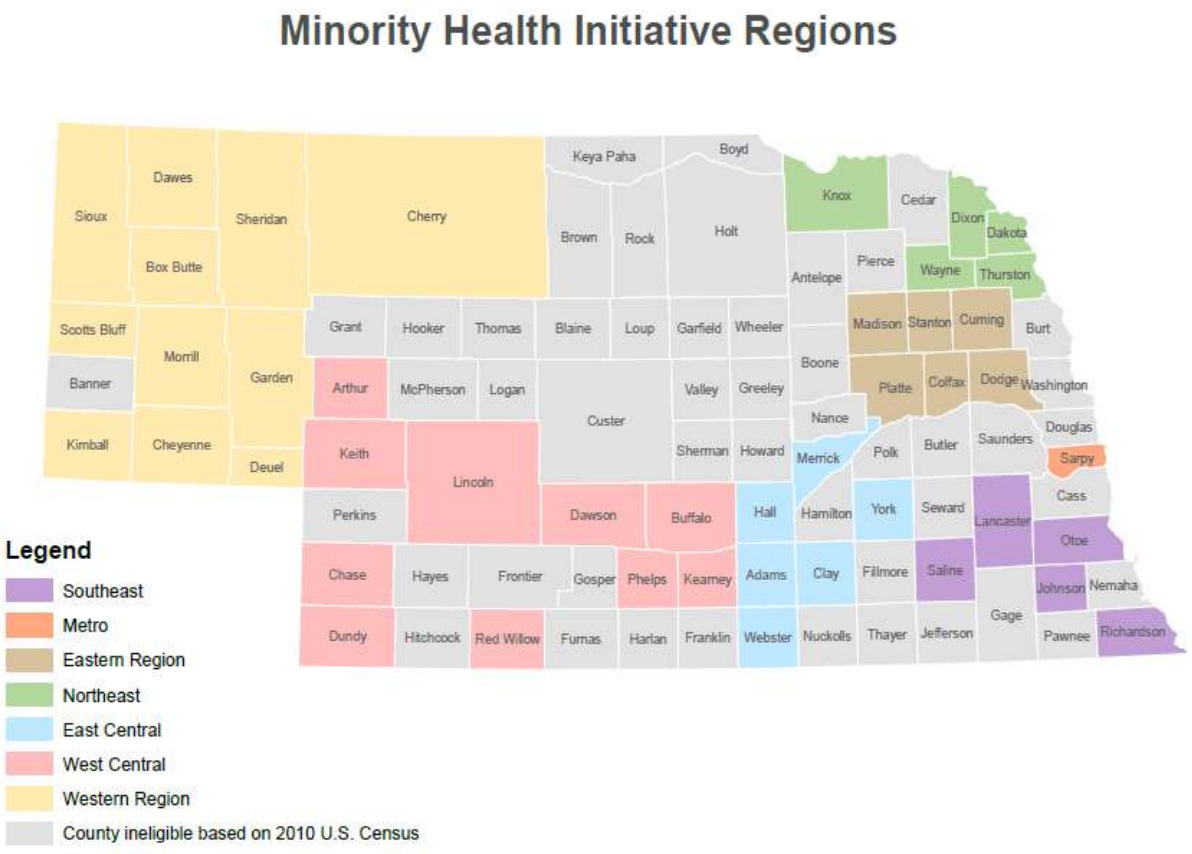
(Supports with interpretation, transportation, mental health, financial, food, and other application assistance)

Diabetes Care Management for Minorities Project Reports

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, 2021 is included on pages 8 through 13. The summaries are arranged alphabetically by contractor name, and include a brief description of each project, the region and counties covered by the project, and a summary of work completed for the 18-month time period that this report covers. The COVID-19 pandemic has had a major impact on the progress of projects. Local response and mitigation by organizations necessitated a redirected focus on immediate public health concerns other than diabetes management. A map of the regions eligible for the Diabetes Care Management for Minorities is shown below.

The data presented in the following individual project pages depicts the variation in service provision across projects. Some of the projects were in transition from capacity-building into implementation of Type 2 diabetes intervention strategies when the onset of COVID-19 required reallocation of community health worker resources by shifting work to respond to those who tested positive for COVID-19 and contact tracing. These immediate needs and activities displaced the work of MHI's identified health priority of diabetes. One project used remote technology to provide diabetes care management for MHI clients.

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 2020 - 2021 reporting year. Reports for the community health centers are displayed on pages 15 and 16. 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 4.



MINORITY HEALTH INITIATIVE
Central District Health Department
2020-2021 Annual Report

Overview of MHI 2020-2021 Activities

MHI 2020-2021 Activities

- Create an access plan with individuals for food sources
- Link to healthcare provider
- Link to community social and behavioral health services
- Ensure regular access to nutritional food without scarcity
- Safeguard healthcare access
- Secure income to care for needs
- Connect with housing services

SUCCESS STORY

Public Health Issue

Central District Health Department collaborated with the Multi-Cultural Coalition to address the COVID-19 health crisis and respond immediately to COVID-19-related impacts and social supports needed by the community.

Activity Summaries

- Safety & isolation status: Identified ability to stay safe during 10-day isolation period, plus 24 hours without symptoms to assure wellbeing and control contagion risk throughout quarantine or illness
- Assisted with healthcare access: individual has a healthcare home, a place for managing healthcare needs and access to ongoing mental and physical healthcare
- Social supports: provided access to social and emotional supportive services for unmet needs.
- Food security stabilized: ensured access to nutritional food without scarcity; and coordinated a plan for maintaining food in the home
- Housing: assisted in finding affordable housing.

A client experiencing domestic violence with COVID-19 was assisted with shelter and provided with adequate food supplies through community resources to help her through quarantine. Calls were made by the Community Health Workers (CHWs) to the client every three days until the quarantine ended to ensure clients need were met. The local crisis center also assisted the client in addressing her housing need by finding her an

Minority Health Initiative
Dakota County Health Department
2020-2021 Annual Report

Overview of MHI 2020-2021 Activities

Total Population Served: 11

MHI 2020-2021 Activities

- Collected A1C measures
- Provided education to four participants
- Referrals (11) to additional resources
- Met with the clinical team on 48 occasions

SUCCESS STORY

Public Health Issue

The Dakota County Health Department partnered with the Omaha Tribe Carl T. Curtis Health Center, Northeast Nebraska Public Health Department, Santee Health Center, and the Siouxland Community Health Center to provide referrals of diabetic minorities from across the service area to the Department's 2 Community Health Workers who provided patients with diabetic case management.

Activity Summaries

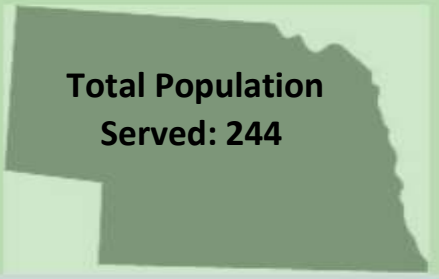
Case Management

- Worked with partner agencies to track and collect the baseline A1C levels
- CHWs provided diabetes prevention educational components ensuring relevance to the community
- Connected patients to the various community resources on 11 occasions (transportation, food pantry, Medicaid, mental health)
- Clinical team met to discuss patient health status, address challenges, associated needs for additional resources to ensure effective

Partnership with the local Community Health Center led to referrals from the 5-county region (Dakota, Dixon, Knox, Thurston, and Wayne Counties). The project had early success with the Diabetes Academy. From consultations during monthly meetings, the clinical team addressed issues participants experienced and provided supportive services during case management encounters. Project was able to eliminate barriers to accessing routine healthcare services.

Minority Health Initiative
MyVitalz East
2020-2021 Annual Report

Overview of MHI 2020-2021 Activities



Total Population Served: 244

MHI 2020-2021 Activities

- Collected baseline and follow-up A1Cs
- Provided diabetes test kits
- Retainage of participants
- Resolve social support needs

SUCCESS STORY

Public Health Issue

MyVitalz partnered with a team of healthcare providers from the Nebraska Hospital Association to reduce Type 2 diabetes among at-risk minority patients. Patients were provided with their own equipment to collect and record daily glucose readings. Diabetes Education Center of the Midlands (DECM) acted in a [modified] Community Health Worker role by utilizing technology to monitor patients and coordinate case management.

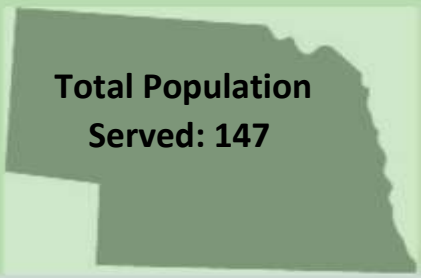
Activity Summaries

- Baseline A1Cs were collected from 244 patients during this period
- Distributed 244 diabetes test kits and provided training to patients
- Utilized a remote patient monitoring program to retain a majority of patients and continue providing services during the COVID pandemic
- Connected patients to transportation, interpretation, and diabetes education services
- End-of-project A1C levels were obtained from 223 (91%) patients

The MyVitalz East project continued to provide Type 2 diabetes services to patients enrolled into the MHI program. As a result, there was effective retention of participants. Consequently, progress with collecting continuous A1C readings (required participation for at least ≥3 months) was achieved, resulting in an overall success rate of 25% across time for the reduction of A1C levels among participants.

Minority Health Initiative
MyVitalz West
2020-2021 Annual Report

Overview of MHI 2020-2021 Activities



MHI 2020-2021 Activities

- Collected baseline and follow-up A1Cs
- Provided diabetes test kits
- Retainage of participants
- Resolve social support needs

SUCCESS STORY

Public Health Issue

MyVitalz partnered with a team of healthcare providers from the Nebraska Hospital Association to reduce Type 2 diabetes among at-risk minority patients. Patients were provided with their own equipment to collect and record daily glucose readings. Diabetes Education Center of the Midlands (DECM) acted in a [modified] Community Health Worker role by utilizing technology to monitor patients and coordinate case management.

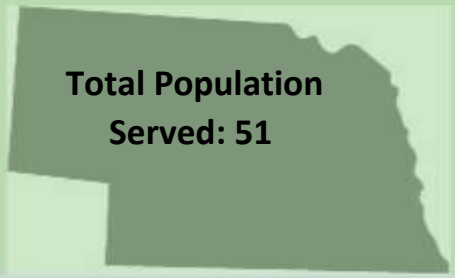
Activity Summaries

- Baseline A1Cs were collected from 147 patients during this period
- Distributed 147 diabetes test kits and provided training for patients
- Utilized a remote patient monitoring program to retain a majority of patients and continue providing services during COVID pandemic
- Connected patients to transportation, interpretation, and diabetes education services.
- End-of-project A1C levels were obtained from 138 (93.8%) patients.
- 33 (24%) patients reduced their A1Cs

The MyVitalz West project continued to provide Type 2 diabetes services to patients enrolled into the MHI program. As a result, there was effective retention of participants. Consequently, progress with collecting continuous A1C readings (required participation for at least ≥3 months) was achieved, resulting in an overall success rate of 33% across time for the reduction of A1C levels among participants.

Minority Health Initiative
OneWorld Community Health Center
2020-2021 Annual Report

Overview of MHI 2020-2021 Activities



MHI 2020-2021 Activities

- Collected baseline and follow-up A1Cs
- Provided referrals to additional resources
- Supported clients to make healthy lifestyle choices

SUCCESS STORY

Public Health Issue

OneWorld Community Health Center works through Community Health Workers (CHWs/Promotores) 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 and connection to a medical home, and were provided with access to other community resources to manage and improve their health conditions.

Activity Summaries

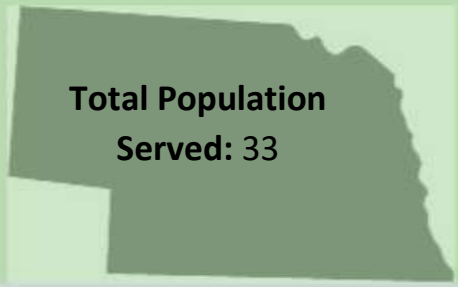
Case Management

- Collected baseline and follow-up A1Cs
- Arranged physician appointments
- Referred patients to additional resources
- Educated patients about selecting healthy nutrition choices and benefits of physical activity
- Informed and coached participants regarding medication adherence
- Routinely checked average blood glucose readings

"Patients are reaching out more to our program, and that there is a connection being made between the patient, CHW, and provider." The CHW assisted people with resources to food pantries, social work, and case management as needed. In addition to diabetes management, the CHW provided COVID information and assisted with arranging COVID-19 vaccines.

Minority Health Initiative
West Central District Health Department
2020-2021 Annual Report

Overview of MHI 2020-2021 Activities



Total Population Served: 33

MHI 2020-2021 Activities

- Community Health Workers recruited and enrolled into program
- Shared diabetes management education
- Collected regular A1C measures
- Provided essential supportive

SUCCESS STORY

Community Health Workers worked closely with participant to assist her in reaching the goals she had set. With encouragement from the CHW, the client's A1C lowered from 10.7 to 6.6. She also lowed her blood pressure and body mass index (BMI).

Public Health Issue

Together with the Southwest District and Two Rivers Health Departments, WCDHD worked to screen and identify at–risk minorities. The patients diagnosed with Type 2 diabetes were referred to a primary care provider and enrolled into the Living Well program. Social supports that impact diabetes management were also addressed, and referrals made to supportive services.

Activity Summaries

Case Management

- WCDHD used COVID-19 risk related personal protective practices to manage MHI services for minorities
- CHW case management work included recruitment, enrollment, education, collecting multiple A1C measures, follow-ups, supportive services, connecting to providers, addressing other social supports (interpretation, childcare, transportation)
- 10 participants reduced their final A1C by 1% and achieved an A1C below 6.5

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

January 1, 2020 - June 30, 2021

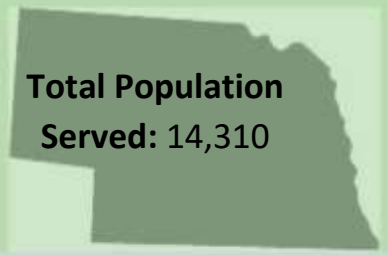
Also included in the appropriation is minority health initiative funding through the annual funding Federal 330 Program, which is to be distributed equally among the federally qualified health centers in the Nebraska's second Congressional District. The funds are also to be used to implement a minority health initiative, which may target, but is not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma. These funds are not included in the competitive request for proposals, therefore the reports included are for the full 2020 - 2021 reporting year.

Community Health Center	Amount
Charles Drew Health Center	$688,550.00
One World Community Health Center	$688,550.00
TOTAL	**$1,377,110.00**

Charles Drew Health Center
Federally Qualified Health Care Funding

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.

Overview of MHI 2020-2021 Activities



Total Population Served: 14,310

MHI 2020-2021

Minority clients

Of the clients served overall, 71% were minorities (Including special populations, Healthcare for the Homeless, and Public Housing Primary Care).

Public Health Issue(s)

Cardiovascular disease, asthma, diabetes, obesity, infant mortality.

Other health issues

Depression, oral health, substance and alcohol use, breast and cervical cancer.

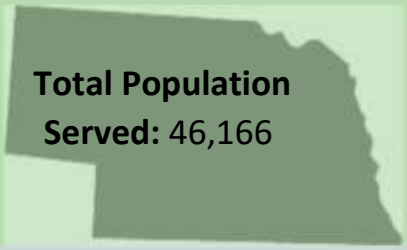
Activities and Outcomes

- Diabetes: 5% of patients 18 years and over were diagnosed with Type I or Type II diabetes; 33% of diabetic patients had an HbA1c less than 9%
- Breast Cancer: 33% of women 51-73 years of age received a mammogram to screen for breast cancer.
- Cervical Cancer: 28% of women 23-64 years of age were screened for cervical cancer
- Cardiovascular: 14% of patients were diagnosed with hypertension; 33% of cardiovascular patients brought their hypertension under control (BP less than 140/90)
- Prenatal: The percentage of women initiating their prenatal care during the first trimester increased to 84%
- Obesity: 76% of patients 3-16 with Body Mass Index (BMI) percentile documentation received weight assessment and counseling for nutrition and physical activity; 44% of adult patients received weight screening and follow-up
- Tobacco Use: 77% of patients aged 18 years of age and older were screened for tobacco use, and if identified to be a tobacco user received cessation counseling intervention
- Dental: CDHC provided sealants for 80% of patients ages six through nine
- Immunizations: 60% of children were fully immunized by their 2nd birthday

OneWorld Community Health Center
Federally Qualified Health Care Funding

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.

Overview of MHI 2020-2021 Activities



Total Population Served: 46,166

Minority clients

Of the clients served overall, 81% were minorities.

The clinic was able to expand their reach of pediatric dental patients with the travelling pediatric care mobile unit.

Public Health Issue(s)

Cardiovascular disease, diabetes, infant health.

Other health issues

Depression, Pediatric Oral Health, Asthma, and Pediatric and Adult Weight Management.

Activities and Outcomes

- 92.6% of adult patients screened and counseled for tobacco use in 2020. This is well above the Healthy People 2020 target of 68.6%
- 2,789 patients had hypertension in 2020; 68% were able to obtain control of their disease
- 75% of [3,759] patients with diabetes had HbA1c results less than or equal to 0.9% (over 76% were minorities)
- 84% of [1,560] prenatal patients began their care in the first trimester; only 7.3% of all babies born were low birth weight
- 3,455 patients with a primary diagnosis of depression and other mood disorders received care.
- 3,234 pediatric dental patients were treated
- 84% of patients (aged 3 to 17) with a documented Body Mass Index (BMI) percentile received counseling; 70% of patients (aged 18+) with a BMI percentile had follow-up plan
- In 2020, 12,000 community members were tested for COVID-19; 4,804 who tested positive were provided care and case management

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.

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 (CHWs): 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, and improves the quality and community understanding of the 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.

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.

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