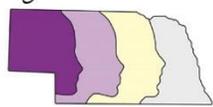


# Community Health Hub Manual

A MANUAL FOR  
IMPLEMENTATION OF CLIENT  
NAVIGATION SYSTEMS

*Every Woman Matters*



NEBRASKA OFFICE OF WOMEN'S HEALTH

**NEBRASKA**

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

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*The Community Health Hub Manual can be found online:*  
<http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx>

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program and the Well Integrated Screening and Evaluation for Women Across the Nation Cooperative Agreements with the Nebraska Department of Health and Human Services System. #5NU58DP003928-05/#5NU58DP004863-04

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# Section 1: CHH Introduction

## Why Community Health Hubs?

The Community Health Hub (CHH) model provides integrated resources from DHHS to be passed down to local communities to build capacity within local health departments to increase preventive screening in adults.

Local health departments collaboratively work with community level partners and DHHS to assess the needs of the community and priority populations around preventive screening with emphasis on breast, cervical, and colon cancer, cardiovascular risk reduction and obesity. Through community partnership and engagement, pathways to care are developed with implementation of evidence based interventions.

Outcomes are meant to improve access to high-quality preventive screening services, enhance community linkages and strengthen data collection and utilization that impact quality of life and health outcomes for Nebraska residents.

### **Outcomes of CHHs include:**

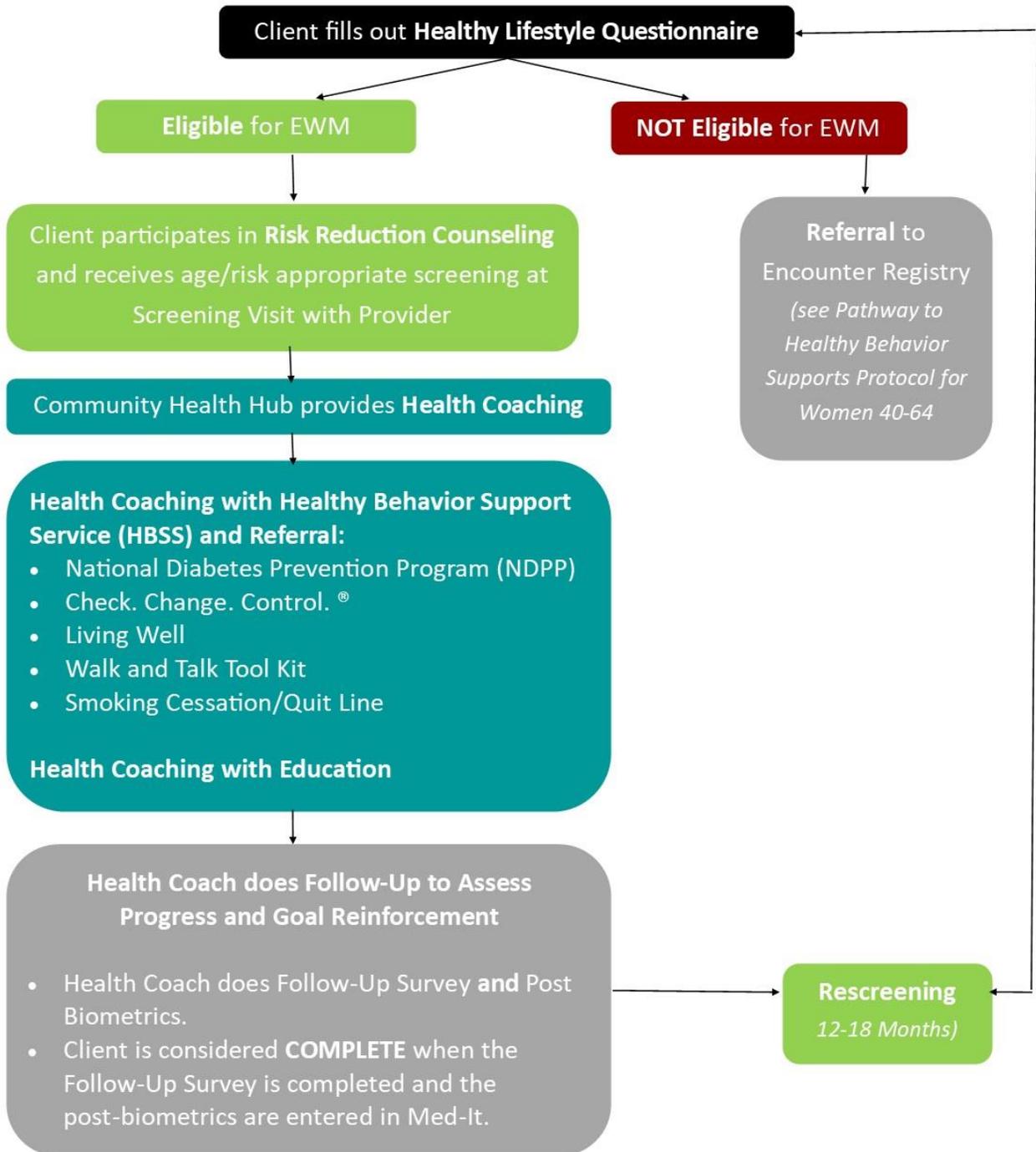
- Integration and efficiencies across programs
- Collaborative and cooperative work across programs
- Utilization and implementation of evidence-based or promising practices to address specific needs and gaps within community
- Continuous quality improvement
- Coordinated strategic assessment of community needs and gaps that impact health outcomes
- Culturally/linguistically appropriate access to screening and education

### **Key activities within the CHH:**

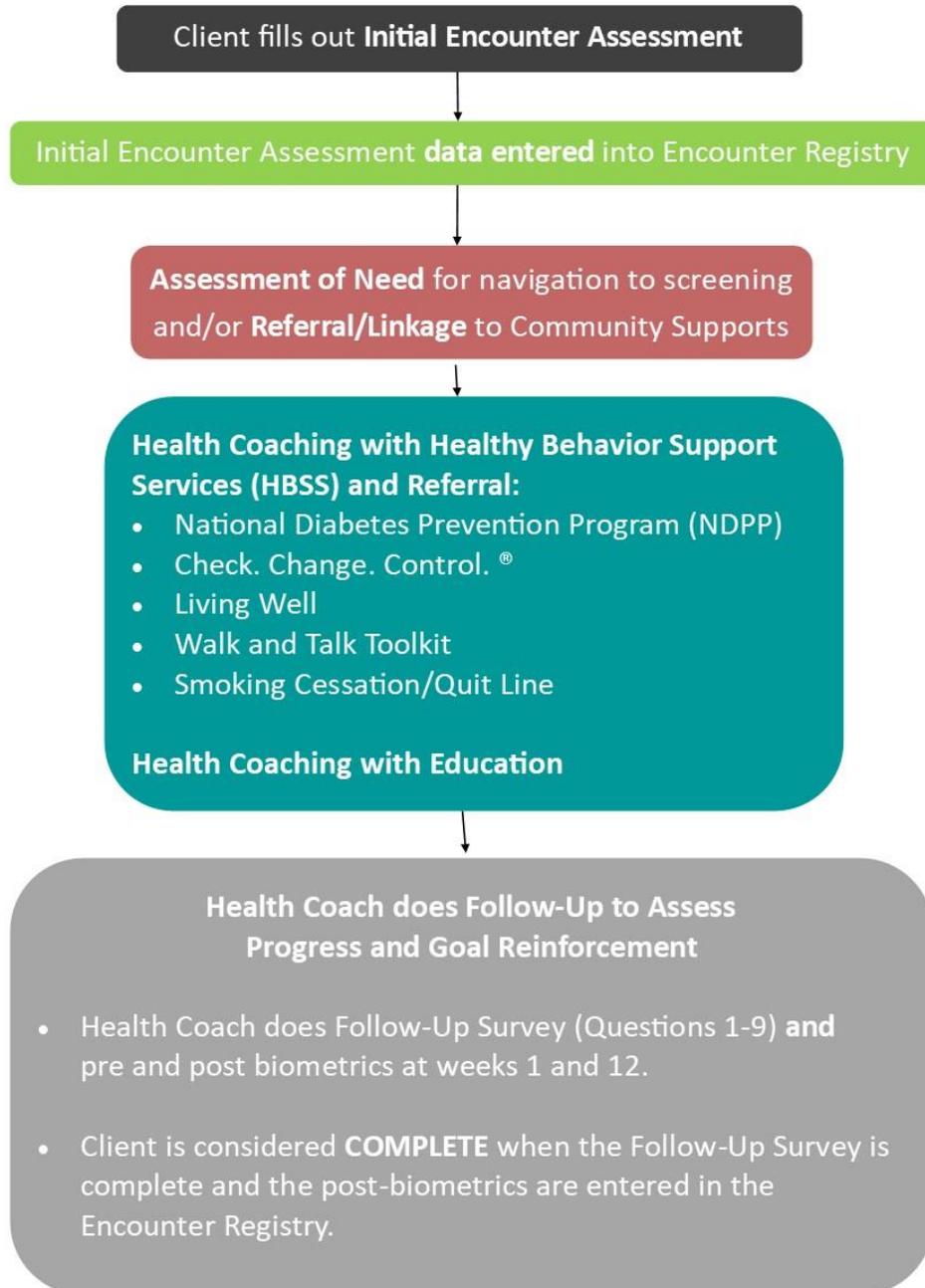
- Environmental scan and assessment of needs and gaps in knowledge, attitudes and behaviors
- Identification of appropriate evidence-based strategies tailored to meet the needs of the community
- Implementation of Community Health Worker model
- Linkages to primary care/medical home
- Benchmarking of screening services
- Implementation of systems change to increase preventive screening
- Linkages from primary care to community-based programming for disease self-management

**Scope of Work** for CHHs can be located in the subaward that is granted each fiscal year.

**Nebraska Women's & Men's Health Programs**  
**Pathway to Screening & Healthy Supports**  
**WISEWOMAN Health Coaching Protocol for Women 40-64**  
**MED-IT**



**Nebraska Women's & Men's Health Programs**  
**Pathway to Healthy Supports**  
**Health Coaching Protocol for Population Based Women 40-64**  
**ENCOUNTER REGISTRY**



# Section 2: CHH Information

**In this section you can place copies of:**

- CHH Resource Allocation Summary Report
- CHH Fixed Cost Subaward and any attachments
- Monthly TA Call Schedule
- Monthly Technical Assistance forms
- Healthy Behavior Support Services documents
- Collaborative Impact Projects documents
- Quarterly Progress Reports
- Success Stories

If you do not have copies of these document please contact your TA

**Community Health Hub  
Monthly Technical Assistance Call Schedule**



<b>Community Health Hub:</b>	
<b>Technical Support Person:</b>	
<b>Monthly TA Call Schedule</b>	
<b>October 2018</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete <i>(list reason)</i> _____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed
<b>November 2018</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete <i>(list reason)</i> _____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed
<b>December 2018</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete <i>(list reason)</i> _____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed
<b>January 2019</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete <i>(list reason)</i> _____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed
<b>February 2019</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete <i>(list reason)</i> _____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed
<b>March 2019</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete <i>(list reason)</i> _____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed
<b>April 2019</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete <i>(list reason)</i> _____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed
<b>May 2019</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete <i>(list reason)</i> _____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed

<b>June 2019</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete ( <i>list reason</i> )_____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed
<b>July 2019</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete ( <i>list reason</i> )_____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed
<b>August 2019</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete ( <i>list reason</i> )_____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed
<b>September 2019</b>	Date: ____/____/____ <input type="checkbox"/> Rescheduled to ____/____/____ <input type="checkbox"/> Completed <input type="checkbox"/> Not complete ( <i>list reason</i> )_____ <input type="checkbox"/> Monthly Technical Assistance Form completed and signed

Version 11/2018



<b>Challenges/Barriers:</b>	
<b>Med-IT/Training Needs:</b>	
<b>Success Stories:</b>	<b>Submitted:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <b>Ideas/Questions/Recommendations:</b>
<b>Date of Next Call:</b>	
<input type="checkbox"/> Sent Monthly TA Form to CHH for review on: _____/_____/_____ <input type="checkbox"/> Received Monthly TA Form from CHH with changes on: _____/_____/_____ <input type="checkbox"/> No changes <input type="checkbox"/> Made necessary changes as indicated from CHH on: _____/_____/_____ <input type="checkbox"/> Monthly TA Form completed on: _____/_____/_____	

Version 11/2018

\_\_\_\_\_  
Community Health Hub Representative Signature

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Technical Assistance Representative Signature

\_\_\_\_\_  
Date of Signature

# Section 3: Data Entry

## Data Entry

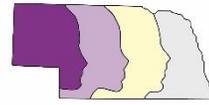
All Data Entry instructions can be found on the Community Health Hub web page under the MedIt Data Entry or Encounter Registry Data Entry tabs:

<http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx>

# **Section 4: Templates, Forms and Letters**

# Community Health Hub HBSS Agreement

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Health Hub: \_\_\_\_\_

Signature of Health Hub Staff submitting: \_\_\_\_\_

Date: \_\_\_\_\_

Women's & Men's Health Programs have received CDC approval for 5 Healthy Behavior Support Services (HBSS) to initiate health coaching. We are now ready for Health Hubs to move forward with engaging clients and connecting women to the supports listed below. At this time, these are the only supports our Program is able to reimburse for. Please indicate (by checking the box) which HBSS' your Health Hub will be offering to Every Woman Matters/WISEWOMAN clients.

## Approved HBSS:

- Check. Change. Control. w/ 3 health coaching sessions
- Health Coaching only (3 sessions)
- Living Well w/ 3 health coaching sessions
- National Diabetes Prevention Program w/ 3 health coaching sessions
- Physical Activity-Walk and Talk Tool Kit w/ 3 health coaching sessions

## HBSS Eligibility

- Every Woman Matters & WISEWOMAN (EWM/WW) clients on DHHS health coaching list

## Health Coaching with HBSS

- **3 health coaching sessions** are required; Opportunity to provide specific coaching for women enrolled in our program or from community venues who meet our age parameters. *Motivational interview training is mandatory for all health coaches.*
- Hubs can use **Letter of Commitment** and have client sign in order to have some form of accountability in place to check on the progress client is or is not making.
- Health Coach links client to HBSS in the community to increase peer and long term support.
- A completed support consists of *3 HC sessions* over the course of *12 weeks*.

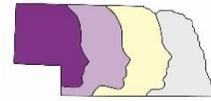
## Data Entry

### Med-It (EWM/WW clients)

- **Enter 3 health coaching sessions-just select the HBSS each time**
- **Post biometrics** (weight & 2 BP's) at or following week 12
- Health coach completes **follow-up assessment** with client during third HC session

# Community Health Hubs National Diabetes Prevention Program (DPP) Guidance

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## Program Requirements

- Completion of Lifestyle Coach training and/or certificate of completion from Emory University or the American Diabetes Association (ADA) to facilitate National DPP classes.
- Establish community partnerships with certified/recognized National DPP lifestyle coaches/sites for local Community Health Hub (CHH) to engage and enroll women **age 40-64** in National DPP and capture required data.
- **CDC Recognition** is now required for CHH National DPP classes to show that your organization meets CDC standards and can effectively deliver the program. Hubs must apply for recognition. The application is very simple and creates fidelity in the program.
  - <https://www.cdc.gov/diabetes/prevention/lifestyle-program/requirements.html>
  - [https://nccd.cdc.gov/DDT\\_DPRP/ApplicationForm.aspx](https://nccd.cdc.gov/DDT_DPRP/ApplicationForm.aspx)

## Reimbursement Eligibility

- Every Woman Matters & WISEWOMAN (EWM/WW) clients on Health Coaching list who enroll in the National DPP and attend week 1 (\$150 per client).
- Women who meet population based screening requirements (Females age 40-64, DOB, height, weight, waist circumference, two blood pressures, **total cholesterol**, completion of Initial Encounter assessment and medical questions) and attend National DPP week 1 (\$150 per client).
- National DPP is now a covered benefit for Medicare clients; to be reimbursed for the program you must apply to become a Medicare DPP supplier. Please contact Brian Coyle for further instructions at (402) 471-1045, via email [Brian.Coyle@nebraska.gov](mailto:Brian.Coyle@nebraska.gov) or visit [www.CMS.gov](http://www.CMS.gov) for more information.

## Health Coaching

- 3 health coaching sessions are required (either before or after National DPP classes and/or by phone). Opportunity to provide specific coaching for women enrolled in our program and from the population who meet our age parameters. Motivational interview training is mandatory for all health coaches.

## Data Entry

### Med-It (EWM/WW clients)

- Enter 3 health coaching sessions by selecting the [National Diabetes Prevention Program](#) as the HBSS each session
- Post biometrics (weight, 2 BP's) at or following week 12 (total cholesterol is NOT required for post)
- Health Coach completes follow-up assessment with client during third HC session

## Encounter

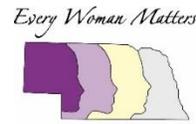
- Input pre biometrics, initial assessment and medical questions for National DPP participants from population based venues following week 1. Health Coach must also complete the medical questions and post biometrics with each client following week 12 to reflect any behavior change.
- CHH's enter health coaching sessions, National DPP support and weekly class attendance in their National DPP Venue in the Encounter Registry.

## QTAC COMPASS

- Web based workshop and data management tool that meets HIPPA standards and CDC requirements. This tool assists organizations to easily collect data from National DPP classes and generate CDC required reports with the click of a button. It is provided at no cost through the Chronic Disease Prevention and Control Program. Please reach out to Brian Coyle for more information.

Version 5/2019

# Community Health Hub Check. Change. Control. (CCC)



## CCC Program Requirements

- Check. Change. Control. is a free, on-line blood pressure (BP) monitoring program by the American Heart Association (AHA). It is replacing former self-monitoring BP supports.
- Session Zero(s) are initiated to promote CCC and collect required pre-biometrics on population based clients. During Session 0 the Health Coach will assess if client has access to regular BP checks in their community and/or identify if client is a viable candidate for in-home BP monitoring.
- Health coach to provide 1 to 1 education when a BP monitor is needed using Check. Change. Control. (CCC) materials available on the AHA website [www.heart.org](http://www.heart.org). Health coach demonstrates use of equipment and provides 5-digit activation code. Client is responsible for registering online using the code provided. They will be asked to create a username and password plus provide their name, gender, ethnicity, date of birth and zip code. Clients enter their BP readings via text, smart phone or computer. If the patient would like to enter their ongoing BP readings via text, they will need to also confirm that they would like to send/receive text messages after the registration process is complete.
- DHHS may provide some initial BP monitors to health hubs initiating CCC as funding allows.
- If client has ability to monitor their BP using local community resources, activation code and explanation of CCC is provided during first health coaching session.
- A complete CCC client consists of 3 CCC entries over the course of 12 weeks.

## CCC Eligibility (must be female age 40-64)

- Pre-hypertensive ( $\geq 120/80$ ) with additional risk factor - obesity, smoking, diabetes, etc.)
- Recurrent uncontrolled ( $\geq 140/90$ )
- Stage 2 hypertension ( $> 160/100$ )\*
- Alert values ( $\geq 180/110$  please contact Physician immediately)\*  
Every Woman Matters/WISEWOMAN (EWM/WW) clients with an alert value will also be contacted by WW Program Nurse to arrange a follow-up office visit.

## CCC Reimbursement

- EWM/WW clients highlighted on Health Coaching list whom you engage in CCC and their first health coaching session (\$63 per client). Please note client's on your EWM/WW HC list who had a recent provider visit, may have already received a CCC activation code from their provider.
- Women who meet population based screening requirements (Female age 40-64, DOB, height, weight, waist circumference, two blood pressures, total cholesterol, completion of initial Encounter assessment and medical questions) engage in CCC and first health coaching session (\$63 per client).

## Health Coaching

- 3 health coaching sessions are required over the course of 12 weeks. Opportunity to provide specific coaching for women enrolled in our program and from the population who meet our age parameters. *Motivational interview training is mandatory for all health coaches.*
- Provider involvement as a health partner is important for sharing results. Health coaches can use the *Letter of Commitment* and have clients from population based venues sign waiver in order to share results with health care provider. EWM/WW client consent is already part of the HLQ enrollment form.
- Clients can continue monitoring their BP indefinitely using the CCC code.

## Data Entry

### Med-It (EWM/WW clients)

- Enter 3 health coaching sessions by selecting **Check. Change. Control.** as the HBSS.
- Daily, every other day or weekly entry of blood pressure online as agreed upon w/ Health Coach.
- Enter post biometrics (weight/2 BP's) at or following week 12 (total cholesterol not required for post biometrics).
- Health coach completes follow-up assessment with client during third HC session.

## Encounter

- Input pre biometrics, initial assessment and medical questions for CCC participants from population based venues following Session Zero or first health coaching session. Health coach must also complete the medical questions and post biometrics with client following week 12 to reflect any behavior change.

# Community Health Hubs Living Well Guidance

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## Program Requirements

- Completion of Living Well Leader training with certificate of completion from Nebraska Chronic Disease Prevention and Control Program. *\*Leader training may have been completed in another state. Verification of leader completion and leader status will take place.*
- Establish community partnerships with active Living Well leaders/sites for local Community Health Hub (CHH) to engage and enroll women **age 40-64** in Living Well and capture required data.
- Work with community partners and introduce Session Zero(s) for potential Living Well Program participants, in order to collect required pre-biometrics for population based clients.

## Reimbursement Eligibility

- Every Woman Matters & WISEWOMAN (EWM/WW) clients on Health Coaching list who enroll in Living Well and attend week 1 (\$63 per client).
- Women who meet population based screening requirements (Females age 40-64, DOB, height, weight, waist circumference, two blood pressures, **total cholesterol**, completion of Initial Encounter assessment and medical questions) and attend Living Well week 1 (\$63 per client).

## Living Well Program Materials

- The Nebraska Chronic Disease Prevention and Control Program will be providing all Living Well program materials (books, cd's, cling sheets, chart paper, name tags and copies).

## Health Coaching

- 3 health coaching sessions are required (can occur before or after Living Well classes and/or by phone) within a 12 week timeframe. Opportunity to provide specific coaching for women enrolled in our program and from the population who meet our age parameters. Motivational interview training is mandatory for all health coaches.
- Completion of follow-up assessment for EWM/WW clients only.

## Data Entry

### Med-It (EWM/WW clients)

- 3 health coaching sessions, by selecting [Living Well](#) as the HBSS
- Post biometrics (weight, two BP's) at or following week 12
- Complete follow-up assessment with client during third HC session

## Encounter

- Input pre biometrics, initial assessment and medical questions for Living Well participants from population based venues following week 1. Each client must also complete the medical questions and post biometrics (total cholesterol is not required for post) following week 12 to reflect any behavior change.
- CHH's enter health coaching sessions, Living Well support and weekly class attendance in their Living Well venue in the Encounter Registry.

## QTAC COMPASS

- Web based workshop and data management tool that meets HIPPA standards and CDC requirements. Currently Chronic Disease Prevention and Control Program does all of the data entry for Living Well classes. Sites collect Participant Information Surveys and submit to Julie Chytil at [Julie.Chytil@nebraska.gov](mailto:Julie.Chytil@nebraska.gov). This tool enables ease of data collection, generates grant required reports and is provided at no cost through the Chronic Disease Prevention and Control Program.

# Community Health Hub (CHH) Health Coaching Guidance



## Program Requirements

- Assess what client has interest in or how you might connect as you begin to establish rapport and build trust with client.
- Initiate goal setting during first Health Coaching (HC) session if client is willing and able.
- Provide 1 to 1 education pertinent to the individual client's needs. Health Coach may utilize resources provided in the [Walk and Talk Tool Kit](#) available on the DHHS CHH website.
- Health coaching role is to be a good listener and ask open ended questions.
- 3 health coaching sessions are **required** (either in person or by phone) within a 12 week timeframe. Opportunity to provide specific coaching for women enrolled in our program and from the population who meet our age parameters. Motivational interview training is **mandatory** for all health coaches.

## Reimbursement Eligibility

- Every Woman Matters & WISEWOMAN (EWM/WW) clients on Health Coaching list who engage in health coaching (please note *soft coach approach* is preferred; we aren't trying to hard sell health coaching but focus on being a good listener and may involve working with client on where they are currently at and life issues).
- Women who meet population based screening requirements (**Females age 40-64**, DOB, height, weight, waist circumference, two blood pressures, **total cholesterol**, completion of Initial Encounter Assessment and medical questions) and are interested in connecting with a Health Coach.

## Data Entry

### Med-It (EWM/WW clients)

- Enter 3 [Health Coaching](#) entries following each HC session. A total of 3 entries are required in order to be reimbursed. Data entry needs to occur within 72 hrs. following each session.
- Post biometrics (weight and 2 BP's) at or following week 12 (pre-biometrics should already be entered from the clients initial doctor/clinic visit).
- Health Coach completes Follow-up Assessment with client during third HC session.

## Encounter

- Input pre biometrics, initial assessment and medical questions for clients from population based venues following week 1. Health Coach must also complete the medical questions and post biometrics with each client following week 12 to reflect any behavior change (total cholesterol is not required for post biometrics).
- CHH's enter [Health Coaching as the HBSS](#) for each HC session.

## Walk and Talk Toolkit

- A Walk and Talk Toolkit was developed by Public Health Solutions and includes promising practices and utilization of a Community Health Worker to establish and implement walking groups while providing small group education. Health Coaches may opt to use this resource during the course of health coaching based on client needs.

# Community Health Hub (CHH) Physical Activity Guidance Walk and Talk Toolkit



## Program Requirements

- **Assess if client has interest** in increasing their physical activity and tracking their steps during your first health coaching call or in person at a community venue.
- **Initiate goal setting** in first Health Coaching (HC) session if client commits to physical activity support; Community Health Worker (CHW) or HC sets 1-2 goals with the client during first session.
- **Provide one-on-one or small group education** pertinent to the individual client's needs. Health Coach utilizes the resources provided in the [Walk and Talk Tool Kit](#) available on the DHHS Community Health Hub website.
- **Pedometer and/or Activity Log** would be a good educational tool to include but is optional; Health Coach provides education on use of the pedometer and placement for accurate monitoring if provided. Activity Log can be mailed to the client for logging steps during the 12 week time period or used as an educational incentive at the start of your in person walk and talk sessions. CHW and/or HC inquiries about physical activity and provides accountability during in person sessions or HC calls with the client.

## Reimbursement Eligibility

- Every Woman Matters & WISEWOMAN (EWM/WW) clients on Health Coaching list who engage in physical activity support and agree to track physical activity, set physical activity goal(s) and/or agree to meet in person for walk/talk sessions. (\$63 per client).
- Women who meet population based screening requirements (Females age 40-64, DOB, height, weight, waist circumference, two blood pressures, total cholesterol, completion of Initial Encounter Assessment and medical questions) and agree to track physical activity, set a physical activity goal(s), and/or agree to meet in person for health coaching walk/talk sessions. (\$63 per client).

## Health Coaching

- **3 health coaching sessions** are required (either in person at walk/talk sessions or by phone). Opportunity to provide specific coaching for women enrolled in our program and from the population who meet our age parameters. Motivational interview training is mandatory for all health coaches. In person walk/talk sessions would be facilitated to connect women to other women, develop group rapport and support to extend beyond the 3 health coaching sessions.

## Data Entry

### Med-It (EWM/WW clients)

- **Enter 3 Physical Activity Walk and Talk entries following each HC session. A total of 3 entries are required in order to be reimbursed. Data entry needs to occur within 72 hrs. following each session.**
- **Post biometrics (weight, 2 BP's)** at or following week 12 (total cholesterol is NOT required for post).
- **Health Coach completes follow-up assessment with client during third HC session.**

## Encounter

- **Input pre biometrics, initial assessment and medical questions** for clients from population based venues following week 1. Health Coach must also complete the **medical questions and post biometrics with each client following week 12 to reflect any behavior change.**
- CHH's enter Physical Activity Walk and Talk for each HC session.

## Walk and Talk Toolkit

- Tool kit research was conducted by Public Health Solutions with 1422 funding during 2018. Walk and Talk Toolkit was developed and includes promising practices and utilization of a Community Health Worker to establish walking groups while providing small group education. Behavior change components include 1-1 goal setting, accountability and connecting clients to other clients for peer support and sustainability beyond health coaching sessions.

# Collaborative Impact for Breast Health Navigation Template Guidance

## **Purpose of Template:**

This template is to assist in identifying, planning and monitoring major activities in implementing a collaborative impact project around breast navigation. Use this tool for oversight of the project and to help guide implementation. Entries must be meaningful and concise.

## **Reimbursement:**

- According to approved budgets

There is a webinar recording about the Collaborative Impact Projects that can be found at:

<http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx>

- Select Collaborative Impact Projects for Breast Health Navigation tab
- Select Collaborative Impact Webinar Recording

All Required Forms can be found at: <http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx>

- Select Collaborative Impact Projects for Breast Health Navigation tab

\*\*Ideas for Collaborative Impact Projects can be found under the Promising Practice Ideas tab.

## Special Projects Template Guidance

### **Purpose of Template:**

This template is to assist in identifying, planning and monitoring major activities in providing reminder systems with clinicians within CHH region or providing rescreening/1<sup>st</sup> prompt recall services. This tool is to be used for oversight of the project and to help guide implementation. Entries must be meaningful and concise.

### **Reimbursement:**

- According to approved budgets

All required Forms can be found at: <http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx>

- Select Special Projects tab

## Initial Encounter Assessment Guidance

**Purpose of Form:** If CHH is at a venue and does not have access to web and/or Encounter Registry this form can be used to collect client demographics and health information. Once information is collected it can be entered at a later time into the Encounter Registry.

Data entry is to be done within a 72 hour timeframe.

### Population Based Screening Required Pre-Assessments

- **Pre and post biometrics and Initial Encounter Assessments** are required for participants from population based events.
- Each client must complete the Initial Encounter Assessment and medical questions to reflect stage of change.
- **CHH are required to enter all data into the Encounter Registry.**

## Initial Encounter Assessment

# CLIENT INFORMATION

### YOUR INFORMATION

First Name: \_\_\_\_\_ Last Name \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email address: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Female Hispanic:  Yes  No  
Race (check all that apply):  White  Black  Mexican  Asian  Native American  Pacific Islander  Other \_\_\_\_\_

Are you limited in any way in any activities because of physical, mental or emotional problems?

Yes  No  Don't Know  Don't want to answer

Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?

Yes  No  Don't Know  Don't want to answer

If yes, what type of disability?

\_\_\_\_\_

Are you a Refugee?  Yes  No  Unknown

If yes, where from? \_\_\_\_\_

County of Residence: \_\_\_\_\_

Preferred Counties: \_\_\_\_\_

Do you have a primary care physician?  Yes  No

Do you have Health Insurance?

Employer Coverage  Health Market  Medicare  
 Medicaid  No

Do you now smoke cigarettes every day, some days, or not at all?  Every Day  Some Days  Not at all

Don't want to answer

Have you ever been told by a doctor, nurse or other health professional that you have high blood pressure?

Yes  No  Don't Know  Don't want to answer

Are you taking any medication prescribed by your doctor, nurse or other health professional for your high blood pressure?

Yes  No  Don't Know  Don't want to answer

Have you ever been told by a doctor, nurse or other health professional that you have diabetes?

Yes  No  Don't Know  Don't want to answer

Are you taking any medication prescribed by your doctor, nurse or other health professional for diabetes?

Yes  No  Don't Know  Don't want to answer

Have you ever been told by a doctor, nurse or other health professional that your blood cholesterol is high?

Yes  No  Don't Know  Don't want to answer

Are you taking any medication prescribed by your doctor, nurse or other health professional for your high cholesterol?

Yes  No  Don't Know  Don't want to answer

Have you had a mammogram in the last 2 years?

Yes  No  Don't Know  Don't want to answer

Have you had a pap test in the last 3 years?

Yes  No  Don't Know  Don't want to answer

Have you been screened for colorectal cancer?

Yes  No  Don't Know  Don't want to answer

Client marked for Navigation:

Yes  No

Client marked for Health Coaching:

Yes  No

## Follow Up Assessment (Post Assessment) Guidance

**Purpose of Form:** This form is used to collect client demographics, health information and post biometrics.

### Population Based Screening Required Post-Assessments

- **Pre and post biometrics and Initial Encounter Assessments** are required.
- Each client must complete the Initial Encounter Assessment and medical questions at week 1 and medical questions again at week 12 to reflect/measure stage of change.
- **CHH are required to enter all data into the Med-It System.**
  - CHH must collect a **completed Initial Encounter Assessment AND pre and post biometrics** for clients (women age 40-64, DOB, zip code, phone number, address, height, weight, waist circumference, two blood pressures and cholesterol)



Please answer the following questions and return it in the envelope provided within 1-2 weeks. This will help us create better programs for women in Nebraska!

You can take this survey online if you prefer by going to this link:  
<https://www.surveymonkey.com/r/EWMAssessment>

**FOR HEALTH COACHES USE ONLY**

Client ID#: \_\_\_\_\_  
 Client County: \_\_\_\_\_  
 Date of Service: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of Call: \_\_\_\_/\_\_\_\_/\_\_\_\_

Thanks! -EWM Staff

<b>DIET &amp; PHYSICAL ACTIVITY</b>	1. How much fruit do you eat in an average day? <i>(1 cup equals 1 large banana or 1 medium apple)</i>	_____ Cups	<input type="radio"/> DK*
	2. How many vegetables do you eat in an average day? <i>(1 cup equals 12 baby carrots or 1 ear corn)</i>	_____ Cups	<input type="radio"/> DK*
	3. Do you eat fish at least two times a week?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> DK*
	4. How many servings of grain products do you eat in a day? <i>(serving equals 1 slice whole wheat bread, 3 cups popped popcorn, 1/2 cup rice/pasta, 3/4 cup oatmeal)</i>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6+ <input type="radio"/> DK*	
	4a. Of these servings, how many are whole grain?	<input type="radio"/> Less than half <input type="radio"/> About half <input type="radio"/> More than half <input type="radio"/> DK*	
	5. Do you drink less than 36 ounces of beverages with added sugars weekly? <i>(3 (12 ounce) cans regular soda, juice, alcohol, specialty drinks)</i>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> DK*
	6. Are you currently watching or reducing your sodium or salt intake?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> DK*
7. How many minutes of physical activity do you get in a <b>WEEK?</b> <i>(walking/running, aerobic dancing, water aerobics, general gardening, bicycling)</i>	_____ Minutes	<input type="radio"/> DK*	

	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	DIABETES
1. Has your doctor, nurse or other health professional <b>EVER</b> told you that you have:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*
2. Do you take any medication prescribed by your doctors <b>NOW</b> to lower:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*
3. During the past 7 days, how many days <i>(including today)</i> did you take your medication as prescribed:	_____ Days <input type="radio"/> DK*	_____ Days <input type="radio"/> DK*	_____ Days <input type="radio"/> DK*
4. On days you did not take your medication as prescribed, please tell us why:	<input type="radio"/> Cost <input type="radio"/> Forgot to take <input type="radio"/> Side Effects <input type="radio"/> Need Refill <input type="radio"/> Don't Want to Take Meds <input type="radio"/> Other _____	<input type="radio"/> Cost <input type="radio"/> Forgot to take <input type="radio"/> Side Effects <input type="radio"/> Need Refill <input type="radio"/> Don't Want to Take Meds <input type="radio"/> Other _____	<input type="radio"/> Cost <input type="radio"/> Forgot to take <input type="radio"/> Side Effects <input type="radio"/> Need Refill <input type="radio"/> Don't Want to Take Meds <input type="radio"/> Other _____
5. Do you check your <b>BLOOD PRESSURE</b> when you are not at the doctor's office <i>(at home, at pharmacy, or at a store, etc.)</i> ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
5a. If no, provide reason:	<input type="radio"/> No, never told to check <input type="radio"/> No, don't know how to check <input type="radio"/> No, don't have equipment		
5b. If yes, how often do you check your <b>BLOOD PRESSURE</b> :	<input type="radio"/> Multiple times a day <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> A few times per week <input type="radio"/> Monthly <input type="radio"/> DK*		
5c. If yes, do you share your <b>BLOOD PRESSURE</b> numbers with your doctor that you take at home, the pharmacy or a store?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		

\*DK - Don't Know/Not Sure

<b>HEART</b>	1. Have you been diagnosed by a healthcare provider as having any of these conditions: (mark all that apply)	
	Coronary Heart Disease/Chest Pain: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK* Congenital Heart Defects: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK* Heart Failure: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK* Stroke/Transient Ischemic Attack (TIA): <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK* Vascular Disease: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK* Heart Attack: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	
	2. Are you taking aspirin daily to help prevent a heart attack or stroke?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*

<b>SMOKING</b>	1. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)	<input type="radio"/> Current Smoker <input type="radio"/> Quit (1-12 months ago) <input type="radio"/> Quit (More than 12 months) <input type="radio"/> Never Smoked
----------------	---	--

<b>DAILY LIFE</b>	1. Thinking about your <u>physical health</u> , which includes physical illness and injury, on how many days during the past 30 days was your physical health not good?	_____ Days <input type="radio"/> DK*
	2. Thinking about your <u>mental health</u> , which includes stress, depression, and problems with emotions, on how many days during the past 30 days was your mental health not good?	_____ Days <input type="radio"/> DK*
	3. During the past 30 days, on about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	_____ Days <input type="radio"/> DK*
	4. Are you limited in any activities because of physical, mental or emotional problems?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*
	5. Do you now have any health problems that requires you to use special equipment, such as a cane, a wheelchair, a special bed or a special telephone?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*
	5a. If yes, what type of disability?	<input type="radio"/> Emotional <input type="radio"/> Intellectual <input type="radio"/> Physical <input type="radio"/> Sensory
	6. Over the past 2 weeks, how often have you been bothered by any of the following problems:	<input type="radio"/> Not at all <input type="radio"/> Several days <input type="radio"/> More than half <input type="radio"/> Nearly every day
6a. Little interest or pleasure in doing things:	<input type="radio"/> Not at all <input type="radio"/> Several days <input type="radio"/> More than half <input type="radio"/> Nearly every day	
6b. Feeling down, depressed, or hopeless:	<input type="radio"/> Not at all <input type="radio"/> Several days <input type="radio"/> More than half <input type="radio"/> Nearly every day	

\*DK - Don't Know/Not Sure

**FOR HEALTH COACHES USE ONLY**

Height (inches): \_\_\_\_\_

Weight (pounds): \_\_\_\_\_

Waist Circumference (inches): \_\_\_\_\_

Blood Pressure 1: \_\_\_\_\_ / \_\_\_\_\_

Blood Pressure 2: \_\_\_\_\_ / \_\_\_\_\_

Total Cholesterol: \_\_\_\_\_



**Women's and Men's Health Programs**  
 301 Centennial Mall South || P.O. Box 94817 || Lincoln, NE 68509  
 Toll-Free: 800-532-2227 || In Lincoln: 402-471-0929  
 Email: [dhhs.ewm@nebraska.gov](mailto:dhhs.ewm@nebraska.gov)  
 Website: [www.dhhs.ne.gov/EWM](http://www.dhhs.ne.gov/EWM)



## Summary Report Guidance

### Venue

**Purpose of Template:** This template is for **identifying, planning and monitoring** community reach through the Encounter Registry.

- All Venues will be entered by DHHS and only the CHH that submitted the template will have access to the Venue.
- Patient pathway for Navigation and Health Coaching must be submitted. Sample pathway for Navigation is on pages 7-8.
- There is a **maximum** of \$4000.00 to be used towards community venues. No pre/post venue time or travel time will be reimbursed. Mileage is allowable when a venue is deemed to be payable. Venues are payable when they have a minimum of 10% of reach navigated.

All priority populations reached at the venue must have a risk assessment and community linkages must be made within the Encounter Registry.

**Venues without 10% of reach navigated will not be payable.**

## Community Venue Q & A

- 1) Do we need to use the Venue Summary Report Template for each community venue we attend?**
  - a. Yes. You will need to fill out and get prior approval from your TA for all Community Venues.
  
- 2) If we send 2 people to a 2 hour venue does that count as 2 hours or 4 hours against our yearly allowable hours?**
  - a. This could count as 2 hours or 4 hours. It is up to the HUB's to enter their employees in the Venue Time to have the hours counted towards their yearly allowable total. The hours you enter would be payable per venue time reimbursement and the venue would be used to calculate overhead. If you did not reach the target population you don't have to enter venue time. This venue won't be counted against your total performance calculation.
    - i. See Venue Time Scenarios for examples.
  
- 3) What is the priority population?**
  - a. Priority population is women 40-64
  
- 4) Does every question on the initial assessment need to be answered for every client?**
  - a. Yes. All of the Initial Assessment questions need to be answered.
  
- 5) Do we need to create a pathway for each venue that we plan to participate it?**
  - a. Yes. Instructions for creating a pathway are located on the CHH website at <http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx> located under the Venues tab

# Venue Time Scenario Examples

Venue – Jill’s Community Health Fair, hours of venue 1:00 – 5:00 pm. venue length 4 hours, predicting high volume of target population.

## Scenario 1

4 employees worked 4 hours each at venue. Target population reached. Hours for all 4 employees can be counted. Total of 16 hours towards yearly allowable hours.

Venue time entered as 4 employees at 4 hours each.

List of Venue Workers						
Last Name	First Name	MI	Prep Time (Mins)	Work Time (Mins)	Volunteer	
Crane	Jill		0	240	N	
Hansen	Jill		0	240	N	
Jones	Jill		0	240	N	
Smith	Jill		0	240	N	

## Scenario 2

4 employees worked 4 hours each at venue, only 2 employees worked on population project. Target population reached. Hours for 2 employees can be counted. Total of 8 hours towards yearly allowable hours.

Venue time entered as 2 employees at 4 hours each, 2 employees can be added as volunteers. Volunteer hours are not covered and not counted toward yearly allowable totals.

List of Venue Workers						
Last Name	First Name	MI	Prep Time (Mins)	Work Time (Mins)	Volunteer	
Crane	Jill		0	240	N	
Hansen	Jill		0	240	N	
Jones	Jill		0	240	Y	
Smith	Jill		0	240	Y	

## Scenario 3

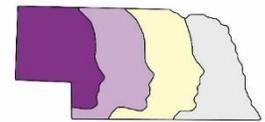
4 employees worked 4 hours each. Target population not reached.

Venue can be entered into the Registry but not billed for. Employees can be entered as volunteers. No hours towards yearly allowable hours.

List of Venue Workers						
Last Name	First Name	MI	Prep Time (Mins)	Work Time (Mins)	Volunteer	
Crane	Jill		0	240	Y	
Hansen	Jill		0	240	Y	
Jones	Jill		0	240	Y	
Smith	Jill		0	240	Y	

# Community Health Hubs Venue Summary Report Template

*Every Woman Matters*



**Purpose of Template:** This template is for **identifying, planning and monitoring** community reach through the Encounter Registry.

- All Venues will be entered by DHHS and only the CHH that submitted the template will have access to the Venue. Information needed to enter the venue into the Encounter Registry is on page 2 of this document.
- Patient pathway for Navigation and Health Coaching must be submitted. Sample pathway for Navigation is attached. See pathway examples on pages 7-8 of the Health HUB Manual.
- There is a **maximum** of \$4000.00 to be used towards community venues. No pre/post venue time or travel time will be reimbursed. Mileage is allowable when a venue is deemed to be payable. Venues are payable when they have a minimum of 10% of reach navigated.

All priority populations reached at the venue must have a risk assessment and community linkages must be made within the Encounter Registry.

**Venues without 10% of reach navigated will not be payable.**

<b>Community Health Hub: Submitted By:</b>		<b>Venue Target Reach:</b> <input type="checkbox"/> Women 18-39 <input type="checkbox"/> Women 40-64	
<b>Venue Name:</b> <i>(Each venue requires its own Template)</i>		<b>Date Submitted:</b> <i>(Date submitted must be at minimum 2 weeks prior to the venue)</i> ____/____/____	
Describe this venue and any partnerships with venue?			
What makes this a good community venue for reaching priority population with the goal of Navigation and/or Health Coaching?			
Have you participated in this venue in the past?  Was this a successful venue in reaching priority population with Navigation and/or Health Coaching?  If the answer is no what makes you think this will be a successful venue now?			
<b>Internal Use Only: Pre Venue</b>			
<b>DHHS Approval</b>			
<input type="checkbox"/> Reasonable expectation of being a successful venue met <input type="checkbox"/> Pathway to navigation logical and meets requirements <input type="checkbox"/> Pathway to health coaching and HBSS logical and meets requirements <input type="checkbox"/> Appropriate Patient Pathway submitted			
<b>DHHS Signature:</b>		<b>Date of Signature:</b> ____/____/____	

## Venue Information

### Venue Type

Choose one of the following:

- |  |  |
|--|--|
| <input type="checkbox"/> Community Based | <input type="checkbox"/> Local Health Department |
| <input type="checkbox"/> Faith Based     | <input type="checkbox"/> School Based            |
| <input type="checkbox"/> Home Visits     | <input type="checkbox"/> Worksite Based          |
| <input type="checkbox"/> Hospital Based  |  |

### Venue Health Focus

You may choose more than one health focus for your venues however to get the best data out of community venues please be as specific as possible:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Smoking           | <input type="checkbox"/> Diabetes                           |
| <input type="checkbox"/> Financial Support    | <input type="checkbox"/> CVD               | <input type="checkbox"/> Hypertension                       |
| <input type="checkbox"/> Medical Access       | <input type="checkbox"/> Mental Health     | <input type="checkbox"/> Physical Safety                    |
| <input type="checkbox"/> Nutrition            | <input type="checkbox"/> Physical Activity | <input type="checkbox"/> Risk Assessment/Tailored Education |
| <input type="checkbox"/> Preventive Screening | <input type="checkbox"/> Stress            | <input type="checkbox"/> Weight                             |

### Location

Venue Name:

Address:

Address:

Zip Code:

### Date/Time

Venue Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Venue End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Start time of Venue (optional):

Time Frame of Venue (optional):  Morning  Afternoon  Evening

Local Health Department		Venue Date:	1/1/2019
<b>Venue Pathway</b>			
Type/Name of Venue	Place Example		
WHO will be assisting with clients filling out 15 question Health Risk	Person helping clients fill out the form		
WHO will be reviewing the assessment to determine if client should receive educational referral or referral to EWM:	Eligibility Person		
If client referred to EWM, WHO will be assisting client in enrolling?:	Enrollment Person		
HOW will client enroll? (Online HLQ, Hard copy Enrollment)	Online HLQ Example		
WHO will be navigating for Breast or Cervical Screening	Navigation Person		
Will client be navigated during event or post event?	Post Event Example		
<b>Navigation Pathway</b>			
HOW will client be navigated (health coaching call, in person)	Health Coaching Call		
WHEN will client be navigated (day of, 1 week, 2 weeks)	Day Of Example		
WHO will be assessing client barriers	Barrier Assessment Person		
WHAT resources are available for client barriers	Transportation, Language, CHW, Volunteer, Childcare, Example		
WHO will document in appropriate data system what barriers were presented and what barrier reductions	Documentation Person		
WHEN will documentation in appropriate data system take place (data entry needs to take place within 72 hours)	24 Hour Example		

## VENUE - NAVIGATION TO SCREEN PATHWAY

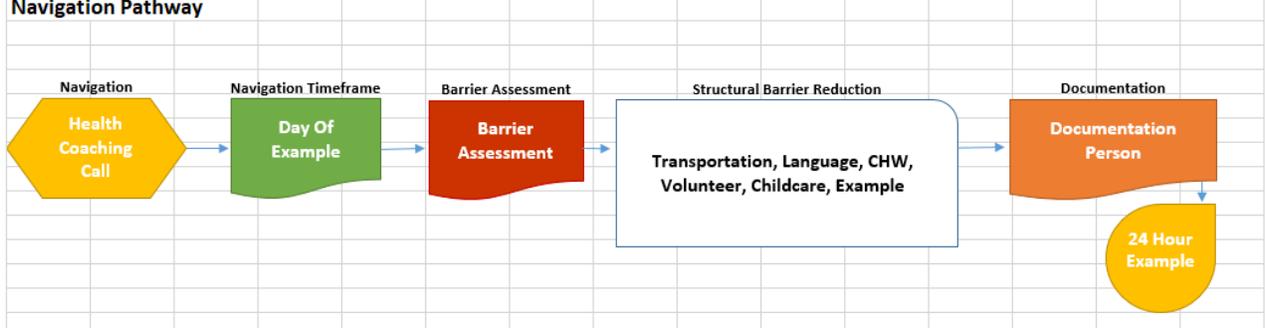
Local Health Department

43466

### Venue Pathway



### Navigation Pathway



## Client “Letter of Commitment”

### **Purpose of Letter:**

The Letter of Commitment is a document that the client fills out once they decide upon a healthy behavior support service. Studies show that when clients commit to something on paper they are more likely to continue the effort and work hard.

This is only a **sample** of a Letter of Commitment. It is up to the CHH to give this to the client and copy/monitor client progress.

CHH Health Coaches can still opt to use the Letter of Commitment. It is not a requirement but a good one-to-one accountability option.

# LETTER OF COMMITMENT

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

This document serves as a personal commitment to better my overall health.

I, \_\_\_\_\_ (name) agree to participate in the following healthy behavior support service (HBSS) and agree this information can be shared with my health care provider. This HBSS consists of:

\_\_\_\_\_

\_\_\_\_\_

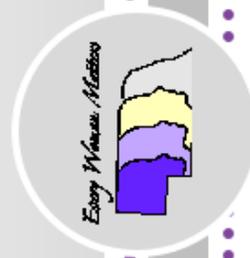
To better reach my goals of:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
PARTICIPANT (SIGNATURE)  
I agree that I am voluntarily participating in these activities and solely responsible for my safety and well-being.

\_\_\_\_\_  
PROGRAM STAFF (SIGNATURE & WRITTEN NAME)



# Section 5: Colon Cancer

## COLON CANCER

The national, state and program goal for colon cancer screening is 80% of Nebraskans to be appropriately screened by 2018.

In order to assist in reaching that goal the Women's and Men's Health Programs want to build up Community Health Hubs (CHH) in order to increase capacity across the Nebraska to increase the number of women and men 50-74 who are appropriately screened for colon cancer in all populations.

### Strategies to Increase FOBT Rates:

For the 2019-2020 FY all contractors distributing FOBT kits through the NCP **must** include one or more of the four strategies to increase FOBT rates:

- Recommendations by local providers to encourage and promote FOBT screening and efficacy of FOBTs.
- Plan for education to FOBT distribution sites such as pharmacies, clinics, and other partners distributing FOBT kits for contractor. Education and training should include: how to select age appropriate participants, how to complete FOBT, importance of colorectal cancer screening, efficacy of screening with FOBT, and appropriate monitoring of FOBT kits.
- 1:1 education to men and women 50-74 years of age regarding importance of colorectal screening, efficacy of FOBT screening, *commitment of individual to complete*, how to complete FOBT.
- Timely follow up of non-returned kits within 3 weeks of distribution of kit at minimum by mail.

### Requirements for CHH:

- Implement community based FOBT screening during the year
- Must have an approved Community Based FOBT Distribution Plan
- Must use an approved FOBT enrollment form
- Must use the FOBT statewide registry for tracking non-returned and **positive tests** and providing aggregate data. Enrollment must be entered into the registry within **five days** of kit distribution and data entry must follow NCP's data entry procedures
- FOBT kits should only be distributed to women and men 50-74 who are Nebraska residents only, have no insurance and must meet income guidelines
- Nebraska Colon Cancer Program (NCP) can provide FOBT kits
- Lab processing can be provided by NCP

### FOBT Kits:

Once your Community Based FOBT Distribution/Screening Plan is approved the program will mail you FOBT kits and labels. After the kits are **labeled correctly** you may begin to distribute.

Check your leftover kits from last year to make sure they are not expired. If they are not expired, use these kits first. **If you have kits from last year be sure to change the year on the FOBT kits to FY20.**

### FOBT Kit and Enrollment Form Labeling:

Start this year's FOBT kits numbering with your coalition's two letter code (see list on page 92) followed by 20 (for 2020 distribution) and then a number with the option to add a unique code for distribution site. EXAMPLE: NC20-1, NC20-2, etc.

Make sure the numbers are entered exactly as they are written on the enrollment form (with or without spaces between the code and numbers, etc.). This is so the lab can find your participant in case they don't write their names and date of birth on the kit. For a refresher on kit labeling, check out the FOBT kit labeling document.

The main envelope has a seal so the lab envelope has to be removed to affix the lab label.

The instruction label you put on the back of the slides is available in Spanish, printed on Avery Labels 5163. We also have English & Spanish instructions sheets. These are only given out upon request by the HUB.

Make sure the FOBT kit and client application have the same number. Example: NC20-1 for both – write client name on kits.

### CHH Letter Codes:

Region	Code
Omaha	OMA
Three Rivers	3RV
Lancaster	LAN
Scottsbluff	SB
Panhandle	PN
South Heartland	SH
Public Health Solutions	PH
North Central	NC
Four Corners	FC
East Central	EC
Elkhorn Logan Valley	EL
Loup Basin	LB
Sandhills	SA
Central District	CD
Health Disparities and Health Equity	HDHE
Charles Drew Health Center	CDHC
Southwest	SW
Southeast	SE
Dakota County	DC
West Central	WC
Northeast Nebraska	NE
Sarpy/Cass Department of Health & Wellness	SC
Two Rivers Public Health	2R

### Tobacco Resources

If you'd like to order tobacco materials you can use the Tobacco Free Nebraska (TFN) Quitline Order Form found at: <http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx>.

### 2019-2020 FOBT Distribution Sites Tracking Form

The purpose of this form is for when CHH need to add an FOBT distribution site. The demographic report in Med-It, the FOBT database, allows HUB's to track where participants picked up a kit. Once you compile your list of sites, send the tracking form and NCP will add the sites into Med-It.

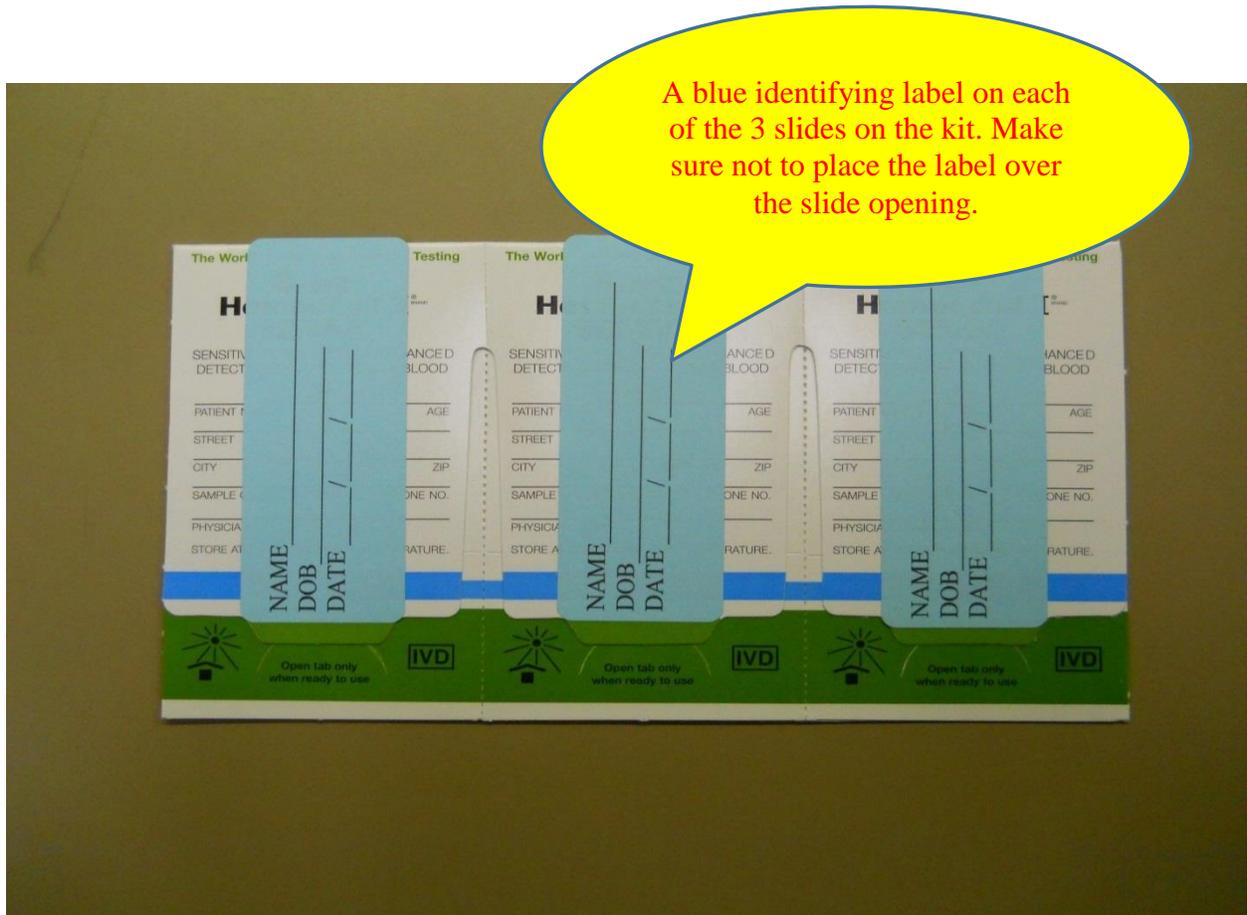
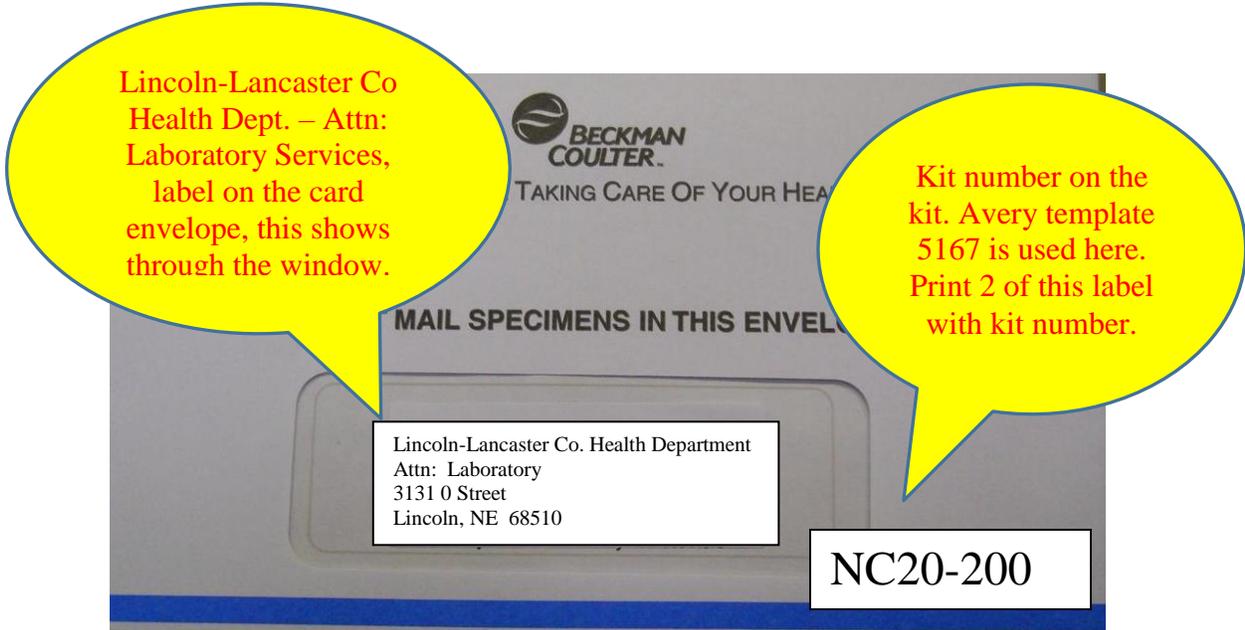
This form can be found at: <http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx>.

### 2019-2020 Primary Care Provider Listing

The purpose of this form is for when CHH need to add a provider(s) for NCP participants. CHH need to fill out this form if the person, clinic or doctor is not on the contact list. If the client does not have a provider your health department will become the provider (Fix It).

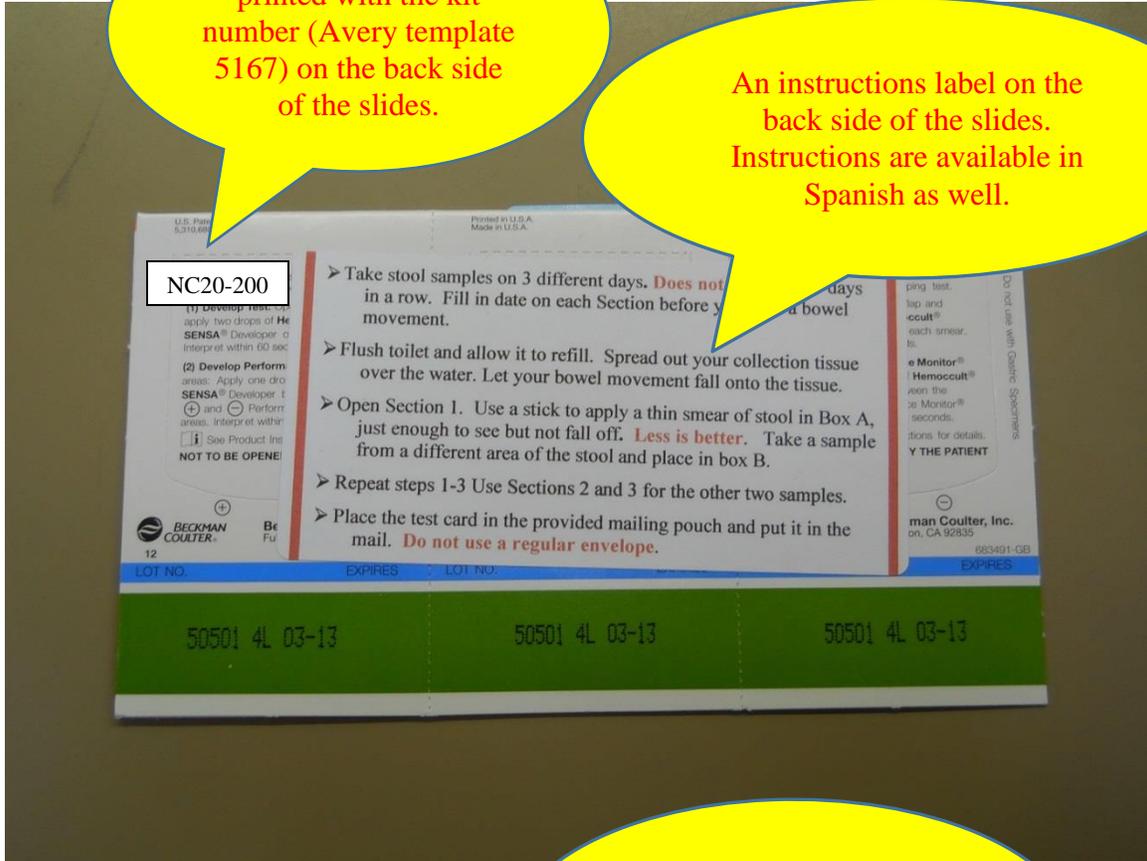
This form can be found at: <http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx>.

# FOBT Kit Labeling Document



Place the 2<sup>nd</sup> label you printed with the kit number (Avery template 5167) on the back side of the slides.

An instructions label on the back side of the slides. Instructions are available in Spanish as well.



Kit number on the enrollment form corresponds to the kit number on the envelope.

**Community Colon & Rectal Cancer Screening Form for Men and Women 50-74** Jan 2012

**NC20-200**

- ALL QUESTIONS MUST BE ANSWERED. Please print clearly.
- Read and sign.
- Give the COMPLETED form to the pharmacist and mail the completed test kit in the return envelope provided.

First Name	Middle Initial	Last Name	Maiden Name	Social Security #
Birthdate	Gender M / F	Address		
City		County	State	Zip
Day Phone ( )		Evening Phone ( )		
In case we can't reach you: Contact person: _____ Relationship: _____ Phone: (____) _____ Address: _____ City: _____ State: _____ Zip: _____		How did you hear about this colon cancer screening program? <input type="checkbox"/> television <input type="checkbox"/> radio <input type="checkbox"/> newspaper <input type="checkbox"/> friend/relative <input type="checkbox"/> your doctor <input type="checkbox"/> your place of work <input type="checkbox"/> Internet <input type="checkbox"/> In-store display <input type="checkbox"/> church <input type="checkbox"/> other _____		

# Community Health Hub/Coalition Community Based FOBT Distribution Plan Template

- Return rates for FOBT kits distributed by Community Health Hubs (CHH) and Cancer Coalitions contracted with the Nebraska Colon Cancer Program range from 32%-70%.
- Reviewing previous return rates and submitted distribution plans four practices were identified as increasing the likelihood of FOBT kits being returned.
- For the 2019-2020 FY all contractors distributing FOBT kits through the NCP must include one or more of the four strategies to increase FOBT rates.

<b>CHH or existing cancer coalition with 501c3 status</b>		<b>Date Submitted for approval:</b>	____/____/____
<b>Contact Name:</b>			
<b>Type and Brand of FOBT Kit:</b>			
<b>FOBT Kits Provided By:</b>			
<b>Please select the boxes indicating which strategies will be included in the Community Based FOBT Screening Plan:</b>			
<input type="checkbox"/> Recommendations by Local providers to encourage and promote FOBT screening and efficacy of FOBTs.	<b>Narrative description of how CHH/Coalition will implement this strategy:</b>		
<input type="checkbox"/> Plan for education to FOBT distribution sites such as pharmacies, clinics, and other partners distributing FOBT kits for contractor. Education and training should include: how to select age appropriate participants, how to complete FOBT, importance of colorectal cancer screening, efficacy of screening with FOBT, and appropriate monitoring of FOBT kits.	<b>Narrative description of how CHH/Coalition will implement this strategy:</b>		
<input type="checkbox"/> 1:1 education to men and women 50-74 years of age regarding importance of colorectal screening, efficacy of FOBT screening, <i>commitment of individual to complete</i> , how to complete FOBT.	<b>Narrative description of how CHH/Coalition will implement this strategy:</b>		
<input type="checkbox"/> Timely follow up of non-returned kits within 3 weeks of distribution of kit at minimum by mail.	<b>Narrative description of how CHH/Coalition will implement this strategy:</b>		

<b>Goal 1 - Projected number of kits that will be distributed:</b>		<b>Goal 2 – Projected number of kits that will be returned/completed:</b>	
<b>Description of CHH/Coalition Distribution Process:</b>			
<b>Description of CHH/Coalition Process for Follow Up of Non-Returned FOBT Kits:</b>			
<b>Description of CHH/Coalition Coordination with Processing Lab:</b>			
<b>Name of Lab or Labs processing FOBTs:</b>			
<b>Description of CHH/Coalition Follow up for Positive FOBT:</b>			
<b>Process for referring potential eligible Nebraska clients to NCP for colonoscopy:</b>			
<input type="checkbox"/> <b>Copy of Enrollment/Intake/Demographic Form Collected from FOBT Recipients provided to DHHS for review</b>			
<b>Designated Person for FOBT Registry Data Entry:</b>	<b>Address:</b>	<b>Phone:</b> (____) _____	
		<b>Fax:</b> (____) _____	
		<b>E-mail:</b>	
<b>List of In Kind Activities/Services</b>	<b>Estimated Value:</b>		
<b>DHHS Response/Plan Feedback:</b>			<b>Date:</b> ____/____/____
<b>CHH/Coalition Response to DHHS Feedback:</b>			<b>Date:</b> ____/____/____
<b>DHHS Approval:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	<b>Reason:</b>	
<b>DHHS Signature:</b>		<b>Date of Signature:</b> ____/____/____	

## 2019-2020 FOBT Distribution Sites

**Purpose of Form:** When a CHH needs to add an FOBT distribution site, CHH must have a **approved Community Based FOBT Distribution Plan**

**Name of Community Health Hub:**

**Date Submitted:**

**Contact Name:**

**Name/Place**

**Address**

**City**

**State**

**Zip**

**Year/Code**

*Year/Code assigned by DHHS*

**The 2019-20 FOBT Distribution Sites Form needs to be sent to DHHS in order to be put into the system. Please allow 2 weeks for your sites to be entered. Thank you!**

**Send this form to:**

Nebraska Colon Cancer Screening Program  
301 Centennial Mall South, P.O. Box 94817  
Lincoln, NE 68509-4817  
Fax: 402-471-0913  
Email: [dhhs.nccsp@nebraska.gov](mailto:dhhs.nccsp@nebraska.gov)

**Date DHHS Received Form:**

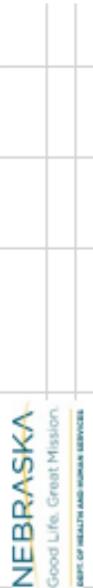
**Date DHHS Entered Form:**

**Date TA Notified:**

Version 6/2019

## 2019-2020 Primary Care Provider Listing

**Purpose of Form:** When a CHH needs to add a provider(s) for MCP clients.  
**CHH must have a approved Community Based FOBT Distribution Plan**



**Name of Community Health Hub:**

**Contact Name:**

**Provider/Clinic Name**

**Address**

**City**

**State**

**Zip**

**Telephone #**

**Additional Physicians (if known)**

**Date Submitted:**

**The 2019-20 Primary Care Provider Listing needs to be sent to DHHS in order to be put into the system. Please allow 2 weeks for your sites to be entered. Thank you!**

**Send this form to:**

Nebraska Colon Cancer Screening Program  
 301 Centennial Mall South, P.O. Box 94817  
 Lincoln, NE 68509-4817  
 Fax: 402-471-0913  
 Email: dhhs.nccsp@nebraska.gov

**Date DHHS Received Form:**

**Date DHHS Entered Form:**

**Date TA Notified:**

Version 6/2019



# Section 6: Success Stories

## Community Health Hub Success Stories

### Why are we capturing success stories?

- Stories are powerful.
- They help defend our work.
  - Success stories are an opportunity to share your successes and innovations with others, providing inspiration, tools and other resources to strengthen cancer prevention and control efforts.
- Capturing stores is a requirement of receiving EWM sub-award dollars.

**Requirement:** Community Health Hubs need to submit one (1) Success Story per quarter in addition to their quarterly reports.

### Success Stories vs. Accomplishments

Success Stories	Accomplishments
<ul style="list-style-type: none"> <li>• An anecdote that we hear.</li> <li>• A norm change that we observe</li> <li>• A policy passed after substantial work.</li> <li>• Significant earned media is garnered on a pertinent topic.</li> </ul>	<ul style="list-style-type: none"> <li>• A regular newsletter is published.</li> <li>• An annual meeting takes place.</li> <li>• A news release is issued.</li> <li>• Necessary and vital to our work but routinely done or noted as an activity</li> </ul>

### Submitting your Success Story:

1. If you need ideas for a Success Story talk with your TA or Tracey Bonneau.
2. Create the story in Word first, use spellcheck, cut/paste your information into the online form.
  - a. Access the form through Internet Explorer or Firefox web browsers.
  - b. Don't spend time on formatting. Your formatting will be lost when submitted.
3. Go to: <http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx>
4. Click on "Success Stories" tab
5. Click on "Submit a Success Story"
  - a. Select your Name from the drop down box
  - b. Choose the program area
  - c. Select your Individuals/Target Audience
  - d. Include narrative for the:
    - i. Setting (when/where the success story took place)
    - ii. Overview of Problem, Issue, Challenge, Opportunity (the why; obstacle, barriers)
    - iii. Project Objective (the what)
    - iv. Project Activities/Intervention (the how; describe key activities that were critical)
    - v. Key Partners (list partners that contributed)
    - vi. Accomplishments, Evaluation, Outcome, Impact (the what; measurable or concrete evidence of change; how this story helps demonstrate success)
    - vii. Lessons Learned (describe what you learned; barriers/challenges, changes made as a result of what was learned)
    - viii. Contact Information (your contact information)
2. Click "Submit"
  - a. Once you "Submit" you will receive an acknowledgement that you submitted the success story.
  - b. At this point, the story is submitted. You will no longer be able to edit.

## **You've submitted the story, now what?**

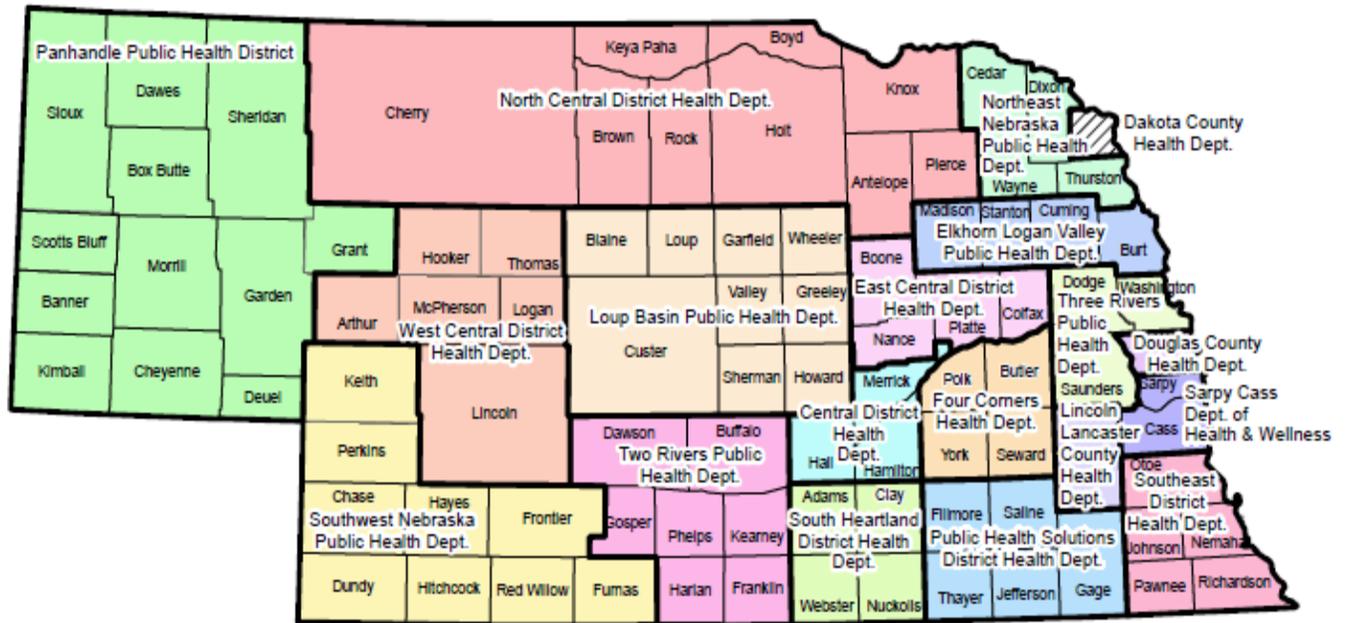
1. Once you submit your success story through the online form, the story is automatically sent to Tracey Bonneau's email.
2. 1<sup>st</sup> Review: Tracey Bonneau will review and provide input and recommendations. Success Story will be shared with TA.
3. 2<sup>nd</sup> Review: CHH TA will review and provide input and recommendations.
4. Correspondence: Tracey Bonneau will correspond with CHH staff to finalize any changes.
5. Once changes have been made and finalized, Tracey Bonneau will post to the CHH Success Story library that is located on the website.
  - Go to: <http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx>
  - Click on "Success Stories" to see the library of CHH Success Stories. The CHH Success Stories link is the location where all success stories will be stored
  - All stories will be easy to access and share.
  - Time investment is minimal.
  - Strength lies in volume. The more stories there are, the more evidence there is to help strengthen cancer prevention and control efforts.

# 2019-2020 Community Health Hubs Success Story Template

<b>Date Submitted:</b>	
<b>Name:</b>	
<b>Program Area(s):</b> <i>(may choose multiple)</i>	<input type="checkbox"/> National Diabetes Prevention Program <input type="checkbox"/> Self-Monitored Blood Pressure <input type="checkbox"/> Health Coaching w/Education <input type="checkbox"/> Breast Cancer Navigation <input type="checkbox"/> Cervical Cancer Navigation <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Living Well / Living Well with Diabetes <input type="checkbox"/> Check. Change. Control. ® <input type="checkbox"/> Walk & Talk Toolkit <input type="checkbox"/> Cholesterol <input type="checkbox"/> Other _____
<b>Individuals/Target Audience:</b> <i>(may choose multiple)</i> <i>(the who)</i>	<input type="checkbox"/> Women 40-74 <input type="checkbox"/> Men 50-74 <input type="checkbox"/> Other _____
<b>Title of Success Story:</b> <i>(capture overall message of story; include action verb; capture reader attention)</i>	
<b>Setting:</b> <i>(when/where this took place)</i>	
<b>Overview of Problem, Issue, Challenge, Opportunity:</b> <i>(the why; obstacle, barrier, problem)</i>	
<b>Project Objective:</b> <i>(the what)</i>	
<b>Project Activities/Intervention:</b> <i>(the how; describe key activities that were critical to success)</i>	
<b>Key Partners:</b> <i>(list partners who contributed to your success)</i>	
<b>Accomplishments, Evaluation, Outcome, Impact:</b> <i>(the what; measurable or concrete evidence of change; how this success story helps us demonstrate need or measure success)</i>	
<b>Lessons Learned:</b> <i>(describe what you learned; barriers/challenges and how you overcame, changes you made as a result of what was learned)</i>	
<b>Contact Information:</b> <i>(name and/or agency, address, website, etc.)</i>	

# Section 7: CHH Resources

## Nebraska Local Health Departments



**Legend**  
 Local Health Department that does not Qualify for LB 692\* Funding

0 45 90 Miles

\*LB 692 passed during the 2001 Legislative Session and provides funds to qualifying local public health departments.

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Source: Nebraska Department of Health and Human Services

## Community Health Hub Contact Information

Community Health Hub	County Coverage:
<p><b>Central District Health Department</b>            1137 South Locust            Grand Island, NE 68801            Phone: 308-385-5175            Toll Free: 877-216-9092            Website: <a href="http://www.cdhd.ne.gov">www.cdhd.ne.gov</a></p>	<p>Hall, Merrick, Hamilton</p>
<p><b>East Central District Health Department</b>            4321 41<sup>st</sup> Avenue            Columbus, NE 68602            Phone: 402-562-7500            Website: <a href="http://www.ecdhd.ne.gov">www.ecdhd.ne.gov</a></p>	<p>Boone, Nance, Platte, Colfax</p>
<p><b>Elkhorn Logan Valley Health Department</b>            2104 21<sup>st</sup> Circle            Wisner, NE 68791            Phone: 402-529-2233            Website: <a href="http://www.elvphd.org">www.elvphd.org</a></p>	<p>Madison, Stanton, Cuming, Burt</p>
<p><b>Lincoln-Lancaster Health Department</b>            3140 N Street            Lincoln, NE 68510            Phone: 402-441-8000            Website: <a href="http://www.lincoln.ne.gov">www.lincoln.ne.gov</a></p>	<p>Lancaster</p>
<p><b>North Central Health Department</b>            422 E. Douglas Street            O'Neill, NE 68763            Phone: 877-336-2406            Website: <a href="http://www.ncdhd.ne.gov">www.ncdhd.ne.gov</a></p>	<p>Cherry, Keya Paha, Brown, Rock, Holt, Boyd, Knox, Antelope, Pierce</p>
<p><b>Northeast NE Health Department</b>            215 North Pearl Street            P.O. Box 68            Wayne, NE 68787            Phone: 402-375-2200            Website: <a href="http://www.nnphd.org">www.nnphd.org</a></p>	<p>Cedar, Dixon, Thurston, Wayne</p>
<p><b>Panhandle Public Health Department</b>            808 Box Butte Avenue            P.O. Box 337            Hemingford, NE 69348            Phone: 308-487-3600            Website: <a href="http://www.pphd.org">www.pphd.org</a></p>	<p>Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Grant, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux</p>

<p><b>Public Health Solutions</b>  995 E. Hwy 33, Suite 1  Crete, NE 68333  Phone: 402-826-3880  Web: <a href="http://www.phsneb.org">www.phsneb.org</a></p>		<p>Fillmore, Gage,  Jefferson, Saline,  Thayer</p>
<p><b>Sarpy/Cass Health Department</b>  701 Olson Drive, Suite 101  Papillion, NE 68046  Phone: 402-339-4334  Web:  <a href="http://www.sarpycasshealthdepartment.org">www.sarpycasshealthdepartment.org</a></p>		<p>Sarpy, Cass</p>
<p><b>South Heartland Health Department</b>  606 N. Minnesota Avenue, Suite 2  Hastings, NE 68901  Phone: 402-462-6211  Web: <a href="http://www.southheartlandhealth.org">www.southheartlandhealth.org</a></p>		<p>Adams, Clay, Webster,  Nuckolls</p>
<p><b>Southeast District Health Department</b>  2511 Schneider Avenue  Auburn, NE 68305  Phone: 402-274-3993  Web: <a href="http://www.sedhd.org">www.sedhd.org</a></p>		<p>Johnson, Nemaha,  Otoe, Pawnee,  Richardson</p>
<p><b>Southwest District Health Department</b>  404 West 10<sup>th</sup> Street  P.O. Box 1235  McCook, NE 69001  Phone: 308-345-4223  Website: <a href="http://www.swhealth.ne.gov">www.swhealth.ne.gov</a></p>		<p>Chase, Dundy,  Frontier, Furnas,  Hayes, Hitchcock,  Keith, Perkins, Red  Willow</p>
<p><b>Three Rivers Public Health Department</b>  2400 North Lincoln Avenue  Fremont, NE 68025  Phone: 402-727-5396  Web: <a href="http://www.threeriverspublichealth.org">www.threeriverspublichealth.org</a></p>		<p>Dodge, Saunders,  Washington</p>
<p><b>Two Rivers Public Health Department</b>  701 4<sup>th</sup> Avenue, Suite 1  Holdrege, NE 68949  Phone: 888-669-7154  Web: <a href="http://www.trphd.org">www.trphd.org</a></p>		<p>Buffalo, Dawson,  Franklin, Gosper,  Harlan, Kearney,  Phelps</p>

## Federally Qualified Health Centers

### Charles Drew Health Center

2915 Grant Street  
Omaha, NE 68111  
Ph. 402-451-3553  
Fax: 402-453-1970  
Website: [www.charlesdrew.com](http://www.charlesdrew.com)



Charles Drew Health Center, Inc.

### Community Action Partnership of Western Nebraska Health Center

975 Crescent Drive  
Gering, NE 69341  
Ph. 308-632-2540  
Fax: 308-632-2752  
Website: [www.capwn.org](http://www.capwn.org)



COMMUNITY ACTION PARTNERSHIP of WESTERN NEBRASKA

### Good Neighbor Community Health Center

4321 41st Avenue, PO Box 1028  
Columbus, NE 68602  
Ph. 402-562-7500  
Fax: 402-564-0611  
Website: [www.ecdhd.ne.gov](http://www.ecdhd.ne.gov)



EAST-CENTRAL DISTRICT  
Health Department

health+



#### Satellite Clinic:

Good Neighbor Fremont Clinic  
2400 N. Lincoln Avenue  
Fremont, NE 68025  
Ph. 402-721-0951

### Heartland Health Center

3307 West Capital Avenue  
Grand Island, NE 68803  
Ph. 308-382-4297  
FAX: 308-382-4376  
Website: [www.heartlandhealthcenter.org](http://www.heartlandhealthcenter.org)

Heartland Health Center

a nebraska health+ center

### Midtown Health Center

302 West Phillip Avenue  
Norfolk, NE 68701  
Ph. 402-371-8000  
Fax: 402-371-0971  
Website: [www.midtownhealthne.org](http://www.midtownhealthne.org)

MIDTOWN  
HEALTH CENTER

#### Satellite Clinic:

Madison Medical Clinic  
222 Main Street  
Madison, NE 68748  
Phone: 402-454-3304

**OneWorld Community Health Centers, Inc.**

4920 South 30<sup>th</sup> Street

Omaha, NE 68107

Ph. 402-734-4110

Administration: 402-502-8845

Fax: 402-991-5642

Website: [www.oneworldomaha.org](http://www.oneworldomaha.org)



**OneWorld**  
Community Health Centers, Inc.

**Satellite Clinics:**

Cass Family Medical 409 Main Street Plattsmouth, NE 68048 Ph. 402-296-2345	West Omaha 4101 S. 120 <sup>th</sup> Street Omaha, NE 68137 Ph. 402-505-3907	Northwest Omaha 4229 N. 90th Street Omaha, NE 68134 Ph. 402-401-6000
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Teen & Young Adult Health Center 4310 South 24th Street Omaha, NE 68107 Ph. 402-502-8940	Bellevue 2207 Georgia Avenue Bellevue, NE 68005 Ph. 402-502-8855
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**Bluestem Health**

1021 North 27<sup>th</sup> Street

Lincoln, NE 68503

Ph. 402-476-1455 ext. 1007

Fax: 402-476-1655

Website: [www.phclincoln.org](http://www.phclincoln.org)



**Bluestem Health**

**Satellite Clinics:**

Bluestem Health Thompson Clinic 2222 S. 16 <sup>th</sup> St., Ste. 435 Lincoln, NE 68502 Ph. 402-474-7445	Bluestem Health Kreshel Clinic 3100 N. 14 <sup>th</sup> St., Ste. 201 Lincoln, NE 68521 Ph. 402-477-6600	Bluestem Health 2246 O Street Lincoln, NE 68510 Ph. 402-476-1455
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Bluestem Health  
Health 360  
2301 O Street  
Lincoln, NE 68510  
Ph. 402-476-1455

## Women's & Men's Health Program Contacts

Nebraska Department of Health & Human Services  
Women's & Men's Health Programs - Every Woman Matters  
301 Centennial Mall South || P.O. Box 94817 || Lincoln, NE 68509-4817

**Phone:** 402.471.0929 or 800.532.2227 || **Fax:** 402.471.0913  
**Email:** [dhhs.ewm@nebraska.gov](mailto:dhhs.ewm@nebraska.gov)  
**Web:** [www.dhhs.ne.gov/EWM](http://www.dhhs.ne.gov/EWM)

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*Every Woman Matters*



### Program Management:

Melissa D. Leypoldt, RN, Program Manager  
Phone: 402-471-0314  
Email: [Melissa.Leypoldt@nebraska.gov](mailto:Melissa.Leypoldt@nebraska.gov)

Michelle Heffelfinger, WW Program Manager  
Phone: 402-471-0595  
Email: [Michelle.Heffelfinger@nebraska.gov](mailto:Michelle.Heffelfinger@nebraska.gov)

### CHH Technical Assistance:

Natalie Kingston, Health Educator  
Phone: 402-471-0568  
Email: [Natalie.Kingston@nebraska.gov](mailto:Natalie.Kingston@nebraska.gov)

**CHH:** Central District Health Department; Elkhorn Logan Valley Health Department; Panhandle Public Health Department; Public Health Solutions; Sarpy/Cass Health Department; South Heartland Health Department; Southeast District Health Department, Southwest District Health Department

Aaron Sweazy, Health Educator  
Phone: 402-471-6567  
Email: [Aaron.Sweazy@nebraska.gov](mailto:Aaron.Sweazy@nebraska.gov)

**CHH:** East Central District Health Department; Lincoln-Lancaster County Health Department; North Central Health Department; Northeast Nebraska Health Department; Three Rivers Public Health Department; Two Rivers Public Health Department

### Billing/Invoicing:

Pam Findlay, Finance Coordinator  
Phone: 402-471-6583  
Email: [Pam.Findlay@nebraska.gov](mailto:Pam.Findlay@nebraska.gov)

### Data Entry:

Jill Crane, Data Manager  
Phone: 402-471-6007  
Email: [Jill.Crane@nebraska.gov](mailto:Jill.Crane@nebraska.gov)

### Media/Marketing:

Tracey Bonneau, Marketing Coordinator  
Phone: 402-471-2922  
Email: [Tracey.Bonneau@nebraska.gov](mailto:Tracey.Bonneau@nebraska.gov)

## Glossary/Definitions

Below is a listing of common terms or definitions that are frequently used throughout the Community Health Hub Manual.

### A

**A1c:** a blood test used to measure average blood sugar over the previous two to three months and a crucial step in monitoring how well blood sugar is being controlled in diabetics. The A1c test is also referred to as the HbA1c test, the glycated hemoglobin test or the glycohemoglobin test.

**age criteria:** Every Woman Matters is 40-74; Nebraska Colon Cancer Screening Program is 50-74. This is interpreted as the starting age for receiving services is age 40 or 50 years old. They are not eligible to receive screening services once they turn age 75.

### B

**barriers:** any problem or obstacle that could potentially prevent a client from obtaining necessary screening or treatment (e.g., no transportation, no child care, language barriers that may require an interpreter, etc.)

**blood glucose:** the main sugar that the body makes from the three elements of food – proteins, fats, and carbohydrates.

**blood pressure:** the force that the circulating blood exerts on the walls of the arteries.

**body composition:** the relative amounts of muscle, fat, bone, and other anatomical components that contribute to a person's total body weight.

**Body Mass Index (BMI):** a measurement of body mass that is correlated with skinfold thickness and body density.

**BSE:** acronym for Breast Self-Exam.

**breast biopsy:** the removal and examination, usually microscopically, of breast tissue.

**breast ultrasound:** a test that uses ultrasonic waves to scan the breast.

### C

**CDC:** acronym for Centers for Disease Control and Prevention.

**cervical biopsy:** the removal and examination, usually microscopically, of cervical tissue

**Check.Change.Control.®:** an evidence-based hypertension management program that utilizes blood pressure self-monitoring to empower participants to take ownership of their cardiovascular health. The program incorporates the concepts of remote monitoring, online tracking and recruits local volunteer health mentors to encourage participants.

**cholesterol:** a waxy, fat-like substance present in every cell in the body and in many foods.

**Clinical Breast Exam (CBE):** an exam of the breast by a clinician.

**Colonoscopy:** a procedure that allows a doctor to see inside the large intestine to find polyps or cancer. During this procedure, the doctor can remove polyps and some very early stage colon cancers.

**Community Health Hub (CHH):** framework of where public health resources are passed down to community utilizing collaborative synergy and activities in a systemic way that improves access to high-quality preventive screening services, enhances community linkages and strengthens data collection and utilization that impacts quality of life and health outcomes for Nebraska residents.

**Community Venue:** A Community Venue is any event with 1 to 1 engagement with your community, such as a Health Fair, Worksite Wellness or Faith based event. You are expected to have the client answer the initial assessment questions and if they need a community referral to refer them through the Encounter Registry. A Community Venue does not include an event where you just hand out FOBT kits or other educational information nor can you enter an event where you are just giving a talk on community education.

**complete** = 3 HC Calls/Post Biometrics recorded and follow-up survey complete

**CVD:** acronym for Cardiovascular Disease.

**cycles:** EWM/WW clients screened through program are assigned a cycle number based on their eligibility and time of screening. Please make sure you are health coaching the client under their current screening cycle. The cycle is listed on the EWM/WW Health Coaching list that is sent out bi-monthly (Column J – titled Cycle Number).

## D

**diabetes:** diabetes mellitus is a chronic syndrome of impaired carbohydrate, protein, and fat metabolism due to insufficient secretion of insulin or to target tissue insulin resistance.

**diagnostic mammogram:** Breast x-rays, which generally include four views of the breasts. Performed when any or all of the following reasons/conditions are present: palpable mass, pain, discharge, and/or breast implants. Also performed as a follow-up exam for suspicious findings obtained during physical examinations or screening mammograms.

**diagnostic referral:** a client who has a positive finding and referred to a diagnostic specialist for further testing

**diagnostic services:** services rendered to a client who needs follow up after a screening visit that resulted in an abnormal finding.

**diastolic:** The diastolic reading, or the bottom number, is the pressure in the arteries when the heart rests between beats. This is the time when the heart fills with blood and gets oxygen. A normal diastolic blood pressure is lower than 80.

## E

**Encounter Registry:** A real time web based application. Assists CHW in assessing, advocating, referring individuals to appropriate community resources and healthcare. A repository for statewide and local resources related to improving health outcomes. A system to match health resources with individuals based on their specific health status and needs. Provides a picture of health knowledge, needs and status of communities served.

**EWM:** acronym for Every Woman Matters.

## F

**fasting:** abstaining from all food and drink.

**Fecal Occult Blood Test (FOBT):** a test for hidden blood in the stool. Hemoccult Sensa II test kits will be used for the Nebraska Program.

**follow-up assessment/survey:** (required on the 3<sup>rd</sup> Health Coaching session for MedIt Clients) – These questions measure behavior change through stage of change questions, as a result of linking client to an HBSS. The questions are mandatory for the health coach to complete with the client on their 3<sup>rd</sup> and final health coaching session and are to be entered into Med-IT.

## H

**HDL:** acronym for High-Density Lipoproteins which carry cholesterol in the blood stream.

**health coaching:** also referred to as wellness coaching, is a process that facilitates healthy, sustainable behavior change by challenging a client to develop their inner wisdom, identify their values, and transform their goals into action. **Health coaching** draws on the principles from positive psychology and appreciative inquiry, and the practices of motivational interviewing and goal setting.

**health navigation:** also known as peer navigation and patient navigation, and can share similar approaches to some care coordination and case management interventions. There is no standard definition of navigation because each navigation program targets the specific needs of clients in the local context.

**Health Navigation to Screening:** Assistance provided by Health Coach to help a EWM/WW client complete her mammogram or population based clients complete their mammogram or Pap. This could be in the form of linking her to care, scheduling her appointment and removing barriers to screen (i.e., transportation, interpretation, etc.)

**Health Navigation to Diagnosis & Treatment:** Assistance provided by Health Coach to help those population based clients screened where a diagnostic issue is detected. It is facilitating those next steps of care. Again, this could be in the form of linking her to a provider and/or specialist, scheduling her biopsy, etc., and removing barriers to getting to appointments surrounding diagnosis and treatment.

**Healthy Lifestyle Questionnaire (HLQ):** a program eligibility enrollment document that includes behavior and health assessment information that is completed by the client. The HLQ is used during screening visits to aids the clinician in determining the need for healthy behavior support services to reduce the risk of CVD and diabetes.

**Healthy Behavior Support Services:** support programs that are evidence based in the form of nutrition, physical activity (Walk and Talk Toolkit), Check.Change.Control.® , Living Well (LW) and the National Diabetes Prevention Program. Supports vary by local health department. Local supports are identified and put into place by the Health Coach and help clients address behavior change and improve health outcomes.

**hypertension:** persistently high arterial blood pressure.

## I

**Initial Encounter Assessment:** The Initial Assessment gives you a brief snapshot of the client with age, race, gender, county of residence, whether or not they have a primary provider, if they have insurance and clients screening history. The initial assessment is required to be filled out completely for all clients.

**intervention:** any measure intended to improve health or alter the course of a disease.

## L

**LDL:** acronym for Low-Density Lipoproteins, which are a combination of a fat and a protein which acts as a carrier for cholesterol and fats in the bloodstream.

**lifestyle intervention:** a conscious change in patterns of eating, exercise or unhealthy habits (e.g., smoking, alcohol intake) to produce a positive change in a person's overall health.

**lipid panel:** a group of blood tests that determines risk of coronary heart disease; includes total cholesterol, HDL, LDL, and triglycerides.

**Living Well (LW):** a class that helps clients take control of their health by using small steps towards positive changes and healthier living. Class sizes range from 8-15 participants. Anyone who lives with an ongoing health condition or is caring for someone with an ongoing health condition may attend. Conditions may include: depression, anxiety, obesity, high blood pressure, migraines, arthritis, fibromyalgia, and heart disease. Format is 2.5 hours a week for six weeks. Participants learn about problem solving, communicating health issues, medication management, goal setting, physical activity and healthy eating.

## M

**mammogram:** a breast screening process/ x-ray of the breast.

**MedIT:** Online **MED**ical Information **T**racking system developed by OxBow Data Management System, LLC.

**Medical Questions in Encounter** (required on 1<sup>st</sup> and 3<sup>rd</sup> Health Coaching sessions) – These questions measure behavior change through stage of change questions, as a result of linking the population based client to an HBSS. The questions are necessary for the health coach to complete for population based clients and are to be entered into the Encounter Registry.

## N

**National Diabetes Prevention Program (NDPP):** a partnership of public and private organizations working to prevent or delay type 2 diabetes. The partners work to make it easier for people with pre-diabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health.

**nutritional assessment:** the process of assessing an individuals' nutritional status by evaluating dietary intake for a period of time.

## O

**obese:** Having a body mass index (BMI) of 30 or above.

## P

**Pap test (Papanicolaou Smear):** a screening test of the cells of the cervix used to detect early cervical abnormalities.

**pelvic exam:** an internal physical examination used to detect a variety of gynecological disorders. Includes a visual inspection of the vagina and cervix as well as palpation of the uterus and ovaries.

**Physical Activity (PA):** Walk and Talk Toolkit

**polyp:** a growth, usually benign, protruding from a mucous membrane.

**Pre and Post Biometrics:** Woman age 40 to 64 from population based venues are required to have pre and post biometrics. Pre and post biometrics required are height, weight, waist circumference, cholesterol and two blood pressures 5 minutes apart to measure behavior change and outcomes around LSP's.

**pre-diabetes:** a condition characterized by slightly elevated blood glucose levels, regarded as indicative that a person is at risk of progressing to Type 2 diabetes.

**priority population:** demographic factors such as age, gender, race/ethnicity, income level, education attainment or grade level, marital status, or health care coverage status; geography such as a region of a state or a specific community; or a location in which the priority population may be reached such as a workplace, school or church.

## Q

**quality assurance:** necessary to determine how well needs and expectations are met within available resources, involving all staff members to develop various approaches to implement actions to improve services.

## S

**screening cycle:** a screening cycle begins when a client has a breast or cervical screening exam along with a cardiovascular screening exam on the EWM Program and ends with one of the following:

- normal screening results
- definitive diagnosis of not cancer
- initiation of treatment if client diagnosed with cancer or pre-cancer
- completion of a lifestyle intervention if referred

**screening guidelines:** screening requirements for Every Woman Matters (EWM) for reimbursement by program funder.

**success story:** a story that is a compilation of anecdotes that are heard, a norm change that is observed, a policy that is passed after substantial work, significant earned media that is garnered on a topic. A success story help defend your work and is an opportunity to share successes and innovations with others, providing inspiration, tools and other resources to strengthen cancer prevention and control efforts.

**systolic:** When your heart beats, it squeezes and pushes blood through your arteries to the rest of your body. This force creates pressure on those blood vessels, and that's your systolic blood pressure. A normal systolic pressure is below 120. A reading of 140 or more is high blood pressure (also called hypertension)

## T

**three (3) attempts:** Local health departments initiate three phone attempts at various times of the day and different days of the week, to reach EWM/WW clients on their health coaching list.

**timely data entry:** CHH have 72 hours to enter data into the Med-IT or Encounter Registry Systems.

**total blood glucose:** the main sugar that the body makes from the three elements of food – proteins, fats, and carbohydrates.

**triglycerides:** a neutral fat synthesized from carbohydrates for storage in animal fat cells.

## V

**Venue Quality Measure Score:** Calculation of the percentage, if eligible, of population based reach and quality completion of brief risk assessments

**Venue Name:** Venue names should identify the place where the venue is being held. Name of business, facility or event name. The name of the event is followed by the date the event was held with month day and year. If more than one day make sure to add the end date of the venue also. Most HUBs are using acronym at the beginning of the venue name to easier access Venue on the home page. (i.e. LLC HD St Elizabeth Health Fair 7-1-2017/7-3-2017)

## W

**withdrawals:** Health coaches initiate three attempts to reach clients by phone. When unsuccessful, the Health Coach should WITHDRAW the client from Health Coaching in Med-It and Mark to Send Letter in an attempt to reach the client by mail.