Improving Health Outcomes for Culturally Diverse Populations in Nebraska

2011-2012 Minority Health Initiative Funding

Report on Progress

December 1, 2012

In accordance with Nebraska State Statute 71-1628.07

Office of Health Disparities & Health Equity

Division of Public Health

Nebraska Department of Health & Human Services

Department of Health & Human Services
DHHS
NEBRASKA

Executive Summary

Minority Health Initiative funding is awarded in Congressional Districts 1 and 3 for two-year project periods, and this report includes information on the projects and outcomes of the first year (July 1, 2011-June 30, 2012) of the current project period (July 1, 2011-June 30, 2013). Thirteen projects and four contracts were funded for this period. In addition, funding is allocated to the federally qualified health centers in Congressional District 2. Reporting on the latter is different from that required of the former, so the following information applies only to the 13 awards and four contracts funded under the competitive process.

Funding is allocated per county on a per capita basis, using the most current decennial census data. The 2010 U.S. Census data was released just prior to release of the competitive request for applications for the 2011-2013 Minority Health Initiative projects. This resulted in significant shifting of funding. Sixteen additional counties became eligible for funding and one was removed from the list. In addition, population shifts resulted in less funding available for western counties and more for the eastern part of the state.

Each project targets at least one of the priorities named in the legislation, but each funded project is unique. The projects were designed to address the cultural and linguistic needs of the populations targeted in each area.

Some of the projects began later than July 1, for a variety of reasons. For those projects that started later in the year, notation was included on the individual grantee report page.

In total, the Minority Health Initiative projects served 11,175 clients during this year via provision of 19,923 encounters. The encounters included assistance in establishing a medical or dental home, case management, home visits, transportation, referrals, assistance with low-cost medications, heath fairs, interpretation services, and other activities. Also included were health education sessions and health screenings.

As a result of these efforts, 7,571 improvements in health were reported by clients served by the projects. These included improvements in self-management of medications (2,019), self-management of chronic diseases (2,003), improvements in dental health (958), and improvements in nutrition (656). Improvements in body mass index or weight loss (588) and improvements in blood pressure (549) were also reported.

The grantees and contractors worked with a variety of traditional and nontraditional partners. They included medical centers and hospitals, local health departments, churches, cultural and community centers, community health centers, federally qualified health centers, local employers and businesses, schools, medical clinics, grocery stores, city government, colleges and universities, Tribal organizations, and educational service units.

Each MHI project targets at least one of the priority issues listed in the legislation: cardiovascular disease, obesity, diabetes, infant mortality, and asthma. The table on the following page list the prevalence and/or death rates related to these priority issues. Rates for both 2001-2005 and 2006-2010 are included for comparison purposes.

Prevalence /Death Rates Related to Priority Issues, 2001-2005 and 2006-2010

Health Issues	Race/Ethnicity	2001-2005	2006-2010
Heart Disease Death rate per 100,000 population	White	196.7	160.2
	African American	246.4	214.2
	American Indian	280.1	131.7
	Asian	108.3	64.5
	Hispanic	114.6	89.7
Stroke Death rate per 100,000 population	White	51.7	40.8
	African American	84.2	66.6
	American Indian	62	38.7
	Asian	65.7	28.4
	Hispanic	29.2	23
Diabetes Death rate per 100,000 population	White	20.3	21.1
	African American	67.3	62.1
	American Indian	91	93.2
	Asian	13.9	18.7
	Hispanic	45.6	28.8
Infant Mortality Death rate per 1,000 live births	White	5.7	5.7
	African American	15.1	13.8
	American Indian	15.2	7.7
	Asian	5.5	2.8
	Hispanic	6.8	5.7
Obesity Prevalence of obesity among adults aged 18+	White	23.1%	26.7%
	African American	33.9%	39%
	American Indian	29.6%	41.7%
	Asian	8.4%	10.3%
	Hispanic	25.5%	32%
Asthma Prevalence of asthma among adults aged 18+	White	6.7%	7.7%
	African American	12.3%	11.7%
	American Indian	15.5%	9.7%
	Asian	9.7%	7.3%
	Hispanic	3.8%	4.5%

Minority Health Initiative two-year projects (7/2011-6/2013) were awarded to the following organizations:

Project (CD 1 & 3)	Amount	County(ies)	Page
Blue Valley Community Action	$90,765.71	Saline, York	8
Carl T. Curtis Health Center/Omaha Tribe	$88,204.20	Thurston	10
Central District Health Department	$654,382.42	Buffalo, Dawson, Hall, Kearney, Merrick, Phelps	12
Chadron Native American Center	$54,715.57	Cherry, Dawes, Sheridan	16
Community Action Partnership of Western Nebraska	$275,803.45	Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sioux	18
East Central District Health Department	$200,595.78	Colfax, Platte	20
Elkhorn Logan Valley Public Health Department	$148,693.67	Cuming, Madison, Stanton	22
Lincoln-Lancaster County Health Department	$938,626.18	Lancaster	24
Mary Lanning Memorial Hospital	$93,264.23	Adams, Clay, Webster	28
Norm Waitt YMCA	$197,572.36	Dakota	30
Northeast Nebraska Public Health Department	$29,583.36	Dixon, Wayne	32
One World Community Health Center	$146,288.34	Dodge, Sarpy	35
Ponca Tribe of Nebraska	$24,535.12	Knox, Sarpy	37
Sandhills District Health Department and Clinic (contract)	$13,962.34	Arthur, Keith	39
Southeast District Health Department (contract)	$55,345.46	Johnson, Otoe, Richardson	41
Southwest District Health Department (contract)	$28,155.64	Chase, Dundy, Red Willow	43
West Central District Health Department (contract)	$74,472.81	Lincoln	45
Total	$3,114,966.64		
Federally qualified health centers (CD2)			
Charles Drew Health Center	$714,050.50	CD 2	47
One World Community Health Center	$714,050.50	CD 2	48

Introduction

Minority Health Initiative funding is allocated by the Nebraska Legislature to counties in the first and third Congressional Districts with minority populations of five percent or greater, based on the most recent decennial census. Funding is directed to be distributed on a per capita basis and used to address priority issues of infant mortality, cardiovascular disease, obesity, diabetes, and asthma. Issues such as cancers, HIV/AIDS, sexually transmitted diseases, tobacco or alcohol use, mental health, translation/interpretation, injury prevention, and uninsuredness may be targeted in addition to at least one of the priorities. All projects should be responsive to the special cultural and linguistic needs of the populations they intend to serve.

To meet the directive, the Nebraska Office of Health Disparities and Health Equity uses a competitive request for applications process. Minority Health Initiative funds were awarded for two-year project periods, and 13 projects were awarded funding for the 2011-2013 project period. Four additional projects were implemented via contracts.

This report covers the first year of the two-year project period. It should be noted that due to various circumstances, some projects started later than others, so may include only two or three quarters of data. For example, for several counties, no fundable applications were received. Therefore, local public health departments in those areas were asked and agreed to implement projects in those counties for which they were responsible. In other cases, work plans and budgets required revision before projects could begin.

The Minority Health Initiative grant program is designed to encourage the development or enhancement of innovative health services or programming to eliminate health disparities which disproportionately impact minority populations. The emphasis of this program is on service delivery through creative strategies by a single organization or by forming a network with at least two additional partners. Via collaborations among schools, faith-based organizations, emergency medical service providers, local universities, private practitioners, community-based organizations, and local health departments, communities have an opportunity to bring health parity for minorities. Populations to be addressed include racial ethnic minorities, Native Americans, refugees, and immigrants.

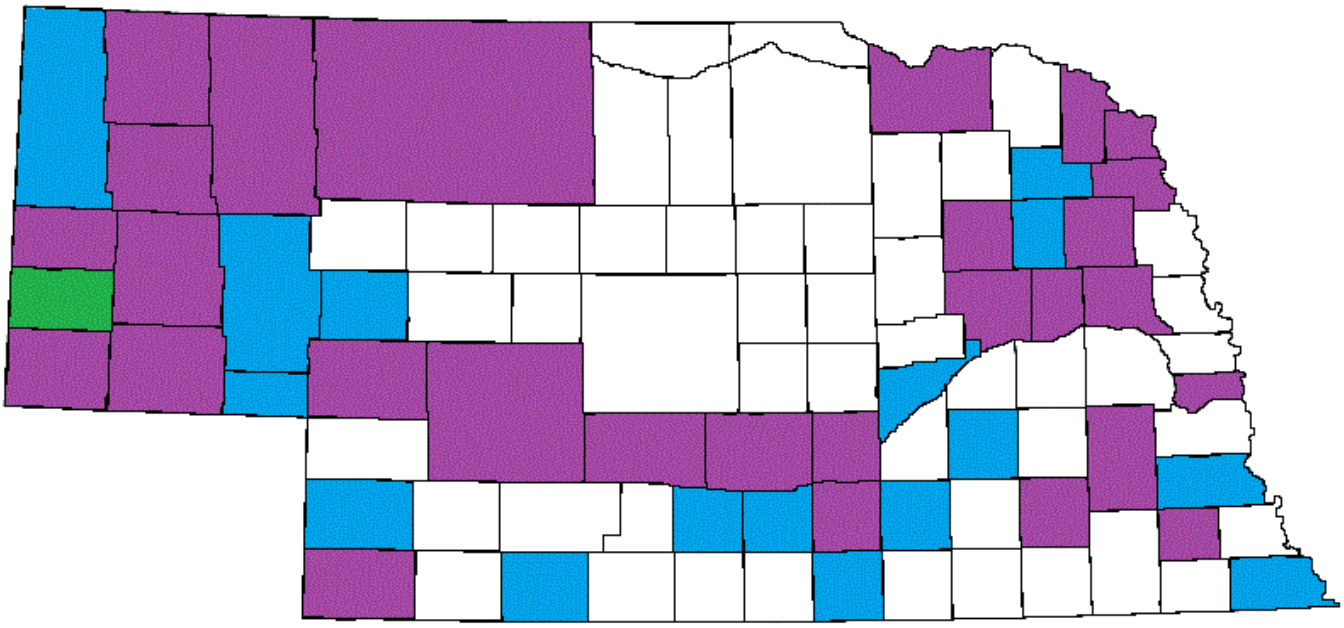
Also included in the appropriation is annual funding to be distributed equally among federally qualified health centers in the second Congressional District (One World Community Health Center and Charles Drew Health Center). Funding is to be used to implement a minority health initiative which may target, but is not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma.

For additional information on these projects, please contact Josie Rodriguez, Nebraska Office of Health Disparities and Health Equity, at 402-471-0152 or minority.health@nebraska.gov.

Changes Since the Last Report

The appropriations legislation that allocates funding and defines the parameters of the Minority Health Initiative projects requires the use of the latest decennial Census data in allocating funding to counties with a five percent or greater minority population. We received the 2010 U.S. Census figures in early 2011, which resulted in some significant shifting of dollars for this project period.

When compared to the previous project period, 2009-2011, 16 additional counties were eligible for funding in this project period and one was removed from the list. Populations also shifted from west to east. The funding is allocated on a per capita basis per the legislation, so this resulted in less funding available for western counties and more for the eastern part of the state. Overall funding was level from the previous project period to this one.



Counties eligible 2009-2011

New counties eligible 2011-2013

Eligible 2009-2011, but not 2011-2013

Definitions

340B Medication Assistance program: a federal drug pricing program that limits the cost of covered outpatient medications to enable safety-net health care providers (e.g., federally qualified health centers, community health centers, tribal or urban Indian health organizations) to save significantly on the cost of prescriptions.[1]

Body mass index (BMI): measure of body fat based on height and weight.[2]

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.[3]

Community health workers: people who assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Also know as lay health ambassadors, promotoras, and bilingual community health partners.[4]

Dental home: model of care characterized by provision and coordination of dental health care at a single location that takes responsibility for the patient's health care needs and arranging for appropriate care with other clinicians; includes a high level of accessibility, excellent communication, and full use of technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.[5]

Health fair: event where organizations have an opportunity to disseminate health information to the public at booths and/or to provide health screenings.[6]

Interpretation: rendering of oral messages from one language to another.[7]

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.[8]

Translation: rendering of written information from one language to another.[9]

Encounters

This page summarizes the encounters experienced by the Minority Health Initiative projects in Congressional Districts 1 and 3 for the period July 1, 2011 through June 30, 2012. The projects are very different; some focus on health screenings and others on more complex services such as assisting people to find a medical home. Therefore, a simple listing of the number of clients served is not expressive of the depth of the work. We therefore added during year one an Encounters page to the data report. This page is used to collect information on activities and services provided by the projects.

Assistance provided	
Establish medical home	348
Establish dental home	913
Case management	620
Home visits	423
Focus groups	139
Apply for public assistance	402
Transportation	238
Referrals	850
Low-cost medications	218
Health fairs	1,034
Interpretation sessions	7,192
Other activities	7,219
Total	19,596

Health screenings	
Blood pressure	4,250
Glucose	771
Smoking cessation	189
BMI	1,259
Cholesterol	330
Dental	493
Breast cancer	30
Immunizations	314
Other	276
Total	7,912

Health Education	People Served
314 sessions provided	8,946

Health education is a key component of almost all of the Minority Health Initiative projects. During year one of the project period (July 1, 2011-June 30, 2012), the projects provided 314 health education sessions on topics including:

- alcohol prevention
- breast cancer
- cardiovascular disease
- childhood depression
- colon cancer prevention
- communication/gaining support
- community health workers
- diabetes
- discovering healthy activities
- drug free for babies and parents
- family bonding
- farmers markets
- flu shots
- goal setting
- HbA1c labs
- health risk assessment
- healthy lifestyles/lifestyle changes
- HIV/AIDS awareness
- importance of health screenings
- keeping babies safe
- mental health/depression
- obesity
- poison/safety
- radon gas
- skin care
- sleep disorders
- stress management
- summer safety
- nutrition facts and labels
- tobacco cessation
- tooth brushing
- traditional use of tobacco
- vaccines
- weatherization of homes

Improved Health

Work by the Minority Health Initiative projects resulted in 7,571 improvements in health for participants.

Health Outcomes

Improvements in BMI/weight loss	588
Improvements in blood glucose levels	18
Improvements in blood pressure	549
Improvements in cholesterol	4
Improvements in dental health	958
Increased physical activity	714
Improved nutrition	656
Improved medication management	2,019
Improved self-management of chronic disease	2,003
Received prenatal care in the first trimester	11
Stopped smoking	51

Clients Served

This page summarizes the clients served by the Minority Health Initiative projects for the period July 1, 2011 through June 30, 2012. These numbers represent the number of people provided services listed on the previous pages of this report. They also include the number of people who demonstrated changes in health indicators such as weight loss and lowering of cholesterol or blood pressure; and improvements in healthy behaviors such as increased physical activity, smoking cessation, or improved self-management of chronic diseases. "Other" includes refugee, immigrant, White, and persons who chose not to self-identify their race and/or ethnicity.

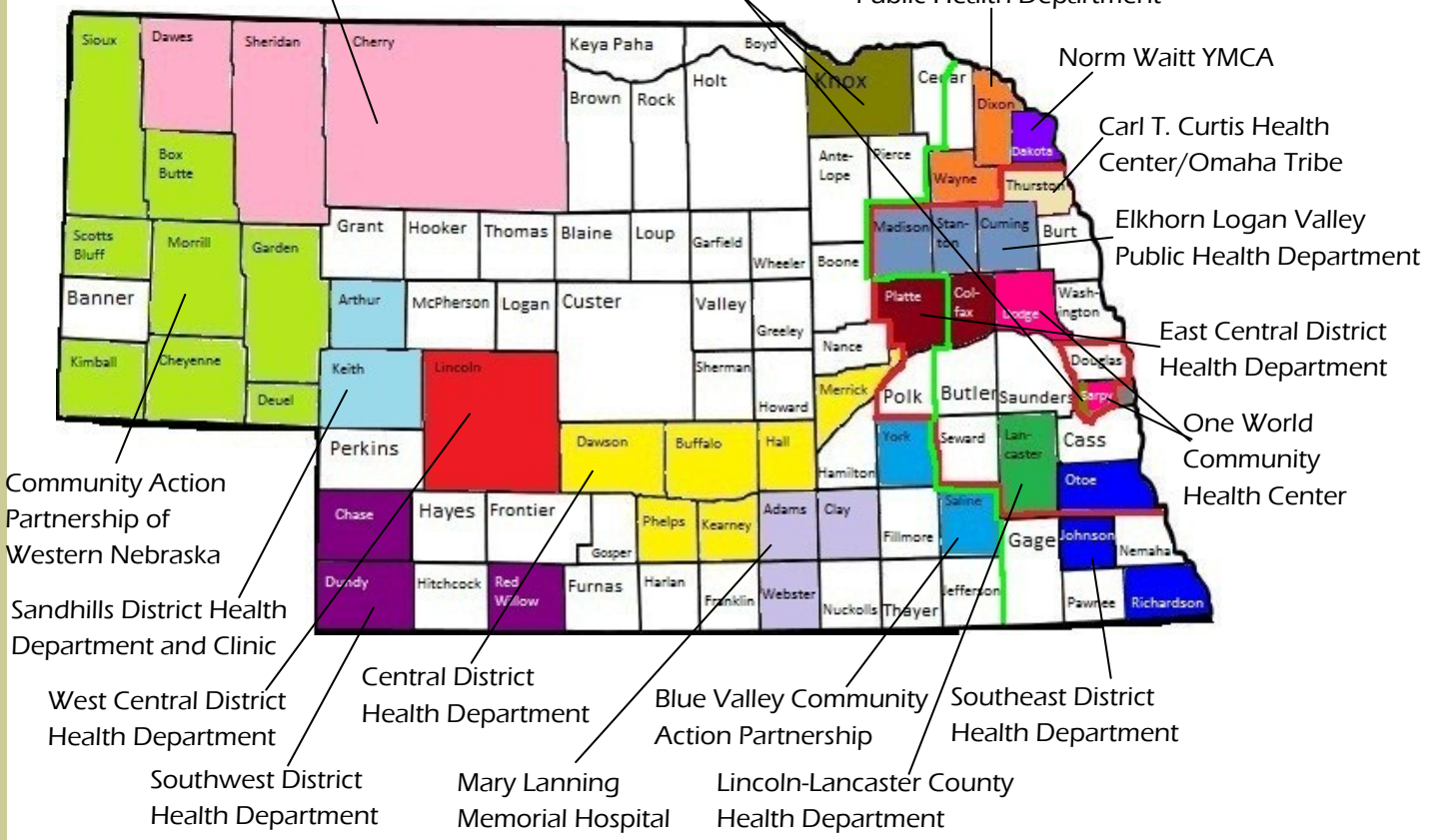
Female							
Age	Total	Non Hispanic					Hispanic
		Black	American Indian/ Alaska Native	Asian	Two or More Races	Other	
All Ages	7,405	374	873	239	253	1,820	3,846
0-9	599	14	29	3	8	279	266
10-19	881	26	59	20	30	242	504
20-29	1,292	70	180	39	22	174	807
30-39	1,619	72	119	54	61	279	1,034
40-49	1,255	72	205	31	57	248	642
50-59	927	68	156	28	36	292	347
60-69	521	33	80	31	24	184	169
70-79	232	12	34	23	10	100	53
80+	79	7	11	10	5	22	24

Male							
Age	Total	Non Hispanic					Hispanic
		Black	American Indian/ Alaska Native	Asian	Two or More Races	Other	
All Ages	3,770	301	477	227	73	1,071	1,621
0-9	483	5	40	0	8	170	260
10-19	576	11	56	19	19	155	316
20-29	487	40	71	30	11	100	235
30-39	623	73	91	39	16	155	249
40-49	631	71	98	27	10	159	266
50-59	488	58	64	31	6	165	164
60-69	303	30	40	37	2	110	84
70-79	129	12	13	27	0	45	32
80+	50	1	4	17	1	12	15

Individual Grantee Reports

The balance of this document includes summaries of the outcomes of the individual project grants in Congressional Districts 1 and 3 and funding allocated to the Federally Qualified Health Centers in Congressional District 2. The reports are arranged alphabetically by grantee name, and include the county(ies) covered by the project, the total funding awarded for the two-year project period, and the populations targeted by the project. They also include the funding priority(ies) and other areas targeted, the number of encounters and clients served during the first year of the project, and project partners.

A brief description of the project is followed by outcomes achieved July 1, 2011 through June 30, 2012. A success story(ies) is also included for each project.



Blue Valley Community Action Partnership

County(ies): Saline, York

Dollars: $90,765.61

Target Populations: Hispanic/ Latino

Target Areas: Infant mortality, obesity, cardiovascular disease, diabetes

Other Areas: Mental health, translation/interpretation, cancers, tobacco use, uninsuredness

Encounters 7/1/2011-6/30/2012: 2,059

Clients Served 7/1/2011-6/30/2012: 524

Project Partners: Four Corners District Health Department, Blue Valley Behavioral Health, Crete Area Medical Center, University of Nebraska at Lincoln Nutrition Education Department

Outcomes July 1, 2011—June 30, 2012

This project addresses outcomes that can decrease targeted health disparities for pregnant Hispanic/Latina women and their families by addressing risk factors and access to care.

Saline County:

- 40 new women received one or more case management services
- All 28 of the women who participated in mental health screenings reported increased knowledge of signs and symptoms of depression
- 3 women received additional mental health services
- 55 women who enrolled in the healthy weight class received 4 educational sessions; all demonstrated increased knowledge
- 4 additional educational classes were offered, and all 82 women attending demonstrated increased knowledge
- 55 women completed a six-week physical activity class and all reported increased physical activity as a result

York County:

- 13 new pregnant Hispanic women were enrolled into case management services
- All 29 participants of 2 health education sessions about mental health demonstrated increased knowledge of signs and symptoms of depression
- 19 people attended a mental health screening event and 1 was referred for additional services
- 7 health education sessions were provided and 55 women attended and demonstrated increased knowledge of risk factors and preventive measures to improve health outcomes
- York Community Partners group was formed with 12 members from schools, churches, the medical community, and public health; group members will improve their knowledge of available services and provide support for educational classes and events

The Road from Homelessness to Success

In 2008, Grace moved to Crete, NE, a small rural community with a growing Hispanic population. She had been told by relatives she could move here and find a good life for her family. Grace, her husband, and two children came to Crete homeless and stayed for a while with relatives.

The family was enrolled into the Minority Healthcare Case Management, supported by Minority Health Initiative funding through the Office of Health Disparities and Health Equity. Through this program, the family was assisted to find housing, food, and clothing; establish a medical home, enroll the children in Head Start, and find employment for the husband. Grace and her children were enrolled in the WIC program, and it was here Grace found employment helping interpret for other non-English speaking participants. The case manager enrolled Grace in the new *Healthy Weight in Women* program, where she participated in an eight-week program that provided physical activity and health education for minority women.

Grace wanted to do more with her life but her lack of education and inability to drive were barriers in finding employment. The minority health case manager continued to work with Grace and encouraged her to enroll in GED classes. With continued support, Grace did enroll and completed her GED. The case manager also supported Grace by teaching her to drive and practice for her driving test. In 2010, Grace received her driver's license and bought a car. Grace had now accomplished the goals she and her case manager had set for her to help her family become even more independent and provide a better life for them.

The *Healthy Weight in Women* program targeted reductions in risk factors related to diabetes, hypertension, and obesity; and provides health education on related topics including healthy nutrition and exercise. Grace applied and was hired as the minority healthcare case manager for the project. She completed her first year with the project, providing case management services to pregnant Hispanic women that include finding a medical home, medical coverage, enrollment into the WIC program, and other support services they may need to ensure a healthy outcome for mom and baby.

Funding that supports projects like the minority health case management not only helps address the immediate needs of families, but can open doors to move people from homelessness to independence, improve health outcomes, reduce disparities, reduce tax spending, and make communities a better place to live.

Grace and her family are now independent, have employment, and have purchased a new home. Grace continues to work with programs that have helped improve life for her and her family.

Carl T. Curtis Health Center/Omaha Tribe

County(ies): Thurston

Dollars: $88,204.20

Target Populations: Native American

Target Areas: Diabetes, cardiovascular disease

Other Areas: Tobacco use

Encounters 7/1/2011-6/30/2012: 1,992

Clients Served 7/1/2011-6/30/2012: 964

Project Partners: Omaha Tribal Tobacco Coalition

Outcomes July 1, 2011—June 30, 2012

The focus of this project is reduction of smoking and prevention of complications from Type 2 diabetes among members of the Omaha Tribe.

- 32 people were recruited to participate in tobacco cessation classes
- Attendance of classes is tracked in electronic health records
- Health fairs have been used as recruitment events for the tobacco cessation classes
- People who attended the cessation classes in the past have returned to share their stories and experiences
- A spiritual leader and martial arts instructor spent the last 20 minutes of each class teaching tai chi as a relaxation and stress-reduction exercise
- The leader/instructor also visits the project site once a week to offer additional teaching for anyone interested

Mindy's Story

Mindy Bertucci first lit her cigarette when she was 16 years old. She found many reasons to smoke. At first when she was younger it was to be cool with her friends, "social smoking." And over the years it became habit. "I felt like I needed a cigarette all the time" Mindy stated; "at work, during breaks, late nights especially when I couldn't sleep, even just when I had a friend at my home I would invite them outside so I could smoke a cigarette," she said. Mindy never smoked in her home or in her vehicles but smoked anywhere else she could.

She is a 33-year-old Omaha female, mother of an 8-year-old daughter, and wife to an Omaha Tribal Law Enforcement Police Officer.

She started to get sinus infections and had to be on medication and antibiotics; then these infections started to become a regular thing with her.

Eight months ago another infection started and "this was the last straw and my breaking point" Mindy says. "I began to think of how my daughter needed me around longer and I needed to live without being sick all the time. I was scared of cancer too." I needed to QUIT SMOKING she said!

She wanted this for herself and then a cessation support group began at the Carl T. Curtis Health Education Center and she was invited to attend. "I continue to have urges at times when I feel stressed, but I have learned to deal with it in a more positive way, I exercise! I also receive extra support from the program and know who to call if I need to vent. This was my extra motivation to quit and I am thankful because it has now been eight months that I have been smoke free."

Central District Health Department

County(ies): Buffalo, Dawson, Hall, Kearney, Merrick, Phelps

Dollars: $654,382.42

Target Populations: Native American, Hispanic/Latino, immigrant, refugee

Target Areas: Infant mortality, obesity, cardiovascular disease, diabetes

Other Areas: Translation/ interpretation, HIV/AIDS, tobacco use, sexually transmitted infections, cancers

Encounters 7/1/2011-6/30/2012: 103

Clients Served 7/1/2011-6/30/2012: 1,493

Project Partners: Two Rivers Public Health Department, Central Health Center, Central Nebraska Council on Alcohol Addiction, Community Fitness Initiative, St. Ann's Church, St. Mary's Church, Somali Community Centers in Lexington and Grand Island, Tri County Hospital, Dawson County Interagency Team

Outcomes July 1, 2011—June 30, 2012

The Choosing Health and Maximizing Prevention (CHAMP) program concentrates on expectant mothers, emphasizing healthy lifestyle choices and a continuum of care from pre-conception to the end of the reproductive years.

- 173 providers/offices in the 6 counties were sent a letter about the program twice in the first year
- 591 participants enrolled in the first year
- 408 participants who had one-to-one counseling sessions developed a personal health improvement plan (PHIP)
- 265 participants completed PHIPs
- Of the participants in program sessions, improved knowledge of the following topics was demonstrated by:
    - 79% regarding nutrition information labels
    - 94% regarding healthy nutrition
    - 88% regarding physical activity
    - 93% regarding health screenings
    - 84% regarding obesity prevention
    - 84% regarding cardiovascular disease prevention
    - 79% regarding diabetes prevention
    - 35% regarding healthy lifestyles
- At 3-6 months after the sessions, participants are asked about their successes in maintaining healthy behaviors they developed during the program. Results indicated at the end of 3-months post-program, 73%-93% of participants had maintained healthy behaviors, an increase from 50%-64% immediately post-program
- Performance scores are reported to project partners quarterly, to be used in efforts to improve programming.

<u>Hall and Merrick counties</u>: Six 6-week sessions of Coordinated Approach to Child Health (CATCH) kids club were provided and 8 series of Discovery kids were provided, reaching 236 youth and an additional 432 family members

Of CATCH kids club participants:

- 100% increased knowledge of healthy food choices
- 84% of family members reported their families had made improved nutrition or physical activity choices
- 100% tried a new healthy snack food
- 100% increased their ability to read and understand nutrition labels

- 85% who completed the evaluation reported eating more fruits each day and 72% reported eating more vegetables
- 67% reported an increase of fiber-rich foods (whole grains)
- 76% reported a decrease in intake of "sometimes" foods (those that should be eaten only infrequently)
- 82% reported an increase of time spent doing physical activity

Of Discovery kids participants:

- 95% reported knowing the steps they need to take to reach their goals in the post-test, compared to 87% in the pre-test
- 47% reported making good choices because they stop and think before doing something in the post-test, compared to 39% in the pre-test
- 94% believed that they knew different ways to say "no" to things they know are not good for them in the post-test, compared to 90% in the pre-test
- 88% believed that they knew how to say "no" to alcohol in the post-test, compared to 73% in the pre-test
- 87% believed that they knew how to say "no" to tobacco in the post-test, compared to 74% in the pre-test
- 89% believed that they knew how to say "no" to drugs in the post-test, compared to 73% in the pre-test
- 64% reported that they did not hit others when they are angry in the post-test, compared to 60% in the pre-test
- 80% reported knowing at least two ways to let their feelings out in ways that are not hurtful in the post-test, compared to 72% in the pre-test
- The Discovery kids sessions impacted 98 youth, most significantly in informing and empowering kids to make good choices, say no to drugs and alcohol, and control negative emotions

Dawson county: 5 CATCH kids club sessions were provided, reaching approximately 200 students

- Of the 62 participants who were surveyed: 68% eat more fruit, 33% eat more vegetables, and 44% report being more active
- 73% reported learning at least two things they could use to improve their health, 21% learned at least one thing
- 100% tried at least one new healthy snack during the sessions

Success Stories

Nancy

Hi my name is Nancy. I went through the CHAMP program and lost 20 pounds. I love the program, how it has brought my family closer together. We play basketball as a family, we exercise as a family with the PlayStation, and we even challenge each other to see who does it better. I stopped keeping pop and cookies in my house, so we are drinking 1% milk and it has helped my son a lot. At first it was odd for me to see him eat fruit or a granola bar because he always had to have his cookies and milk and they were not in the correct portion sizes. He has lost 10-15 pounds by not drinking pop. He has always been active but now he has more energy because he is eating and drinking healthier. I am proud of my accomplishments of eating healthier, making better choices when grocery shopping, but most of all the way it has brought us together as a family. We spend more quality family time with the help of the program CHAMP.

Jose

My name is Jose. My wife and I went to Central Health Center Clinic to have a physical exam done and to check our cholesterol, diabetes, and weight. Almost everything came out fine with an exception of my high cholesterol: it was 298. They referred us to the nutritionist with the CHAMP program to teach us how to live a healthier life, eat better, teach us how much to eat and what type of food to eat. Everything is going well. We both have lost weight. I started weighing 200lbs and now weigh 188lbs. I have not lost any more weight but my clothes are fitting better. We feel much better and have more energy. We are eating much better and everything keeps going well. Thanks to God and you guys (nutritionist and peer health educator).

Juventino

Juventino joined the CHAMP program at St. Ann's Catholic Church in Lexington. The church offers blood pressure checks and his blood pressure was high. He wanted to learn to eat healthier. When he first started the program his portions were unhealthy and he did not consume vegetables or fruits. He began to eat vegetables with meals. He also started to choose healthier portion sizes. He also started to eat more whole grain foods such as oatmeal and 100% whole grain bread. By the end of the program, Juventino lowered his blood pressure to a healthier range.

Michele

Michele was referred to the program for a BMI of 40. She wanted to lose weight and eat healthier. She also wanted to lower her blood pressure. Her portions needed work and she did not consume fruits and vegetables. She got limited physical activity. She too started to get more physical activity each week. She also started to watch her portions and incorporated healthier foods into her diet. She lowered her blood pressure and lost a total of 15lbs through the course of the program. On her last day of the program, she got her blood pressure checked, and it read 122/80. She stood up and did a little victory dance and yelled YEAH! She did a dance all the way out of the door. She ended up gaining weight back but still is maintaining a blood pressure of around 126/84. She stated, "CHAMP completely stopped me from overeating. I now limit my sodium and processed food intake. I read labels all of the time

now."

Youth Presentations

Central Nebraska Council on Alcohol Addiction recruited 21 Discovery kids and CATCH kids club participants to make a presentation to a group of community volunteers with United Way who oversee the allocation of funds. Each youth was given an opportunity to share first-hand what they've learned. Several of the youth wrote short essays/speeches which were read to the group. In CATCH Kids Club, each youth is asked to try new foods (healthy snack foods) and each youth tries any number of "new" foods – or at least foods they won't try for Mom, but they will for us – that's success in and of itself, however, it's not unusual to have more than half of the kids LOVE the new food they just tried – even greater success!! Now they go home and ask Mom/Dad to buy this new food so they can continue to enjoy it!!

Community Contributions

The CATCH program in Lexington was strongly supported throughout the community. The Lexington Walmart worked very hard to accommodate the weekly snacks for CATCH. Five schools participated in the CATCH program, and the largest CATCH group totaled over120 kids weekly. Each week, Walmart would have supplies counted out and boxed up for each school. On the days the CATCH snack required sliced fruits or vegetables, Walmart sliced the food and had it all separated for each school. The produce manager was overwhelmingly helpful in giving us the best value but did not charge for the extra labor involved in preparing the snacks each week. McDonald's was also a huge part of this program. They not only donated a portion of the yogurt parfaits for CATCH snacks but had one employee work overnight to make the 215 parfaits that were necessary for all the CATCH students. Finally, the Lexington Public School system asked school principals and after-school program directors to encourage and support the program. They offered not only use of the school building, but all equipment and supplies that we needed.

A local physician has commented on the success of the CATCH program as she sees it in her office with her patients. One such story is of a patient who was diagnosed with diabetes. As the physician was trying to educate her patient on healthy eating and exercise as an alternative to medication, the patient proudly said "I know all about diet and exercise! My kids have been coming home every week after that after school health class and telling me how bad we eat at home, how we need to try more healthy foods and different vegetables."

Chadron Native American Center

County(ies): Cherry, Dawes, Sheridan

Dollars: $54,715.57

Target Populations: Native American, Hispanic/Latino

Target Areas: Infant mortality, obesity, cardiovascular disease, diabetes

Other Areas: Mental health, HIV/AIDS, tobacco use, uninsuredness

Encounters 7/1/2011-6/30/2012: 419

Clients Served 7/1/2011-6/30/2012: 210

Project Partners: Western Community Health Resources, Panhandle Public Health District

Outcomes July 1, 2011—June 30, 2012

This project will expand community-based health promotion and disease prevention efforts in three counties. The focus is a model of personal health assessment to improve health behaviors.

- 168 Personal Health Assessments were completed
- Nine people used case management services such as follow-up blood pressure screenings and answers to questions
- Cultural competence of the project is ensured via working with Native American leaders
- Two health fairs were held, resulting in nearly 40 adults getting personal health assessments
- A basketball tournament held to give age-appropriate health messages to the younger generation resulted in 78 personal health assessments being completed
- To encourage physical exercise among youth, four youth coordinators who work together to schedule activities such as a 5K run, walking, and swimming on a regular basis
- Personal health assessments have been used to make client referrals to other services and determine follow-up necessary
- Nurses travel on a regular basis through all three counties to conduct health assessments and perform follow-up activities
- Other agencies which conduct HIV screening, family planning, and WIC involve the project nurses and collaborate with the project
- The project has been working with school personnel to encourage individual referrals for cases of substance abuse recovery, which is done using culturally-appropriate methods such as connecting the individual/family to a Medicine Man for spiritual healing as a component of well-being

Brian's Story

Brian is in his 60s and is 5'5" and 270 pounds, with several health conditions. Brian attended one of the health fairs held by CNAC where he went through a personal health assessment. Brian shared with the nurses that he had been having anxiety attacks. Based on his health assessment score, Brian was referred to a medical doctor for further exams. He has high blood pressure, diabetes, and a heart condition. The doctor he was referred to has put Brian on several medications for his anxiety attacks, diabetes, and high blood pressure. At this time, Brian is being highly monitored by his doctor, receives regular visits from the Chadron Native American Center nurses, and has made a change to his diet. Brian's change in what he eats is making him healthier and preparing him for a scheduled surgery.

Community Action Partnership of Western Nebraska

County(ies): Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sioux

Dollars: $275,803.45

Target Populations: Hispanic/ Latino, Native American

Target Areas: Obesity, diabetes, cardiovascular disease

Other Areas: Translation/ interpretation, uninsuredness

Encounters 7/1/2011-6/30/2012: 3,441

Clients Served 7/1/2011-6/30/2012: 574

Project Partners: University of Nebraska Medical Center West Nebraska Division College of Nursing, Western Community Health Services, Regional West Medical Center, Scotts Bluff County Commissioners, Kimball Health Services, Memorial Health Center, Panhandle Public Health District, Indian Center Inc.

Outcomes July 1, 2011—June 30, 2012

This project will address health risk factors, provide health screenings, and address language barriers that impede access to health care.

- 855 flyers about program activities were distributed
- Public service announcements (PSAs) were presented in the *Scottsbluff Star-Herald*, local radio station KDUH, and local television station KNEB
- 440 questionnaires were completed regarding how people learned about health screening events
    - 106 were informed by a friend, family member, or were told about the event
    - 151 learned about events via flyers or PSAs
- 453 people were screened for high blood pressure; of those, 47% had abnormal readings
- 444 people were screened for glucose; of those, 30% had abnormal readings
- All 345 people with abnormal screening results were referred to a health care provider for additional services
- All 131 people with abnormal glucose screening results received motivational interviewing
- 218 minorities participated in 16 body composition screenings in Scotts Bluff County
- 150 high-risk diabetic patients received education on their condition
- 510 people were screened for obesity
- 371 people received motivational interviewing; of those, 85 or 23% made behavioral changes to improve their health
- 125 Hispanic/Latina women and 60 Native American women attended a Red Dress/Red Shawl event
- 1,991 interpretation sessions were provided
- 52 transports were provided to 70 Native American participants and 209 medications were delivered to Native Americans from Pine Ridge, South Dakota
- 48 Native American people accessed health care
- In collaboration with Regional West Medical center, 173 transports were provided, 67 people were served, and 9 people accessed health care quarterly
- 38 people completed a random follow-up survey regarding the efficiency and value of the transportation services; without the services, 85 appointments would have been missed

Red Dress/Red Shawl Events

CAPWN Health Center and members of the Latina Red Dress Committee and UNMC put together an event that raises awareness of cardiovascular disease in Hispanic/ Latina women.

Many women attend this event every year, and we offer free blood glucose screenings, blood pressure screenings, and a body composition screening that is performed with our bio impedance scale. From one of these screenings, one of the ladies, a 61-year-old, 4'11" tall, who had been struggling with uncontrolled diabetes and hypertension, mentioned she was tired of always being ill, fatigued, and needing medications. She asked what she could do to improve her lifestyle. At our 2011 event our participant weighed in at 247 lbs. with a BMI of 53.2, fat mass of 129 lbs. After seeing these results, she became very emotional but motivated to make a lifestyle change that would improve her quality of life and health. Our participant received motivational interviewing and was told how important it is to eat right, exercise and have a positive outlook on reaching one's goals.

Following instruction, our participant made a drastic lifestyle change. She began eliminating all fried foods and added more fresh vegetables and fruits to her diet. She ate every two hours to raise her metabolism rate, and included exercise in her daily routine. Our participant mentioned that it was very difficult to get motivated but help from her family members, who would either join her in eating a salad or accompany her to take a 30 minute walk, made it much easier to reach her goal.

At our 2012 event, our participant weighed in at 217 lbs. with a BMI of 43.7, and fat mass of 105.8. After losing almost 31 pounds, our participant mentioned that she now has her diabetes and hypertension under control and has lots of energy to enjoy her family as well as enhancing her lifestyle. She took our information/advice and applied it to her daily living. Although she understands that she is still overweight for her height she states that she feels wonderful. Her goal is to lose enough weight to be able to stop taking medications. She will continue to work on her weight loss and feels that the Latina Red Dress event boosted her will to improve her life. Our participant mentioned that the information raised her awareness of cardiovascular disease and how this can kill silently. She said she wants to live a long life to be able to enjoy her grandchildren as well as the rest of her family. "It was very challenging, I love my tortillas, my soda, my Mexican cooking but I love myself more and I needed to make these changes in order for me to live," she said. "Being Latina, it is very hard to make these kinds of changes as we usually put our children, grandchildren, spouses, and friends before us and leave ourselves for last."

East Central District Health Department

County(ies): Colfax, Platte

Dollars: $200,595.78

Target Populations: Native American, Hispanic, refugee, immigrant

Target Areas: Obesity, diabetes, cardiovascular disease

Other Areas: Translation/ interpretation, uninsuredness

Encounters 7/1/2011-6/30/2012: 1,190

Clients Served 7/1/2011-6/30/2012: 604

Project Partners: Divine Mercy Church/St. Augustine, Templo Dios es Amor, Alegent Health Clinic, Central Nebraska Community Services, Cargill-Schuyler, Good Neighbor Community Health Center, St. Bonaventure Church

Outcomes July 1, 2011—June 30, 2012

This project will target risk health factors through education, the application of knowledge, and an increase of physical activity.

- 105 individuals completed diabetes education classes, 42 in Platte County and 63 in Colfax County—this goal for the two-year program was met in the first year alone
- 114 screenings were conducted at 4 events throughout the year
- 17 participants were referred to physicians for high glucose levels
- 34 participated in diabetes education classes as a result of the screenings
- 280 people joined a group that included physical activity opportunities and diabetes education; they tracked their walking with a log and pedometer
- 5 *Promotoras* educated 105 people on physical activity, nutrition, and healthy weight
- Aerobics classes were offered 3 times weekly and nutrition education classes were offered twice a week

Success Stories

Promotoras

During a diabetes class, the Minority Health Coordinator announced that she was looking for *Promotoras* in Schuyler and explained the program to attendees. Two people registered or enrolled to become *Promotoras*.

One of the volunteers stated, "This class has helped me. A lot of the information and the education received has been very useful for me and I would like to share this information with others, but when I invite people to the classes they say they don't have time. But now I can take the information to their home. I had high cholesterol two months ago now I'm back to normal, only by eating better and exercising."

The Promotoras program is an agreement between the agency and the individual in which the Promotora agrees to educate five people in the community on a weekly basis for12 weeks on topics and material provided by the Minority Health Coordinator. The Promotoras take the information to people who cannot attend the classes. They are the motivators and educators for the people they enrolled in the program.

"It's never too late to learn how to ride a bike"

During a diabetes class in Schuyler, a 75-year-old participant stated, "I ride my bike everywhere and I exercise every morning and he (the other man in class) doesn't have any health issues. I came to the class because I want to learn more about nutrition." Another gentleman, 68 years old, raised his hand and stated, "I walk around Schuyler because, I don't have a car and I have to exercise because I have high cholesterol, heart problems, and depression. When my wife told me about this class we wanted to come. I always wanted to learn how to ride a bike." The 75-year-old said, "I will teach you". The 68-year-old stated that he did not have a bike. Another participant offered to give the man a bike she had at no charge. The next week, the 68-year-old man shared with the class that he went to pick up the bike and he started to learn how to ride it. Now he is out of the house more and exercising more.

Help with Medications

Maria, a Hispanic female, 53 years old, came in to a diabetes screening with a glucose level of 468. The diabetes educator showed her some of the written information that was displayed and asked her if she was taking medication. Maria responded, "I'm diabetic and I have not visited my doctor for a while. I don't have the money for my insulin." she also explained some family issues she was experiencing and expressed that she had lost her husband recently. "I can't make time for myself. And if I go to the doctor, my doctor is going to be mad at me because I have not followed up on my appointments," she said. After giving her condolences and some words of hope, the diabetes educator explained to her that because she was already a patient of the Good Neighbor Community Health Center, she qualified for a program to help her get her medication. Two days later the diabetes educator saw Maria at the park. Maria told her, "I made the appointment. I'm going to see my doctor."

Elkhorn Logan Valley Public Health Department

County(ies): Cuming, Madison, Stanton

Dollars: $148,693.67

Target Populations: Native American, African American, Hispanic/Latino, immigrant

Target Areas: Obesity, diabetes, cardiovascular disease

Encounters 7/1/2011-6/30/2012: 8,354

Clients Served 7/1/2011-6/30/2012: 931

Project Partners: Norfolk Community Health Care Clinic, Madison Medical Clinic, Planned Approach to Community Health, Healthy Communities Initiative, Tyson Fresh Meats, schools, community and cultural centers

Outcomes July 1, 2011—June 30, 2012

Minority Education for Greater Access to Health (Project MEGAHealth) is designed to help populations access assistive services, agencies, community partners, and programs; increasing access to health care in an effort to reduce health risk factors.

- 45 people received education on diabetes/cardiovascular disease self-management
- 22 people received one-to-one instruction on diabetes, cardiovascular health, obesity, and other chronic diseases
- 23 people received in-home instruction on diabetes, cardiovascular health, obesity, and other chronic diseases
- Of those, 19 (83%) completed the curriculum; 6 (32%) lost weight and another 6 decreased their A1c values
- 107 businesses were approached with materials regarding the program
- 2 health fairs were attended, at which 110 people were provided health education
- Key informant interviews were performed with 115 people in the 3 target counties to collect data regarding health issues, ways to improve health outcomes, and reduce barriers to health care
- 17 health education presentations based on the results of the key informant interviews were presented to 899 people
- Pre- and post-testing was used to assess changes in knowledge resulting from health education sessions; the mean scores increased from 70% on the pre-test to 92% on the post-test
- The directory of local services available was updated and used to provide 252 referrals
- To ensure follow up by patients (a quality assurance measure), all referrals were tracked within 48 hours
- A customer satisfaction survey was implemented, and customer comments included:
    - The program has gone above our expectations in reaching out to minority populations with energy and grace
    - The program has allowed many to have information on health issues not necessarily covered by others
    - I feel the program has given our Spanish-speaking clients opportunities to access health education and also to ask questions about programs available
    - They are a very good resource in the

A New Path Toward Change

Idalys is a 46 year-old woman with five children. She was diagnosed with diabetes type II about 10 years ago. In 2007, she began education with the diabetes self-management curriculum but didn't finish it. She also had very little success with medication treatment due to secondary effects of the medications (e.g., dizziness, constipation). In addition, Idalys suffered from other factors such as lack of appetite, exercise, and sleep deprivation.

The minority health educator worked with Idalys to set and meet goals based on motivational interviewing. During this year, Idalys completed the entire diabetes self-management curriculum and improved her habits and health:

- Minimized carbohydrates and ate adequate and healthy meals every 3 hours
- Increased physical activity to 30-45 minutes three days per week
- Maintained doctor's visits
- Recognized the positive effects of the prescribed medication without modifying dosage unless instructed by doctor
- Identified effects of hyperglycemia (high blood sugar), hypoglycemia (low blood sugar), and understood when to seek immediate medical attention
- Reduced levels of stress by delegating daily household chores to her children
- Changed work schedule from second shift to first shift in order to better adjust to family needs and allow for increased sleep of 5-7 hours daily
- Notified her doctor and pharmacist when she had unpleasant or severe side effects of medications or when she did not feel well
- Reduced her glucose levels to normal levels and reduced her need for medications

Idalys stated that the education course helped her develop a healthier lifestyle not only for herself but also for her family. Her emotions have also improved since she has more rest and spends more time with her family. She enjoys more activities with her children such as family meals, watching television, going to the park, and her children's athletic events. "I make those around me aware of my health issues with diabetes. It is nothing that I try to hide. I am conscious of the importance of taking my medicines according to recommendations. I laugh and play whenever I can find the opportunity. Diabetes is not a companion that I sought after. It found me. I have embraced it and decided to maintain it in the best, most healthful way possible. Ultimately, I anticipate managing it so well that eventually the oral medicines will not be needed. It is my challenge and I am rising to the occasion every day! "

Lincoln-Lancaster County Health Department

County(ies): Lancaster

Dollars: $938,626.18

Target Populations: African American, Asian, Hispanic/ Latino, Native American, immigrant, refugee

Target Areas: Obesity, diabetes, cardiovascular disease

Other Areas: Mental health, translation/interpretation, uninsuredness, tobacco use

Encounters 7/1/2011-6/30/2012: 25,732

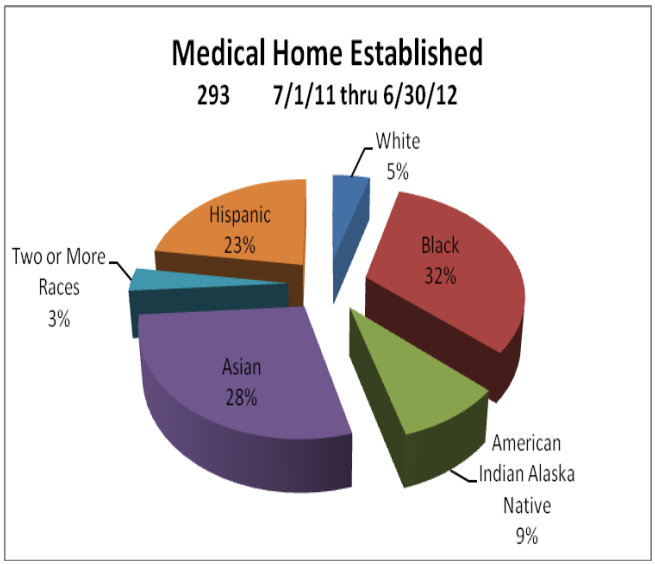
Clients Served 7/1/2011-6/30/2012: 3,666

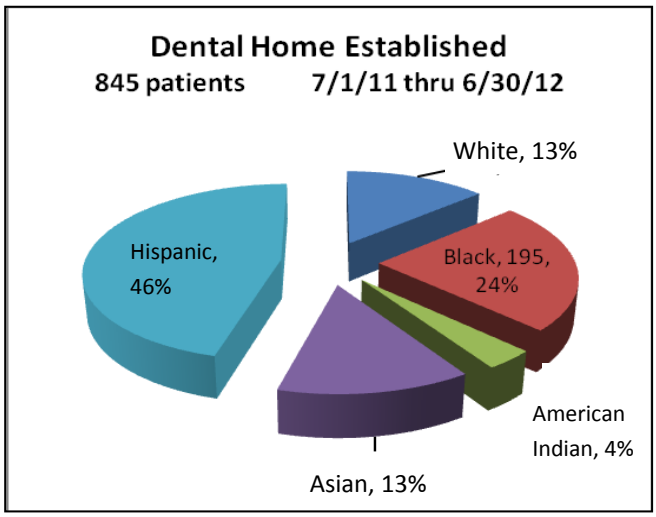
Project Partners: Asian Community & Cultural Center, El Centro de las Americas, Malone Center, Clinic with a Heart, The Health Hub, Lancaster County Medical Society, People's Health Center

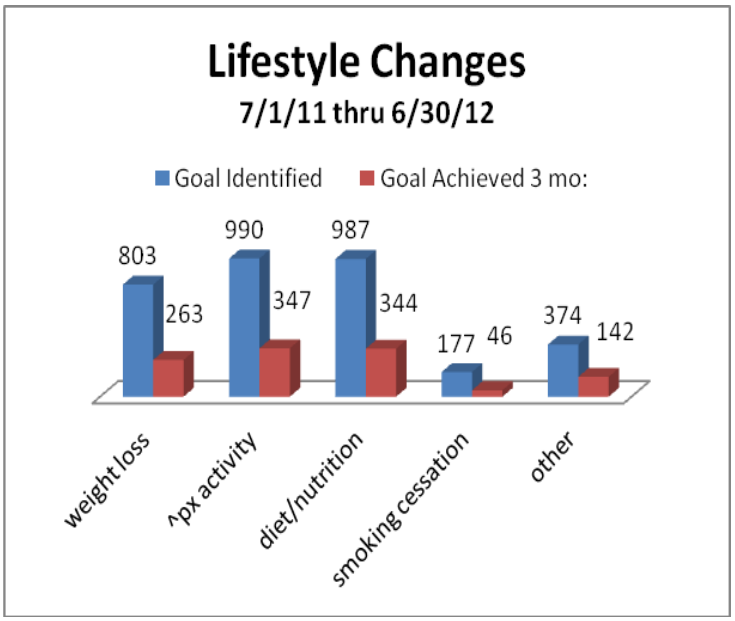
Outcomes July 1, 2011—June 30, 2012

The goal of this project is to reduce health risk factors and associated health disparities.

- 2,241 people received health screening and education on cardiovascular disease; this is 125% of the total two-year project goal
- 309 people were screened and educated at community and cultural centers; this is 103% of the two-year project goal
- Clinic with a Heart provided 1,932 screenings for high blood pressure or diabetes, interpretation sessions, and referrals to the Health Hub; this is 128% of the goal for the two-year project period
- 14 culturally sensitive health education/wellness sessions were held at the community and cultural centers and the Health Hub (155% of two-year goal); 518 people participated in the sessions (296% of the two-year goal)
- 69 people attended 14 bike tour sessions; 29 of those attended three or more sessions
- 293 people established a medical home at People's Health Center (146% of two-year goal)
- 1,403 people were evaluated and referred to a diabetes educator as needed; 444 people achieved 1,142 goals: 263 lost weight, 263 increased physical activity, 314 improved their nutrition, and 46 stopped smoking
- 1,255 new and existing patients met with a diabetes educator to develop an individualized behavior change plan
- 29% of new and existing minority patients screened for high blood pressure reduced at least one of their cardiovascular disease risk factors (blood pressure, cholesterol, body mass index)
- 845 new patients established at dental home—533 at Lincoln-Lancaster County Health Department and 312 at People's Health Center
- 107 dental patients were referred for specialized care
- 49% of dental patients surveyed reported improved understanding of the link between oral health and cardiovascular disease
- 5,165 interpretation service encounters were provided (1033% of two-year goal)
- At least 561 patients without prescription drug insurance were provided medication assistance
- Project staff created an episode of *Health Matters* that addresses the project and related resources: http://www.youtube.com/watch?v=lV_QdSP1QDI&feature=plcp


Medical Home Established
293 7/1/11 thru 6/30/12
White 5%
Black 32%
American Indian Alaska Native 9%
Asian 28%
Two or More Races 3%
Hispanic 23%


Dental Home Established
845 patients 7/1/11 thru 6/30/12
White, 13%
Black, 195, 24%
American Indian, 4%
Asian, 13%
Hispanic, 46%


Lifestyle Changes
7/1/11 thru 6/30/12
Goal Identified
Goal Achieved 3 mo:
803
263
990
347
987
344
177
46
374
142
weight loss
^px activity
diet/nutrition
smoking cessation
other

Success Stories

Dana

Dana informed a staff member that she suffers from fibromyalgia. She learned about the services provided at El Centro de las Americas through her workplace. She was in a lot of pain and in need of medical assistance because she had broken ribs. Staff helped her fill out an intake form and application and submitted it to the People's Health Center. Because of the immediacy of some of her needs, staff drove her to an urgent care facility. She was later given an appointment at the People's Health Center. Dana was grateful for the immediate aid staff provided her and now she has a medical home.

Phan

Phan, a man in his early 60s came in with his wife, who was in her late 50s. they moved here from Vietnam three years ago with their 20-year-old son as political refugees. As they began searching for employment they ran into significant barriers. Not only did the couple have limited English abilities, but they were nearing retirement age. It was difficult for them to perform the factory or manual labor jobs which do not require English skills. Both the husband and the wife remained unemployed, while their son was only able to find a part-time job. The family struggled to get by on their son's earnings, but when both parents started to get sick, the situation became impossible. The couple did not have insurance and did not know what to do. Phan experienced extreme stomach and abdominal pain. He delayed seeking care for a few months, then decided to return to his family doctor, who had worked with them during their first months in the U.S. The doctor discovered that Phan had chronic stomach ulcers and his wife had diabetes. They did not have the money to pay for the care or the necessary treatment for either condition.

Phan visited the Asian Community and Cultural Center to see if there were any options available to them. Project staff assisted them, but Phan's condition worsened and after visiting the doctor again, it was discovered that he had stomach cancer. Phan's condition had grown very serious and he only lived three months longer.

Phan's wife and son continued to struggle. She had difficulty paying for prescriptions and receiving follow-up care, so she came back to the Asian Community and Cultural Center and received assistance under the Minority Health Grant. Staff was able to find a medical home for her at the People's Health Center, where she is also able to afford prescriptions at a set cost. The wife and son now have a medical home with a doctor who knows their medical history and she has access to the medicine and the food she desperately needs. Although this story highlights the tragedy of illness and lack of resources, it also reveals the strength of this grant and its capacity to fill gaps.

Malone Community Center

Some of our clients do not realize that it is less expensive to have a medical/dental home versus utilizing the emergency room for these needs. Many clients cannot afford medical or dental visits because of little or no insurance and or income. Free clinics are useful short-term measures, but not a way to establish a medical or dental home. The implications are clear for our clients. The diseases that are high risk for African

Americans such as diabetes, hypertension, and stroke will shorten life spans.

The Malone Community Center Health Outreach Program collaborates and partners with other health organizations, agencies and our faith communities to host, attend and promote health fairs. We offer community members free health screenings. Because cost is an issue for many people, sponsoring more free screenings is useful in motivating community members to stay healthy. In addition, sponsoring health fairs offers African Americans an opportunity to learn about other health issues, reinforces the need for preventive care, and makes health a priority.

Our health fairs and heritage events have been a success. Our clients take advantage of the free screenings and receive useful information, and we do follow up on the assessments we receive. Our Health Outreach Program has helped African Americans and others in this community to stay healthy and to make health a priority. At one such event, approximately 60 people attended and completed assessment forms, received information on stroke risks and some had EKG-type screenings. Many of the participants complimented our health outreach coordinator on this event and told her that this should be done more often and with more screenings.

People's Health Center

People's Health Center (PHC) receives referrals from the Asian, Hispanic and African American cultural centers in Lincoln, both hospitals, the Lancaster County Medical Society, the Health Hub, other provider offices, and the Lincoln Lancaster County Health Department's refugee program. All of these people, whether insured or uninsured, are referred to PHC for a medical home. Forty-three percent of PHC patients who chose to report their race in 2011 were minorities. Eighty-eight percent of patients are at or below 200% of the poverty level. Forty percent of patients are uninsured, and 40% have Medicaid.

All of these challenges require more staff and more time spent with each patient than is typical in a private family practice. Add to that the large percentage of patients who do not speak English and need an interpreter for completing paperwork, seeing the medical or dental provider, or follow up communication and it is easy to visualize the kind of funding required to provide quality health care to the patient population at PHC.

People's Health Center has an array of services to guarantee a culturally sensitive and quality experience for the extremely large minority patient population we serve. The Minority Health Grant enhances these services by adding a provider to our panel of 7 full-time medical, 2.5 dentists, RN Diabetic Educator, and 14 Specialty Providers. This additional provider allows better access for patients to get their health care needs met in a timely manner. PHC's interpreters are enhanced through the funding of an additional interpreter by this grant. This allows PHC to provide live interpretation for Spanish, Kurdish, Arabic, Vietnamese, French, Portuguese, Burmese, and Karen patients. Without this funding, it would take 5-6 months for a new patient referred to us through community partners to establish a medical home.

Mary Lanning Memorial Hospital

County(ies): Adams, Clay, Webster

Dollars: $93,264.23

Target Populations: Hispanic

Target Areas: Obesity, diabetes, cardiovascular disease

Other Areas: Mental health, translation/interpretation, uninsuredness

Encounters 7/1/2011-6/30/2012: 6,610

Clients Served 7/1/2011-6/30/2012: 160

Project Partners: YMCA, South Heartland District Health Department, Blue Hill Medical Clinic, Sutton Medical Clinic, Edgar Medical Clinic

Outcomes July 1, 2011—June 30, 2012

This project will serve to improve access to comprehensive quality health care services, health education, and prevention methods for disease.

- All program participants who have diabetes, pre-diabetes, or are at risk for diabetes received case management services to a local primary care provider and access to one or more of the following: interpretation, problem solving, help completing paperwork for assistance programs
- Home visits were offered to all participants who received case management—148-200 home visits were offered each quarter during year one
- 17 people attended a community health screening event
- 2 health education sessions on nutrition were provided during support group meetings in Adams County; 70% of participants demonstrated understanding of the importance of nutrition
- 8 people received individual nutrition education
- 17 individuals participated in a community gardening project and another 16 created home gardens
- The proportion of participants who reported regular exercise increased from 43% in quarter one to 56% in quarter four
- 8 fitness assessments were completed, 15-23 people participated in each assessment session
- 27-31 adults and 12-15 kids participated in quarterly physical activity educational programs
- 2 outdoor activity opportunities provided, 31 adults and 12-15 kids participated in the first and 27 adults and 15 kids participated in the second
- Support groups were provided 8 times; attendance was 38-73 adults per session
- 5 people were recruited to be trained and work as *promotoras* in Adams County
- Data collection completed for a needs assessment of Clay and Webster counties
- 4 culturally and linguistically appropriate services (CLAS) trainings were provided to primary care provider clinics, 29 people attended the sessions
- 17 people completed the WellSource health risk assessment
- One volunteer project was organized for program participants to give back to the organizations that support this project, 34 adults participated in the project

A Journey of Wellness in the Hispanic Community

The El Paquete Total program has grown and evolved, changed names, added partners, and recruited new participants over the past 10 years. The original program started with the idea of addressing the impact of diabetes in the Hispanic community in Adams County. This was the first time a program of this kind was implemented in the area with a goal of screening the Hispanic population for diabetes mellitus, one of the prevailing diseases affecting this particular group. An infrastructure was developed that involved support group meetings, diabetes education, additional screenings, assistance with diabetes supplies and medication, and outreach to the minority community with a goal of connecting them to health care and available resources.

The program was expanded to include individuals with a family background of the disease, those at high risk of developing diabetes, and people with any cardiovascular disease or who were at risk, including those who were overweight or obese and/or had a family history of these conditions. The program expanded to involve more family members and children and attained an average of 100+ active adult members and 60+ active children. A community garden element was added, and participants produced a cookbook of easy, healthy, and culturally appropriate recipes. Health risk surveys were added to identify major health issues. This aggregate data help facilitate and guide the program, both as a whole and for individuals.

Despite all of these changes, the goal of and interest in improving health and wellness in the minority population has remained the same. We have recently added a *promotora* program, outdoor family activities, and volunteerism within the community. The current program reaches out to other communities and embraces two new counties. We have a solid infrastructure that allows us to offer our experience to neighboring areas and provide them with similar services.

The impact of this program has been significant. We started with a small group of individuals with diabetes who were identified in a local doctor's office. We provided education and support initially, and expanded to include spouses and family and children. Via a strong relationship with the local YMCA, we also added a substantial exercise component. We have reached hundreds of individuals and family members and made thousands of home visits. We have offered over one hundred support group meetings, did lab work on hundreds of individuals, and have documented thousands of visits to the local YMCA for exercise.

Norm Waitt YMCA

County(ies): Dakota

Dollars: $197,572.36

Target Populations: Hispanic, immigrant

Target Areas: Obesity, diabetes

Encounters 7/1/2011-6/30/2012: 694

Clients Served 7/1/2011-6/30/2012: 258

Project Partners: Hy-Vee, St. Luke's Regional Medical Center

Outcomes July 1, 2011—June 30, 2012

Goals of this program are centered on reducing the onset of obesity and diabetes among Hispanic children through health education.

* This project began late, so outcomes represent 6 months of work rather than a full year

- 72 second- and third-grade students received daily experiential nutrition education over 8 weeks
- Weekly family sessions on nutrition were provided
- Hands-on grocery shopping excursions were provided
- 5 cooking demonstrations were provided during the weekly family nutrition sessions
- Information provided on tools to assess current health and risk factors and for setting health improvement goals
- 71 adults were provided basic blood work (complete blood count [CBC], cholesterol, glucose) and a wellness check (body mass index, blood pressure, heart rate)
- 93% of participants in the physical activity educational programming increased their average amount of daily activity time
- 57% of participants in the physical activity programming adopted new activities outside the program
- Participating families accessed the facilities and services of the YMCA; program demand required additional programming

¡Si Claro!: Creating Lasting Behavioral Change in Hispanic Families

The first session of the 8-week Si Claro after-school program concluded on May 18th. Through healthy lifestyle programming centered on healthy eating, physical activity, and family engagement, many of the families have seen changes in their daily habits.

Raquel commented that her son Christopher has been "playing basketball and wanting to make healthy snacks" and "likes to exercise in the morning or take the kids to the pool in the afternoon." In addition, Raquel takes walks with the family to the park so the kids can play and the family visits the YMCA at least once a week to exercise.

Jose and Irma commented they "come very often to the Y. My kids come almost every day to play basketball or swim. They (the twins) like to come to the pool." Jose also said "it's better than staying at home in the same routine and watching TV. It's a good influence for the kids."

Since the conclusion of the 8-week after school program, two social events have taken place at the Y. An outdoor pool party and a 4th of July celebration attracted more than 160 participants. Not only were Si Claro families part of the activities, but additional neighbors and friends attended as well. Two more social events are planned for the summer for this first cohort of Si Claro families.

Northeast Nebraska Public Health Department

County(ies): Dixon, Wayne

Dollars: $29,583.36

Target Areas: Obesity, diabetes in Hispanic populations

Other Areas: Translation/ interpretation

Encounters 7/1/2011-6/30/2012: 347

Clients Served 7/1/2011-6/30/2012: 91

Project Partners: City of Wakefield, Wayne State College, Goldenrod Hills Community Action, Wakefield Community Schools, Michael Foods

Outcomes July 1, 2011—June 30, 2012

Targeting Type 2 Diabetes, this project will provide health education, implementation of preventive practices, and increase access to healthcare services.

- 12 people were recruited and trained in diabetes prevention; this is 140% of the two-year goal; participants improved their knowledge of diabetes by 51% from pre- to post-test
- 12 people were recruited and trained using the Compañeros Communitarios curriculum; 2 of them have begun to use the diabetes risk assessment with clients
- 19 people were screened using the diabetes health risk assessment
- Evaluation tools were developed for the program and approved by the local partnership members
- 57% of respondents rated their understanding of culturally and linguistically appropriate services (CLAS) as poor before attending education sessions and 79% rated their understanding of CLAS as good to excellent after
- 86% of representatives of local health care service organizations who attended education sessions on the CLAS standards reported an interest in learning more about the topic
- Work is progressing toward identifying steps necessary to make the Compañeros Communitarios a credentialed program

Contributions by Community Health Workers

Juan & Julia

A young family, Juan and Julia, with a baby on the way came into the Compañeros Comunitarios office while they were still expecting, wanting to make sure their baby would be covered by Medicaid, if possible, once the baby was born. We gave them referrals to someone who could assist them with the enrollment process. The couple returned to us after the application was begun because although they complied with every request to submit additional information, the process dragged on for weeks. The nurse was asked to help because of the complexity of the situation. She made numerous calls to inquire about the process, each time relaying the instructions to the parents, who quickly and patiently complied with every request.

After numerous calls, the nurse was eventually told that the process had taken too long and the couple would have to reapply. By this time the baby had been born and diagnosed with a congenital problem. A care plan was developed that included surgery within a critical time frame in order to prevent potential future disability. The community health worker assisted the family with appointment arrangements, interpretation, and travel needs.

The day before the surgery, the nurse received a call from the specialist's office inquiring about the status of the family's Medicaid application. The nurse checked and learned the baby had not yet been approved. The specialist's office told the nurse the hospital did not want to move forward with the surgery unless Medicaid had been approved. The nurse pleaded with the specialist's office staff to allow a little more time to check into things.

The nurse contacted Juan and explained the situation. He shared with the nurse that if they were to wait two more weeks as the specialist wanted to do in order to get the Medicaid coverage, he would not be able to take time off of work due to it being the busiest season for that business. Juan also stated that he had already taken off more time than his supervisor was happy with because of the special needs of the baby and the numerous doctor's appointments that were needed. The nurse agreed to would continue to advocate for his baby and then contacted the specialist's office and persuaded them to go ahead with the surgery as scheduled. When Juan heard the good news, he remarked how happy and thankful he was and told the nurse how sad he had been earlier thinking that his child was not going to get the needed surgery because he had no money.

Leon & Lisa

A community partner called the office asking if the community health worker (CHW) could transport a new father, Leon, from a regional hospital back to their small community. Leon, Lisa (the baby's mother), and the baby had been driven to the hospital by a community member when it was identified that the baby was having some serious problems. Lisa and the baby needed to stay at the hospital and Leon needed to come home to work. The CHW picked Leon up and drove him home.

Leon and Lisa contacted project staff for assistance several times over the next few months. One time, Lisa called and spoke to the nurse because she was unsure if she should take her baby in to see the pediatrician in a town about 45 minutes away or if she could wait until her regular appointment a few days away. The family only had one car and Leon needed it for work. The community health worker assisted Lisa with interpretation so she could speak to the pediatrician and it was determined that the baby needed to be seen that day. The community health worker drove Lisa and the baby to the pediatrician's office, from where the baby was sent to the hospital.

Lisa called once they arrived home to ask the nurse about the medication. She reported that the medicine had been given to her but she did not have a machine to administer the medication with and she wondered where she should get one. The nurse called the physician's office, and the community health worker assisted Lisa to talk with the pediatrician. The doctor had called directly to the pharmacy before hospital dismissal to make sure they had the machine the baby needed but the person at the pharmacy had not given it to Lisa. The nurse was able to make arrangements with a local pharmacy so that the family would not have to drive all the way back to the original pharmacy and the baby was able to get the necessary treatments that day.

Lisa and Leon have learned over the past few months to be more competent and sure of their abilities to care for this baby with special health care needs. She knows that she can call us when needed and the nurse or the community health worker will be there to assist as necessary to maneuver through a challenging health care system.

Employees of MFI- Become Bilingual Community Health Partners

* This article originally appeared in Spanish in the August 2011 company newsletter, *El "Eggs"-aminer*, of Michael Foods in Wakefield.

On August 10, 2011 three employees of Michael Foods became Community Health Bilingual Partners: Letty Armendariz - Human Resources Representative, Ruby Saneamieto Diaz, and Victor Zarate. They attended District Public Health Department classes provided by Northeast Nebraska, in which they were taught how to help those who are not familiar with the resources and culture in their areas so they can better understand and have access to these health services. Some of the activities they will be helping with are to make calls to the offices of physicians or other health related offices and setting up appointments, re-ordering medications, assisting and understanding of documents received in the mail, and assist in the planning and implementation of school-based community classes/training sessions.

In the future, the District Health Department would like to establish a building where the community can go and get these services. The services would be of no cost to the beneficiary. The only payment would be a donation of volunteer hours for community Service. We look forward to the contribution being made by these individuals. Congratulations Letty, Ruby, and Victor for completing this course!

One World Community Health Center

County(ies): Dodge, Sarpy

Dollars: $146,288.34

Target Populations: African American, Asian, Hispanic, immigrant

Target Areas: Diabetes

Other Areas: Uninsuredness

Encounters 7/1/2011-6/30/2012: 554

Clients Served 7/1/2011-6/30/2012: 216

Project Partners: University of Nebraska at Omaha, Nebraska Methodist College

Outcomes July 1, 2011—June 30, 2012

This project targets increasing diabetes awareness, education, and testing among minority communities.

* This project began late, so outcomes represent 6 months of work rather than a full year

Sarpy County:

- 3 people were recruited and completed 100% of the *promotora* training curriculum
- 15 people were screened for glucose, body mass index, and blood pressure via 3 outreach events
- 20 diabetes educational events were provided, with a total attendance of 31 people
- 6 referrals were made for social services

Dodge County:

- 19 people were recruited and 95% completed the *promotora* training; this represents 127% of the two-year goal
- The new *promotoras* provided 4 home visits to provide diabetes education and testing
- 161 people were tested for diabetes at 3 outreach events
- 20 diabetes education sessions were provided, with a total attendance of 139 people
- 45 people were referred for social services
- 6 people who were identified as pre-diabetic were referred for case management
- 4 people established a medical home at One World

Woman Gains Strong Leadership Skills while Training to Become a Community Health Worker for the Minority Health Initiative

One challenge that is addressed by Minority Health Initiative (MHI) projects is access to health care. This challenge affects the community negatively. Community members do not have easy access to a doctor's office, a dentist appointment, or even a nurse to talk to for health related advice. This can lead to a community of poor health and can eventually spread illnesses. The Minority Health Initiative project trains community health workers to act as liaisons between health care resources and community members. Their training includes information on health prevention and promotion, specifically for diabetes. Along with these valuable abilities, community health workers also develop interpersonal skills, leadership skills, and strong communication skills. This project helps us to overcome the challenge by training individuals who care about their community and are eager to become involved to create changes.

Blanca, one of the community health workers, has stood out in the MHI program, demonstrated strong leadership skills, and fully taken on the role of a community health worker. She has taken all the knowledge she gained during training and put it to work. Blanca has started to spread the word and works to inform her community in various ways about the project. She has also started organizing open houses for diabetes testing in her neighborhood. Blanca welcomes family, neighbors, and friends into her home for diabetes testing and health education. Her leadership has been demonstrated by serving as a health resource for community members. She recently became part of the One World patient committee, serving as an advocate for her community. She is a great asset to the Minority Health Initiative and plans to continue to do outreach in her neighborhood and further her education. Overall, Blanca has really helped the project address the access to health care challenge for the minority population.

Ponca Tribe of Nebraska

County(ies): Knox, Sarpy

Dollars: $24,535.12

Target Populations: Native American

Target Areas: Obesity

Encounters 7/1/2011-6/30/2012: 113

Clients Served 7/1/2011-6/30/2012: 83

Project Partners: Ponca Special Diabetes Program for Indians, Ponca Education Department

Outcomes July 1, 2011—June 30, 2012

This project will emphasize healthy lifestyle choices, prevention, and health education in an effort to reduce and/or eliminate the onset of health risk factors and additional complications.

- Recruited and trained 25 family collaboratives/garden sites that served 83 people
- Garden compost, planting, and tilling orders were completed for 27,278 square feet of garden
- 88% of people who responded to a phone survey about the gardens ranked the quality of the gardens good or satisfactory
- Working with the University of Nebraska Medical Center to develop generic and personalized nutrition messages to be delivered via automatic/periodic text messaging

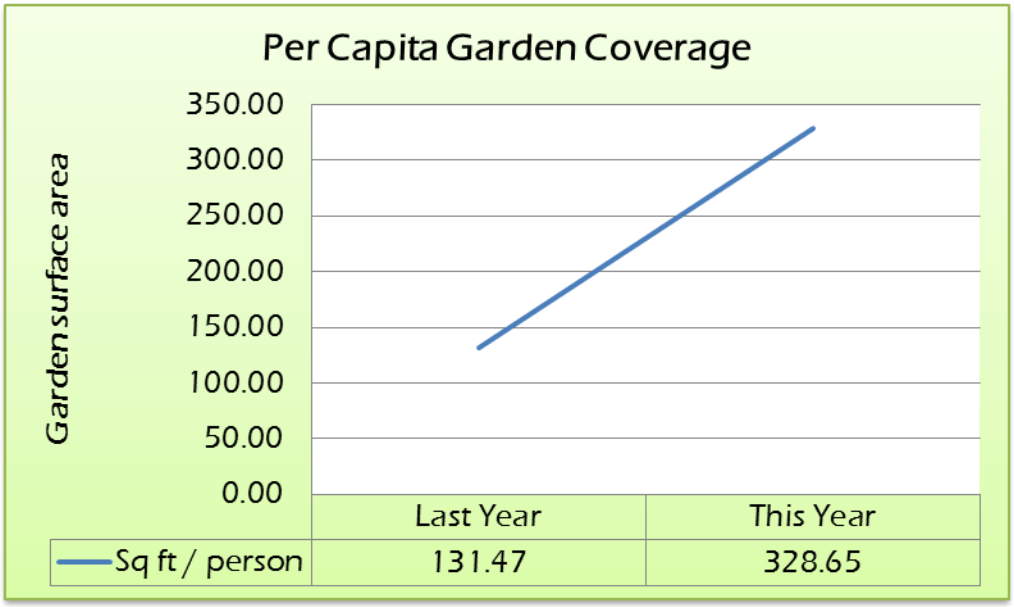
A New Garden Model

The Ponca Tribe has a history of attempting community gardens, but little success due to difficulty getting people to care for the gardens.

Under this project, the Tribe switched from community gardening to the family cooperative garden model (individual properties, but shared yields and responsibility). Other services and supplies offered included garden education and tilling and plant assistance.

All of the gardens are doing well. The table and figure below show high interest in the first year, and an even more dramatic increase in this year.

	Household members	Square feet	Sq ft / person	Anticipated per capita yield (lbs)
This Year	83	27,278	328.65	164.33
Last Year	68	8,940	131.47	65.74



Sandhills District Health Department and Clinic

County(ies): Arthur, Keith

Dollars: $13,962.34

Target Populations: Hispanic/ Latino, African American, immigrant

Target Areas: Diabetes

Other Areas: Translation/ interpretation

Encounters 7/1/2011-6/30/2012: 1,304

Clients Served 7/1/2011-6/30/2012: 1,050

Project Partners: Ogallala Community Hospital, Keith County Ministerial Association, Educational Service Unit 13

Outcomes July 1, 2011—June 30, 2012

This project targets development of partnerships and collaborations to improve the cultural and linguistic appropriateness of health care services.

* This project began late, so outcomes represent 6 months of work rather than a full year

- 21 people were screened for diabetes at the Keith County Hispanic health fair
- 3 patients with Type 2 diabetes were referred for follow up and provided interpretation services
- Met with the Keith County Ministerial Association and Ogallala Community Medical Clinic staff to discuss Spanish-language diabetic health information distribution
- Developed partnership with Educational Service Units13 and 15 and their immigrant workers program
- 33 people were screened for height, weight, body mass index, and blood pressure
- English and Spanish diabetic educational materials distributed during 1,233 patient encounters
- Working to schedule medical interpreter training
- Distributed flyers on the importance of physical activity

Maria and Rosa's Story

We met Maria when she came in to the clinic for health services. She required an interpreter but demonstrated a strong grasp of the terminology used and great communication skills. We therefore asked her if she would consider being on their minority health team and interpret for the clinic. At the time, she was in the process of moving away and declined the invitation.

Maria moved back to the area later and came into the clinic. She was once again asked to join the team to help serve clients who needed interpretation services. She stated that she would appreciate the opportunity to pay forward the help she had received and agreed to work with us to assist limited-English proficient clients access health services.

One of Maria's first projects was to organize a health fair for migrant workers. The event was to take place in the fields, but it was determined that it was too hot to do so, so Maria volunteered the use of her home. The health fair was attended by 33 people. project partners provided refreshments and the health education materials and presentation were provided in Spanish.

One of the attendees, Rosa, kept saying she did not feel well. Project staff were unable to check her blood glucose because the equipment overheated, so project staff asked Rosa to come to the clinic the next day. Rosa did visit the clinic with her family and was diagnosed with diabetes and uncontrolled hypertension. She had been out of blood pressure medication for three months because she had not had time or money to fill the prescription. Project staff helped her refill her medications and set up an appointment with a health care provider. Both Rosa and her health care provider believe the health fair saved Rosa from a stroke or worse.

Rosa visited the clinic again recently to tell project staff how much she appreciated the extra education and care they provided. Since this episode, Rosa has lost weight, added regular cardiovascular exercise to her routine, and improved her nutrition. She is compliant with her medication regimen and feeling better than she ever has before. Rosa has also become an advocate for the program, telling others about the importance of getting screened.

Southeast District Health Department

County(ies): Johnson, Otoe, Richardson

Dollars: $55,345.46

Target Populations: Native American, Hispanic/Latino, immigrant

Target Areas: Needs assessment, capacity building in year one to determine priorities for year two

Other Areas: Translation/ interpretation

Encounters 7/1/2011-6/30/2012: 146

Clients Served 7/1/2011-6/30/2012: 156

Project Partners: Hospitals in Nebraska City, Syracuse, Tecumseh, Community Memorial Hospital

Outcomes July 1, 2011—June 30, 2012

The first year of this two-year project has been focused on a needs assessment of the minority populations, which will be used to determine the most appropriate objectives and activities to be implemented in year two.

* This project began late, so outcomes represent 6 months of work rather than a full year

- 4 Mobilizing for Action through Planning and Partnerships (MAPP) meetings were held in Richardson and Otoe counties; representatives of the minority and Tribal communities were invited and 66 Hispanic community members and employers attended
- Working with the Missing Link program through the Komen Foundation to identify women who lack access to breast exams, mammograms, and other preventive services
- Several project staff participated in the Patient Navigator training offered by the Office of Health Disparities and Health Equity and the Office Women's and Men's Health
- Interpretation services provided to 28 families at immunization clinics
- Met with 2 families about Growing Great Kids, a home visitation program for at-risk moms
- 8 interpreters are working with the minister of the Hispanic church in Otoe County to meet community needs

Success Story

Southeast District Health Department has been conducting meetings throughout the district for the MAPP process, which is a focus-group centered community assessment. During the process, minority leaders have been invited. We have had difficulty with outreach in our district, and have historically worked with the Catholic church and the human resources offices of local employers, which has brought minor success.

During the Otoe County meetings we were introduced to a minister who is a wonderful partner and is assisting us to gain the trust of his community. He has been meeting with us and brainstorming ways to work with his church to educate and involve minority women in prevention activities.

Southwest District Health Department

County(ies): Chase, Dundy, Red Willow

Dollars: $28,155.64

Target Populations:

Target Areas: Needs assessment, capacity building, lay health ambassadors in year one to determine target areas for year two

Outcomes July 1, 2011—June 30, 2012

The first year of this two-year project has been focused on developing collaborations and networking with community partners to identify key minority leaders who will be asked to train and serve as lay health ambassadors or community health workers in year two.

* This project began late, so outcomes represent 6 months of work rather than a full year

- Worked to create a committee of public health partners to complete a needs assessment for the minority population; current members include representatives of Educational Service Unit 15, St. Patrick's church, Chase County Hospital, Chase County school nurses, Department of Agriculture extension educators, and McCook Community College
- Working to recruit and train lay health ambassadors to assist with data collection for the needs assessment
- Working with the Mobilizing for Action through Planning and Partnerships (MAPP) committee to review the general needs assessment completed in 2011 to determine whether information is applicable to minority populations
- Reviewing best practices regarding nutrition and physical activity for selection and implementation during year two

Success Story

This project is challenged in a couple of significant ways, but staff are working to address and overcome them. It includes two counties that were not eligible for Minority Health Initiative funding until the 2011-2013 project period, which required development of a brand new program. In addition, the organization that served the third county under previous project periods was unable to continue the project and is now largely defunct and therefore unable to provide any guidance to the new project.

To address these challenges, project staff are working to complete a needs assessment with the minority community. They are also working to recruit and train lay health ambassadors or community health workers to assist with the needs assessment and learn about the minority communities they wish to serve.

West Central District Health Department

County(ies): Lincoln

Dollars: $74,472.81

Target Populations: Hispanic, immigrant

Target Areas: Needs assessment, capacity building in year one to determine target areas for year two

Other Areas:

Encounters 7/1/2011-6/30/2012: 146

Clients Served 7/1/2011-6/30/2012: 202

Outcomes July 1, 2011—June 30, 2012

The first year of this two-year project has been focused on collection of baseline data on the needs of minority populations and hiring of a minority outreach coordinator who helps limited-English proficient persons to become acquainted with resources and learn about programs and prevention.

* This project began late, so outcomes represent 3 months of work rather than a full year

- Hired two part-time staff to serve as co-minority health coordinators
- Organized the first of 3 focus groups with stakeholders who serve minority communities to develop a needs assessment; 11 people participated in viewing and discussion of an episode of California Newsreel's Unnatural Causes and a subsequent discussion of the needs of the local community
- Created a survey to be used to collect self-perceived health status from the minority communities
- Distributed and collected 202 surveys of self-perceived health status from minority community members for inclusion in the needs assessment

Her Daughter's Epilepsy

"Although the mother spoke no English, her daughter's epilepsy was successfully diagnosed and treated."

Sara had a daughter who was sick and she did not speak English in a town where few interpreters are available. She had no way of knowing what illness her daughter had and she was very worried. The minority health coordinator met Sara during her outreach activities with the Hispanic/Latino community. Sara was surprised and happy that the project included interpretation services, which she used to finally ask and receive answers to her questions about Katy's health. The minority health coordinator worked with Sara to get Katy in to see a pediatrician and apply for Medicaid. It turned out that Katy had epilepsy, a condition which required a trip to Denver for an appointment with a specialist. Sara worked with the minority health coordinator to make the appointment and arrange for transportation. Katy's diagnosis was confirmed and she is responding to treatment.

Language barriers are a significant concern in Lincoln and surrounding counties. The area includes a significant immigrant population, many of whom are shy about accessing health care services due to the language barrier. The Minority Health Initiative program helps people overcome this barrier by providing access to bilingual staff who assist with making and attending appointments.

Charles Drew Health Center

County(ies): Douglas

Dollars: $714,050.50

Target Populations: African American

Target Areas: Cardiovascular disease, asthma, diabetes, obesity, infant mortality

Other Areas: Depression

* As noted earlier, included in the appropriation is annual funding to be distributed equally among federally qualified health centers in the second Congressional District. This is one of those projects.

Clinical outcomes

Diabetes

CDHC has a current diabetic population of 796, of which 85% had a HbA1c less than 7% (goal is 43%). The percent of patients on cardiac risk reduction with ACE-1 or ARB is 88% (goal is 75%). The percent of patients who have had a diabetic foot exam is 57% (goals is 70%).

Asthma

The current number of patients in the asthma collaborative registry is 315. The percent of patients with appropriate treatment with anti-inflammatory medicines is 80% (goal is >75%).

Cardiovascular

The current number of CDHC patients in the cardiovascular collaborative is 1608. The percentage of CVD patients with appropriately controlled blood pressure is 68% (goal is 60%). The percentage of CVD patients with LDL cholesterol to goal is 59% (goal is >60%). The percentage of CVD patients taking a beta blocker is 78% (goal is 70%). The percentage of CVD patients on cardiac risk reduction with ACE or ARB medication is 87% (goal is >70%).

Depression

The current number of patients in the depression collaborative is 481. The percentage of CSD patients with a 50% reduction in PHQ is 27% (goal is 40%). The number of CSD patients with a 5 -point reduction in PHQ score within 6 months is 26% (goal is 50%). The percentage of patients who have a diagnosis of depression with documented self-management goal setting during the past year is 76% (goal is 70%).

One World Community Health Center

County(ies): Douglas

Dollars: $714,050.50

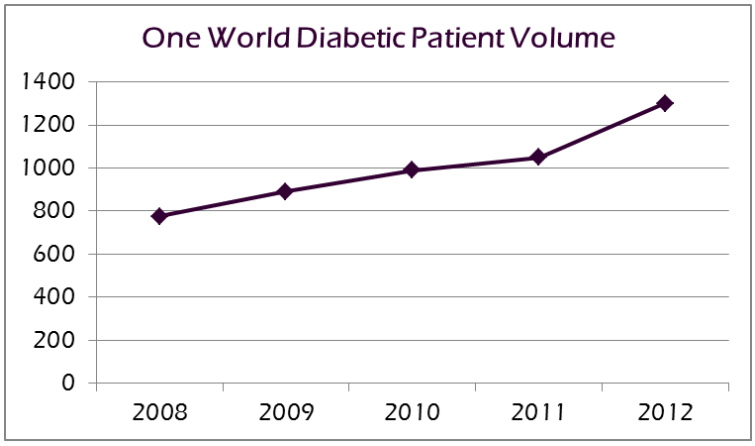
Target Populations: South Omaha

Target Areas: Cardiovascular disease, diabetes

Other Areas: Depression

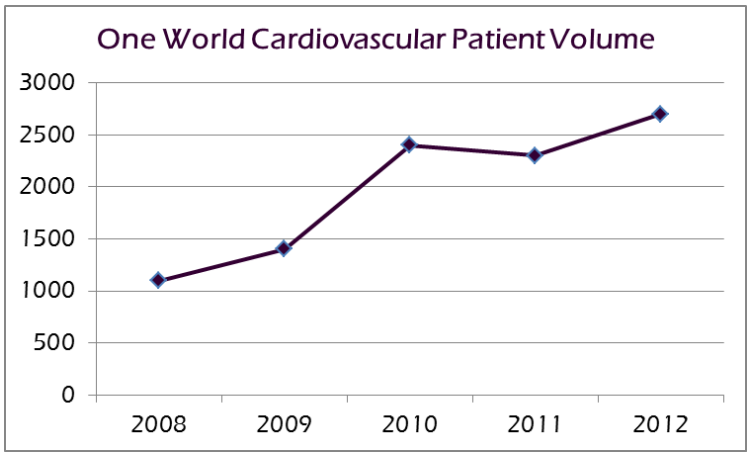
* As noted earlier, included in the appropriation is annual funding to be distributed equally among federally qualified health centers in the second Congressional District. This is one of those projects.

Tobacco	2011	Jan-Jun 2012
Adults patients queried for tobacco use	96.5%	97.8%
Tobacco users received cessation counseling	74.2%	76.8%

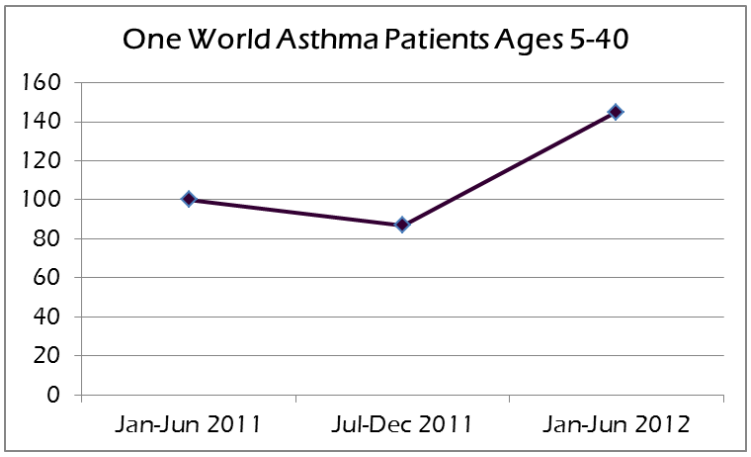


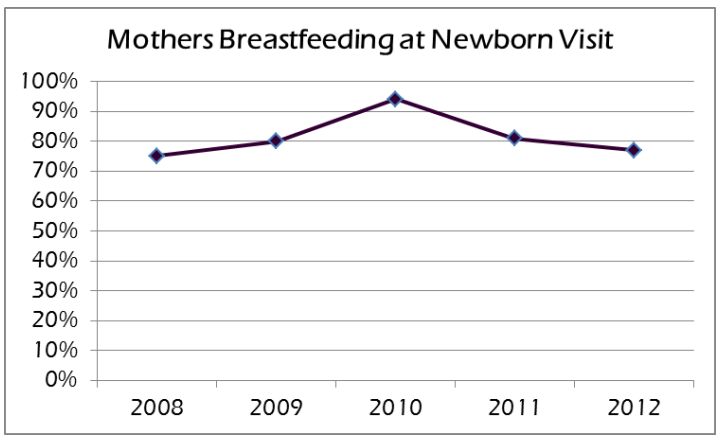
Diabetes Management	7/2011-6/2012
% diabetic patients with one or more HbA1c tests in the last year	67.8%
% diabetic patients with blood pressure <130/80	59.7%
% annual foot exams	62.9%

Cardiovascular Disease	7/2011-6/2012
Two or more blood pressures in past year	79.6%
Patients with LDL cholesterol under control	71%



Asthma	2011	Jan-Jun 2012
Persistent asthma patients with ICS medications prescribed or dispensed	95.1%	88.3%





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Nebraska Office of Health Equity & Health Disparities

402-471-0152

minority.health@nebraska.gov

www.dhhs.ne.gov/healthdisparities