Community Health Hub Manual

A MANUAL FOR IMPLEMENTATION OF CLIENT NAVIGATION SYSTEMS
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
# Table of Contents

## Section 1: CHH Introduction

- Why Community Health Hubs ................................................................. 6
- Pathway to Screening & Healthy Behavior Support Services (HBSS) (Med-It) ........ 7
- Pathway to Healthy Supports (Encounter) .................................................. 8

## Section 2: CHH Information

This is a section of the manual that each CHH can personalize by placing necessary documents, subaward information, technical assistance documents, billing and invoicing.

## Section 3: Data Entry

- Data Entry Guide ...................................................................................... 16

## Section 4: Community Health Hub Templates, Forms and Letters

- Healthy Behavior Support Services Agreement ............................................. 18
- National Diabetes Prevention Program Guidance .......................................... 19
- Check. Change. Control. © Program Guidance ............................................... 20
- Living Well Program Guidance .................................................................... 21
- Health Coaching with Education Guidance .................................................. 22
- Walk and Talk Toolkit Guidance ................................................................. 23
- Collaborative Impact for Breast Health Navigation Guidance and Template .... 24
- Special Projects Template Guidance ............................................................ 25
- Initial Encounter Assessment Guidance and Template ................................. 26
- Follow Up Assessment Guidance and Template ............................................ 28
- Venue Summary Report Guidance and Template ........................................... 31
- Client “Letter of Commitment” Example ..................................................... 37

## Section 5: Colon Cancer

- Colon Cancer FOBT Distribution/Screening Strategies .................................. 40
- Colon Cancer FOBT Distribution/Screening Requirements for CHH ............. 40
- FOBT Kit Labeling ...................................................................................... 40
- Community Health Hub Letter Codes ......................................................... 41
- FOBT Kit Labeling Document ...................................................................... 42
- Community Based FOBT Distribution Plan Template .................................. 44
- 2019-2020 FOBT Distribution Sites Tracking Form ...................................... 46
- 2019-2020 Primary Care Provider Listing ................................................... 47
Section 6: Success Stories

Why Success Stories? .............................................................................................................. 50
Success Stories vs. Accomplishments .................................................................................. 50
Before you Submit your Success Story ................................................................................. 50
Instructions for Submitting Online Success Story ............................................................... 50
Success Story Template ....................................................................................................... 52

Section 7: CHH Resources

Nebraska Local Health Department Locations/Map ............................................................ 54
CHH Contact Information ..................................................................................................... 55
FQHC Contact Information .................................................................................................. 57
Women’s & Men’s Health Program Contact Information ..................................................... 59
Glossary/Definitions ............................................................................................................ 60
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

Client fills out Healthy Lifestyle Questionnaire

Eligible for EWM
Client participates in Risk Reduction Counseling and receives age/risk appropriate screening at Screening Visit with Provider
Community Health Hub provides Health Coaching

Health Coaching with Healthy Behavior Support Service (HBSS) and Referral:
- National Diabetes Prevention Program (NDPP)
- Living Well
- Walk and Talk Tool Kit
- Smoking Cessation/Quit Line

Health Coaching with Education

Health Coach does Follow-Up to Assess Progress and Goal Reinforcement
- Client is considered COMPLETE when the Follow-Up Survey is completed and the post-biometrics are entered in Med-It.

NOT Eligible for EWM
Referral to Encounter Registry (see Pathway to Healthy Behavior Supports Protocol for Women 40-64)

Rescreening 12-18 Months)
Nebraska Women’s & Men’s Health Programs
Pathway to Healthy Supports
Health Coaching Protocol for Population Based Women 40-64
ENCOUNTER REGISTRY

Client fills out Initial Encounter Assessment

Initial Encounter Assessment data entered into Encounter Registry

Assessment of Need for navigation to screening and/or Referral/Linkage to Community Supports

Health Coaching with Healthy Behavior Support Services (HBSS) and Referral:
- National Diabetes Prevention Program (NDPP)
- Check, Change, Control.
- Living Well
- Walk and Talk Toolkit
- Smoking Cessation/Quit Line

Health Coaching with Education

Health Coach does Follow-Up to Assess Progress and Goal Reinforcement

- Health Coach does Follow-Up Survey (Questions 1-9) and pre and post biometrics at weeks 1 and 12.

- Client is considered COMPLETE when the Follow-Up Survey is complete and the post-biometrics are entered in the 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

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<th>Community Health Hub:</th>
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Version 11/2018
Community Health Hub
Monthly Technical Assistance Form

CHH Priorities for 2019-2020:
- Women enrolled in Every Woman Matters
- Women rarely or never screening for breast or cervical cancer
- Women with high burdens of uncontrolled hypertension, diabetes and obesity or late stage cancer diagnoses
- Women from low socioeconomic statuses
- Women without insurance or access to primary care
- Women and Men from minority populations experiencing disparities in health status and health outcomes
- Women and Men (50-74) screened for colon cancer

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| Questions/Recommendations: |  |

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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

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

Revised Version 5/2019
Community Health Hubs
National Diabetes Prevention Program (DPP) Guidance

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://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 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. 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 (>120/80) with additional risk factor - obesity, smoking, diabetes, etc.
- Recurrent uncontrolled (>140/90)
- Stage 2 hypertension (>160/100)*
- Alert values (>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.

Version 5/2019
Community Health Hubs
Living Well Guidance

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. 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.

Version 5/2019
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.

Version 5/2019
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/1st 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 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

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

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

Thanks! -EWM Staff

### DIET & PHYSICAL ACTIVITY

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

### HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, DIABETES

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

*DK - Don’t Know/Not Sure
1. Have you been diagnosed by a healthcare provider as having any of these conditions: (mark all that apply)
   - Coronary Heart Disease/Chest Pain
   - Congenital Heart Defects
   - Heart Failure
   - Stroke/Transient Ischemic Attack (TIA)
   - Vascular Disease
   - Heart Attack
   - Yes  No  DK*

2. Are you taking aspirin daily to help prevent a heart attack or stroke?
   - Yes  No  DK*

1. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)
   - Current Smoker
   - Quit (1-12 months ago)
   - Quit (More than 12 months)
   - Never Smoked

1. Thinking about your physical health, which includes physical illness and injury, on how many days during the past 30 days was your physical health not good?
   - ___ Days  DK*

2. Thinking about your mental health, which includes stress, depression, and problems with emotions, on how many days during the past 30 days was your mental health not good?
   - ___ Days  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  DK*

4. Are you limited in any activities because of physical, mental or emotional problems?
   - Yes  No  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?
   - Physical
   - Emotional
   - Intellectual
   - Sensory

6a. If yes, what type of disability?

6. Over the past 2 weeks, how often have you been bothered by any of the following problems: 6a. Little interest or pleasure in doing things:
   - Not at all
   - More than half
   - Nearly every day
   - DK*

6b. Feeling down, depressed, or hopeless:
   - Not at all
   - More than half
   - Nearly every day
   - DK*

*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: ____________
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.


- 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 in?
   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 – 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.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Prep Time (Minutes)</th>
<th>Work Time (Minutes)</th>
<th>Volunteering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cane</td>
<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>N</td>
</tr>
<tr>
<td>Hansen</td>
<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>N</td>
</tr>
<tr>
<td>Jones</td>
<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>N</td>
</tr>
<tr>
<td>Smith</td>
<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>N</td>
</tr>
</tbody>
</table>

**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 countered. 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.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Prep Time (Minutes)</th>
<th>Work Time (Minutes)</th>
<th>Volunteering</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>N</td>
</tr>
<tr>
<td>Hansen</td>
<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>N</td>
</tr>
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<td>Jones</td>
<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>N</td>
</tr>
<tr>
<td>Smith</td>
<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>Y</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Prep Time (Minutes)</th>
<th>Work Time (Minutes)</th>
<th>Volunteering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cane</td>
<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>Y</td>
</tr>
<tr>
<td>Hansen</td>
<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>Y</td>
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<tr>
<td>Jones</td>
<td>Jill</td>
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<tr>
<td>Smith</td>
<td>Jill</td>
<td></td>
<td>0</td>
<td>240</td>
<td>Y</td>
</tr>
</tbody>
</table>
Community Health Hubs Venue Summary Report Template

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.
- 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.

<table>
<thead>
<tr>
<th>Community Health Hub: Submitted By:</th>
<th>Venue Target Reach:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Women 18-39 ☐ Women 40-64</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Venue Name: (Each venue requires its own Template)</th>
<th>Date Submitted: (Date submitted must be at minimum 2 weeks prior to the venue)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em><strong><strong>/</strong></strong></em>/______</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Internal Use Only: Pre Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHHS Approval</td>
</tr>
<tr>
<td>☐ Reasonable expectation of being a successful venue met</td>
</tr>
<tr>
<td>☐ Pathway to navigation logical and meets requirements</td>
</tr>
<tr>
<td>☐ Pathway to health coaching and HBSS logical and meets requirements</td>
</tr>
<tr>
<td>☐ Appropriate Patient Pathway submitted</td>
</tr>
<tr>
<td>DHHS Signature:</td>
</tr>
</tbody>
</table>

Version 11/2018 Page 1 of 2
Venue Information

Venue Type
Choose one of the following:
- Community Based
- Faith Based
- Home Visits
- Hospital Based
- Local Health Department
- School Based
- Worksite 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:
- Cancer
- Financial Support
- Medical Access
- Nutrition
- Preventive Screening
- Smoking
- CVD
- Mental Health
- Physical Activity
- Stress
- Diabetes
- Hypertension
- Physical Safety
- Risk Assessment/Tailored Education
- 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
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) PROGRAM STAFF (SIGNATURE & WRITTEN NAME)

I agree that I am voluntarily participating in these activities and solely responsible for my safety and well-being.
**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:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omaha</td>
<td>OMA</td>
</tr>
<tr>
<td>Three Rivers</td>
<td>3RV</td>
</tr>
<tr>
<td>Lancaster</td>
<td>LAN</td>
</tr>
<tr>
<td>Southeast</td>
<td>SE</td>
</tr>
<tr>
<td>Panhandle</td>
<td>PN</td>
</tr>
<tr>
<td>South plains</td>
<td>SP</td>
</tr>
<tr>
<td>Public Health Solutions</td>
<td>PH</td>
</tr>
<tr>
<td>North Central</td>
<td>NC</td>
</tr>
<tr>
<td>Four Corners</td>
<td>FC</td>
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<tr>
<td>East Central</td>
<td>EC</td>
</tr>
<tr>
<td>Elkhorn Logan Valley</td>
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</tr>
<tr>
<td>Love Basin</td>
<td>LB</td>
</tr>
<tr>
<td>Sandhills</td>
<td>SA</td>
</tr>
<tr>
<td>Central District</td>
<td>CD</td>
</tr>
<tr>
<td>Health Disparities and Health Equity</td>
<td>HDHE</td>
</tr>
<tr>
<td>Charles Drew Health Center</td>
<td>CDHC</td>
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<tr>
<td>Southwest</td>
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<td>Southeast</td>
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<td>Dakota County</td>
<td>DC</td>
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<tr>
<td>West Central</td>
<td>WC</td>
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<tr>
<td>Northeast Nebraska</td>
<td>NE</td>
</tr>
<tr>
<td>Sarpy/Cass Department of Health &amp; Wellness</td>
<td>SC</td>
</tr>
<tr>
<td>Two Rivers Public Health</td>
<td>DR</td>
</tr>
</tbody>
</table>

**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](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](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](http://dhhs.ne.gov/Pages/EWM-Health-Hub.aspx).
Lincoln-Lancaster Co Health Dept. – Attn: Laboratory Services, label on the card envelope, this shows through the window.

Kit number on the kit. Avery template 5167 is used here. Print 2 of this label with kit number.

Lincoln-Lancaster Co. Health Department
Attn: Laboratory
3131 0 Street
Lincoln, NE 68510

A blue identifying label on each of the 3 slides on the kit. Make sure not to place the label over the slide opening.
Kit number on the enrollment form corresponds to the kit number on the envelope.

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

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

<table>
<thead>
<tr>
<th>CHH or existing cancer coalition with 501c3 status</th>
<th>Date Submitted for approval:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name:</td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Type and Brand of FOBT Kit:</td>
<td></td>
</tr>
<tr>
<td>FOBT Kits Provided By:</td>
<td></td>
</tr>
</tbody>
</table>

Please select the boxes indicating which strategies will be included in the Community Based FOBT Screening Plan:

- Recommendations by Local providers to encourage and promote FOBT screening and efficacy of FOBTs.
  
  **Narrative description of how CHH/Coalition will implement this strategy:**

- 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.
  
  **Narrative description of how CHH/Coalition will implement this strategy:**

- 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.
  
  **Narrative description of how CHH/Coalition will implement this strategy:**

- Timely follow up of non-returned kits within 3 weeks of distribution of kit at minimum by mail.
  
  **Narrative description of how CHH/Coalition will implement this strategy:**
<table>
<thead>
<tr>
<th>Goal 1 - Projected number of kits that will be distributed:</th>
<th>Goal 2 – Projected number of kits that will be returned/completed:</th>
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<tbody>
<tr>
<td>Description of CHH/Coalition Distribution Process:</td>
<td>Description of CHH/Coalition Process for Follow Up of Non-Returned FOBT Kits:</td>
</tr>
<tr>
<td>Description of CHH/Coalition Process for Follow Up of Non-Returned FOBT Kits:</td>
<td>Description of CHH/Coalition Coordination with Processing Lab:</td>
</tr>
<tr>
<td>Description of CHH/Coalition Coordination with Processing Lab:</td>
<td>Name of Lab or Labs processing FOBTs:</td>
</tr>
<tr>
<td>Description of CHH/Coalition Follow up for Positive FOBT:</td>
<td>Description of CHH/Coalition Follow up for Positive FOBT:</td>
</tr>
<tr>
<td>Process for referring potential eligible Nebraska clients to NCP for colonoscopy:</td>
<td>Process for referring potential eligible Nebraska clients to NCP for colonoscopy:</td>
</tr>
<tr>
<td>☐ Copy of Enrollment/Intake/Demographic Form Collected from FOBT Recipients provided to DHHS for review</td>
<td>DHHS Approval: □ Yes □ No □ Pending</td>
</tr>
<tr>
<td>Designated Person for FOBT Registry Data Entry: Address:</td>
<td>DHHS Approval: □ Yes □ No □ Pending</td>
</tr>
<tr>
<td>Phone: (__<strong>)</strong>_______</td>
<td>Reason:</td>
</tr>
<tr>
<td>Fax: (__<strong>)</strong>_______</td>
<td></td>
</tr>
<tr>
<td>E-mail:</td>
<td></td>
</tr>
<tr>
<td>List of In Kind Activities/Services</td>
<td>Estimated Value:</td>
</tr>
<tr>
<td>DHHS Response/Plan Feedback:</td>
<td>DHHS Response/Plan Feedback:</td>
</tr>
<tr>
<td>Date: <strong><strong>/</strong></strong>/____</td>
<td>Date: <strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>CHH/Coalition Response to DHHS Feedback:</td>
<td>CHH/Coalition Response to DHHS Feedback:</td>
</tr>
<tr>
<td>Date: <strong><strong>/</strong></strong>/____</td>
<td>Date: <strong><strong>/</strong></strong>/____</td>
</tr>
</tbody>
</table>

DHHS Signature: Date of Signature: ____/____/____
# 2019-2020 FOBT Distribution Sites

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

<table>
<thead>
<tr>
<th>Name of Community Health Hub</th>
<th>Date Submitted</th>
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<tbody>
<tr>
<td>Contact Name</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name/Place</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Year/Code</th>
</tr>
</thead>
</table>

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: 402-471-0313  
Email: dhhs.nccsp@nebraska.gov

**Date DHHS Received Form:**  
**Date DHHS Entered Form:**  
**Date TA Notified:**
# 2019-2020 Primary Care Provider Listing

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

<table>
<thead>
<tr>
<th>Name of Community Health Hub:</th>
<th>Date Submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name:</td>
<td></td>
</tr>
<tr>
<td>Provider/Clinic Name</td>
<td>Address</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------</td>
</tr>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 34817  
Lincoln, NE 68509-4817  
Fax: 402-471-0913  
Email: dhhs.ncosp@nebraska.gov

**Date DHHS Received Form:**  
**Date DHHS Entered Form:**  
**Date TA Notified:**
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

<table>
<thead>
<tr>
<th>Success Stories</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• An anecdote that we hear.</td>
<td>• A regular newsletter is published.</td>
</tr>
<tr>
<td>• A norm change that we observe</td>
<td>• An annual meeting takes place.</td>
</tr>
<tr>
<td>• A policy passed after substantial work.</td>
<td>• A news release is issued.</td>
</tr>
<tr>
<td>• Significant earned media is garnered on a pertinent topic.</td>
<td>• Necessary and vital to our work but routinely done or noted as an activity</td>
</tr>
</tbody>
</table>

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. 1st Review: Tracey Bonneau will review and provide input and recommendations. Success Story will be shared with TA.
3. 2nd 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.
   o 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.
<table>
<thead>
<tr>
<th><strong>Date Submitted:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td></td>
</tr>
</tbody>
</table>

| **Program Area(s): (may choose multiple)** | National Diabetes Prevention Program  
Self-Monitored Blood Pressure  
Health Coaching w/Education  
Breast Cancer Navigation  
Cervical Cancer Navigation  
Colon Cancer  
Living Well / Living Well with Diabetes  
Check. Change. Control. ®  
Walk & Talk Toolkit  
Cholesterol  
Other ___________________ |

| **Individuals/Target Audience: (may choose multiple)** | Women 40-74  
Men 50-74  
Other ___________________ |

| **Title of Success Story:** (capture overall message of story; include action verb; capture reader attention) |  |
| **Setting:** (when/where this took place) |  |
| **Overview of Problem, Issue, Challenge, Opportunity:** (the why; obstacle, barrier, problem) |  |
| **Project Objective:** (the what) |  |
| **Project Activities/Intervention:** (the how; describe key activities that were critical to success) |  |
| **Key Partners:** (list partners who contributed to your success) |  |
| **Accomplishments, Evaluation, Outcome, Impact:** (the what; measurable or concrete evidence of change; how this success story helps us demonstrate need or measure success) |  |
| **Lessons Learned:** (describe what you learned; barriers/challenges and how you overcame, changes you made as a result of what was learned) |  |
| **Contact Information:** (name and/or agency, address, website, etc.) |  |
Section 7: CHH Resources
### Community Health Hub Contact Information

<table>
<thead>
<tr>
<th>Community Health Hub</th>
<th>County Coverage</th>
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<tbody>
<tr>
<td><strong>Central District Health Department</strong></td>
<td>Hall, Merrick, Hamilton</td>
</tr>
<tr>
<td>1137 South Locust</td>
<td></td>
</tr>
<tr>
<td>Grand Island, NE 68801</td>
<td></td>
</tr>
<tr>
<td>Phone: 308-385-5175</td>
<td></td>
</tr>
<tr>
<td>Toll Free: 877-216-9092</td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://www.cdhd.ne.gov">www.cdhd.ne.gov</a></td>
<td></td>
</tr>
<tr>
<td><strong>East Central District Health Department</strong></td>
<td>Boone, Nance, Platte, Colfax</td>
</tr>
<tr>
<td>4321 41st Avenue</td>
<td></td>
</tr>
<tr>
<td>Columbus, NE 68602</td>
<td></td>
</tr>
<tr>
<td>Phone: 402-562-7500</td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://www.ecdhd.ne.gov">www.ecdhd.ne.gov</a></td>
<td></td>
</tr>
<tr>
<td><strong>Elkhorn Logan Valley Health Department</strong></td>
<td>Madison, Stanton, Cuming, Burt</td>
</tr>
<tr>
<td>2104 21st Circle</td>
<td></td>
</tr>
<tr>
<td>Wisner, NE 68791</td>
<td></td>
</tr>
<tr>
<td>Phone: 402-529-2233</td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://www.elvphd.org">www.elvphd.org</a></td>
<td></td>
</tr>
<tr>
<td><strong>Lincoln-Lancaster Health Department</strong></td>
<td>Lancaster</td>
</tr>
<tr>
<td>3140 N Street</td>
<td></td>
</tr>
<tr>
<td>Lincoln, NE 68510</td>
<td></td>
</tr>
<tr>
<td>Phone: 402-441-8000</td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://www.lincoln.ne.gov">www.lincoln.ne.gov</a></td>
<td></td>
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<tr>
<td><strong>North Central Health Department</strong></td>
<td>Cherry, Keya Paha, Brown, Rock, Holt, Boyd, Knox, Antelope, Pierce</td>
</tr>
<tr>
<td>422 E. Douglas Street</td>
<td></td>
</tr>
<tr>
<td>O'Neill, NE 68763</td>
<td></td>
</tr>
<tr>
<td>Phone: 877-336-2406</td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://www.ncdhd.ne.gov">www.ncdhd.ne.gov</a></td>
<td></td>
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<tr>
<td><strong>Northeast NE Health Department</strong></td>
<td>Cedar, Dixon, Thurston, Wayne</td>
</tr>
<tr>
<td>215 North Pearl Street</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 68</td>
<td></td>
</tr>
<tr>
<td>Wayne, NE 68787</td>
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</tr>
<tr>
<td>Phone: 402-375-2200</td>
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<tr>
<td>Website: <a href="http://www.nnphd.org">www.nnphd.org</a></td>
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<tr>
<td><strong>Panhandle Public Health Department</strong></td>
<td>Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Grant, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux</td>
</tr>
<tr>
<td>808 Box Butte Avenue</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 337</td>
<td></td>
</tr>
<tr>
<td>Hemingford, NE 69348</td>
<td></td>
</tr>
<tr>
<td>Phone: 308-487-3600</td>
<td></td>
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<tr>
<td>Website: <a href="http://www.pphd.org">www.pphd.org</a></td>
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<tr>
<td>Public Health Solutions</td>
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<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>995 E. Hwy 33, Suite 1</td>
<td></td>
</tr>
<tr>
<td>Crete, NE  68333</td>
<td></td>
</tr>
<tr>
<td>Phone:  402-826-3880</td>
<td></td>
</tr>
<tr>
<td>Web:  <a href="http://www.phsneb.org">www.phsneb.org</a></td>
<td></td>
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<tr>
<td>Fillmore, Gage,</td>
<td></td>
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<tr>
<td>Jefferson, Saline,</td>
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<td>Thayer</td>
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<table>
<thead>
<tr>
<th>Sarpy/Cass Health Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>701 Olson Drive, Suite 101</td>
</tr>
<tr>
<td>Papillion, NE  68046</td>
</tr>
<tr>
<td>Phone:  402-339-4334</td>
</tr>
<tr>
<td>Web:  <a href="http://www.sarpycasshealthdepartment.org">www.sarpycasshealthdepartment.org</a></td>
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<td>Sarpy, Cass</td>
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<th>South Heartland Health Department</th>
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<tbody>
<tr>
<td>606 N. Minnesota Avenue, Suite 2</td>
</tr>
<tr>
<td>Hastings, NE  68901</td>
</tr>
<tr>
<td>Phone:  402-462-6211</td>
</tr>
<tr>
<td>Web:  <a href="http://www.southheartlandhealth.org">www.southheartlandhealth.org</a></td>
</tr>
<tr>
<td>Adams, Clay, Webster, Nuckolls</td>
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<th>Southeast District Health Department</th>
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<tr>
<td>2511 Schneider Avenue</td>
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<tr>
<td>Auburn, NE  68305</td>
</tr>
<tr>
<td>Phone:  402-274-3993</td>
</tr>
<tr>
<td>Web:  <a href="http://www.sedhd.org">www.sedhd.org</a></td>
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<tr>
<td>Johnson, Nemaha, Otoe, Pawnee,</td>
</tr>
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<td>Richardson</td>
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<th>Southwest District Health Department</th>
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<tbody>
<tr>
<td>404 West 10th Street</td>
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<tr>
<td>P.O. Box 1235</td>
</tr>
<tr>
<td>McCook, NE  69001</td>
</tr>
<tr>
<td>Phone:  308-345-4223</td>
</tr>
<tr>
<td>Website:  <a href="http://www.swhealth.ne.gov">www.swhealth.ne.gov</a></td>
</tr>
<tr>
<td>Chase, Dundy, Frontier, Furnas,</td>
</tr>
<tr>
<td>Hayes, Hitchcock, Keith, Perkins,</td>
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<td>Red Willow</td>
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<tbody>
<tr>
<td>2400 North Lincoln Avenue</td>
</tr>
<tr>
<td>Fremont, NE  68025</td>
</tr>
<tr>
<td>Phone:  402-727-5396</td>
</tr>
<tr>
<td>Web:  <a href="http://www.threeriverspublichealth.org">www.threeriverspublichealth.org</a></td>
</tr>
<tr>
<td>Dodge, Saunders, Washington</td>
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<tr>
<td>701 4th Avenue, Suite 1</td>
</tr>
<tr>
<td>Holdrege, NE  68949</td>
</tr>
<tr>
<td>Phone:  888-669-7154</td>
</tr>
<tr>
<td>Web:  <a href="http://www.trphd.org">www.trphd.org</a></td>
</tr>
<tr>
<td>Buffalo, Dawson, Franklin, Gosper,</td>
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<tr>
<td>Harlan, Kearney, Phelps</td>
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## Federally Qualified Health Centers

<table>
<thead>
<tr>
<th>Center Name</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles Drew Health Center</td>
<td>2915 Grant Street, Omaha, NE 68111</td>
<td>402-451-3553</td>
<td>402-453-1970</td>
<td><a href="http://www.charlesdrew.com">charlesdrew.com</a></td>
</tr>
<tr>
<td>Community Action Partnership of Western Nebraska Health Center</td>
<td>975 Crescent Drive, Gering, NE 69341</td>
<td>308-632-2540</td>
<td>308-632-2752</td>
<td><a href="http://www.capwn.org">capwn.org</a></td>
</tr>
<tr>
<td>Good Neighbor Community Health Center</td>
<td>4321 41st Avenue, PO Box 1028, Columbus, NE 68602</td>
<td>402-562-7500</td>
<td>402-564-0611</td>
<td><a href="http://www.ecdhd.ne.gov">ecdhd.ne.gov</a></td>
</tr>
<tr>
<td>Heartland Health Center</td>
<td>3307 West Capital Avenue, Grand Island, NE 68803</td>
<td>308-382-4297</td>
<td>308-382-4376</td>
<td><a href="http://www.heartlandhealthcenter.org">heartlandhealthcenter.org</a></td>
</tr>
<tr>
<td>Midtown Health Center</td>
<td>302 West Phillip Avenue, Norfolk, NE 68701</td>
<td>402-371-8000</td>
<td>402-371-0971</td>
<td><a href="http://www.midtownhealthne.org">midtownhealthne.org</a></td>
</tr>
</tbody>
</table>

### Satellite Clinics

- **Good Neighbor Fremont Clinic**
  - Address: 2400 N. Lincoln Avenue, Fremont, NE 68025
  - Phone: 402-721-0951

- **Madison Medical Clinic**
  - Address: 222 Main Street, Madison, NE 68748
  - Phone: 402-454-3304
### OneWorld Community Health Centers, Inc.
4920 South 30th Street  
Omaha, NE 68107  
Ph. 402-734-4110  
Administration: 402-502-8845  
Fax: 402-991-5642  
Website: www.oneworldomaha.org

| Satellite Clinics | Cass Family Medical  
409 Main Street  
Plattsmouth, NE  
68048  
Ph. 402-296-2345 | West Omaha  
4101 S. 120th Street  
Omaha, NE 68137  
Ph. 402-505-3907 | Northwest Omaha  
4229 N. 90th Street  
Omaha, NE 68134  
Ph. 402-401-6000 |
|------------------|------------------|------------------|
| 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 |

### Bluestem Health
1021 North 27th Street  
Lincoln, NE 68503  
Ph. 402-476-1455 ext. 1007  
Fax: 402-476-1655  
Website: www.phclincoln.org

| Satellite Clinics | Bluestem Health Thompson Clinic  
2222 S. 16th St., Ste. 435  
Lincoln, NE 68502  
Ph. 402-474-7445 | Bluestem Health Kreshel Clinic  
3100 N. 14th St., Ste. 201  
Lincoln, NE 68521  
Ph. 402-477-6600 | Bluestem Health  
2246 O Street  
Lincoln, NE 68510  
Ph. 402-476-1455 |
|------------------|------------------|------------------|
| Bluestem Health Health 360  
2301 O Street  
Lincoln, NE 68510  
Ph. 402-476-1455 | Bluestem Health  
2246 O Street  
Lincoln, NE 68510  
Ph. 402-476-1455 | Bluestem Health  
2246 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
Web: www.dhhs.ne.gov/EWM

Program Management:

Melissa D. Leypoldt, RN, Program Manager
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CHH Technical Assistance:

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Aaron Sweazy, Health Educator
Phone: 402-471-6567
Email: Aaron.Sweazy@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

Billing/Invoicing:

Pam Findlay, Finance Coordinator
Phone: 402-471-6583
Email: Pam.Findlay@nebraska.gov

Data Entry:

Jill Crane, Data Manager
Phone: 402-471-6007
Email: Jill.Crane@nebraska.gov

Media/Marketing:

Tracey Bonneau, Marketing Coordinator
Phone: 402-471-2922
Email: 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 3rd 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 3rd 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.
**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.

**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.

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

**MedIT:** Online MEDical Information Tracking system developed by OxBow Data Management System, LLC.

**Medical Questions in Encounter** (required on 1st and 3rd 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.

**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.

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

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.

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. LLCHD 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.