



2013-2014 MINORITY HEALTH INITIATIVE Annual Report

December 1, 2014

In accordance with Nebraska State Statute 71-1628.07



Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services

From the Administrator...

This report was created by the Nebraska Department of Health and Human Services, Office of Health Disparities and Health Equity for the Nebraska Legislature to highlight the activities and outcomes of the Minority Health Initiative funding for the 2013 – 2014 year. The Minority Health Initiative (MHI) funding is allocated by the Nebraska Legislature to counties in the first and third Congressional Districts with minority populations of five percent or greater, based on the most recent decennial census. Funding is directed to be distributed on a per capita basis and used to address, but not be limited to, priority issues of infant mortality, cardiovascular disease, obesity, diabetes, and asthma.

To meet the directive, the Office of Health Disparities and Health Equity (OHDHE) uses a competitive request for applications process. This report covers the first year of a two-year Minority Health Initiative project period for 2013-2015. Sixteen projects were awarded funding for the 2013-2015 period. Funding for Arthur and Keith counties remains unallocated at this time as the Office of Health Disparities and Health Equity received no applications. Also included in the appropriation is annual funding to be distributed equally among federally qualified health centers in the second Congressional District (One World Community Health Center and Charles Drew Health Center). Funding for the federally qualified health centers is also to be used to implement a minority health initiative which may target, but is not limited to, cardiovascular disease, infant mortality, obesity, diabetes, and asthma.

The Minority Health Initiative grant projects should support the direct delivery of health care services by expanding existing services or enhancing health service delivery through health education, promotion, and prevention. The Minority Health Initiative grant program is designed to encourage the development or enhancement of innovative health services or programming to eliminate health disparities which disproportionately impact minority populations via collaborations among schools, faith-based organizations, local universities, private practitioners, community-based organizations, and local health departments, and other key stakeholders to bring health parity for minorities. Populations to be addressed include racial and ethnic minorities, American Indians, refugees, and immigrants.

During the 2013-2015 project period, the Office of Health Disparities and Health Equity incorporated several new components into the MHI grant process to improve the program achievements and outcomes. Among these were integration of community health workers, linking of the projects to the work plan of a federal grant, and the use of external evaluators for each project.

The Office of Health Disparities and Health Equity recognizes the important role community health workers play in improving health of communities. Research has demonstrated that integration of CHE's into community-based interventions is an effective strategy to assist in the prevention of chronic diseases as they are able to provide outreach and cultural linkages between communities and delivery systems. As chronic diseases are a focus of the MHI funding and are leading causes of death for minorities, the OHDHE encouraged the use of CHW's as a strategy for projects during the 2013-2014 project period.

The MHI projects were also included in the work plan of the application for the State Partnership Grant Program to Improve Minority Health (SPG), funded by the U.S. DHHS Office of Minority Health during this project period. The OHDHE leveraged the MHI funding in its application for federal funds, and its inclusion was cited as a significant strength in the decision to provide funding to the Nebraska DHHS Office of Health Disparities and Health Equity funding decisions. Nebraska was the only state in the U.S. DHHS Region VII to receive SPG funding.

The use of external evaluators among each grant program was another component that was added during this project period. External evaluators were added to enhance program outcomes by assisting grantees in analyzing data, and implementation and enhancement of objective and activities to achieve planned results.

As you will see in this report, the work that is being done by the 2013-2014 MHI projects is fostering positive change and improving the health among minority populations in Nebraska. On behalf of the Office of Health Disparities and Health Equity, the projects funded during this past year, and Nebraska's minority population, we thank the Nebraska Legislature for providing the Minority Health Initiative funding to improve health outcomes for Nebraska's racial and ethnic populations.

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

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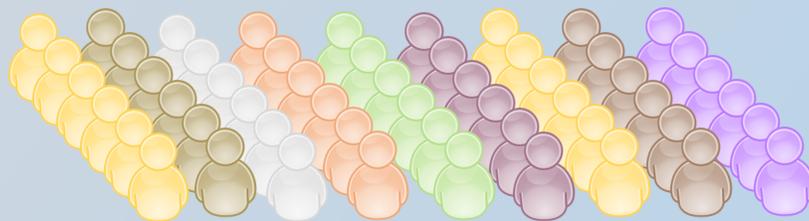
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2013-2014 Minority Health Initiative Projects

16 projects

served →

20,084 people

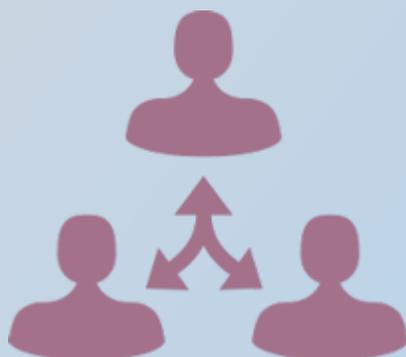


1,320 people assisted to find a medical home

932 people assisted to find a dental home



27,141 interpretation sessions provided



Spanish	19,609
Arabic	2,763
Vietnamese	1,180
Karen/Burmese	651
French	115
Other	1,605



11,397 health screenings provided
 5,579 blood pressure
 817 cholesterol
 1,870 diabetes
 4,789 obesity

90% of those found to be at-risk were referred for additional services

2013-2014 Minority Health Initiative Projects

139 Community Health Workers



helped

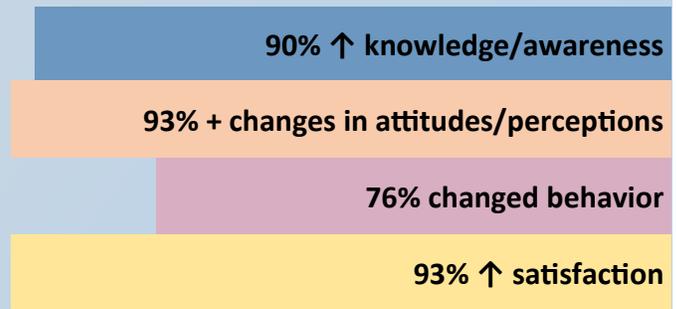
4,661 people



With

- Health education
- Case management
- Create/maintain links to community services/resources
- Ensured cultural and linguistic appropriateness of messaging
- Informal counseling/social support
- Peer counseling
- Health navigation
- Health screenings
- Health referrals
- Assess needs of clients
- Assist with accessing public assistance
- Assist with enrolling in medication assistance programs
- Advocate for clients and communities
- Empowered clients
- Recruited peers into training programs
- Provide supportive services
- Lead physical activity sessions
- Interpretation

3,487 health education sessions
11,177 participants



Topics

- Cardiovascular disease
- Childhood depression and anxiety
- Chronic disease prevention
- CPR Training
- Diabetes
- Drug and alcohol resistance
- Emergency preparedness
- Hand washing/hygiene
- Health insurance
- Health status of minorities
- Healthy nutrition/food portions
- Healthy relationships and self esteem
- Hormones
- Hypertension
- Medical homes
- Obesity
- Oral health
- Physical fitness/activity
- Poverty
- Pre- and Post-natal care
- STD and HIV/AIDS



363 people assisted with transportation to medical appointments

Clients Served

This page summarizes the clients served by the Minority Health Initiative projects for the period July 1, 2013 through June 30, 2014. These numbers represent the number of people provided services by the projects as a group. They also include the number of people who demonstrated changes in health indicators such as weight loss and lowering of cholesterol or blood pressure; and improvements in healthy behaviors such as increased physical activity, smoking cessation, or improved self-management of chronic diseases. “Other” includes Arab, Middle Eastern, Russian, Karen, Portuguese, Eastern Indian, White Hispanic, and persons who chose not to identify their race and/or ethnicity—people served but for whom funding was not appropriated.

Female							
Age	Total	Non Hispanic				Hispanic	Other
		Black	American Indian/ Alaska Native	Asian	Two or More Races		
All Ages	11,539	1,438	1,050	1,064	166	6,542	1,279
0-17	2,679	368	130	259	99	1,412	411
18-24	1,170	173	106	154	25	563	149
25-64	6,802	797	636	560	40	4,131	638
65+	888	100	178	91	2	436	81

Male							
Age	Total	Non Hispanic				Hispanic	Other
		Black	American Indian/ Alaska Native	Asian	Two or More Races		
All Ages	8,545	1,350	683	964	137	4,453	958
0-17	2,796	460	141	399	40	1,474	282
18-24	679	81	43	79	52	342	82
25-64	4,358	745	393	353	35	2,325	507
65+	712	64	106	133	10	312	87

Death Rates Related to Priority Issues, 2003-2007 and 2008-2012

Health Issue	Race/Ethnicity	2003-2007	2008-2012	Change
Heart Disease Death rate per 100,000 population	African American	233.6	191.8	↓
	American Indian	195.1	127.6	↓
	Asian	100.2	59.7	↓
	Hispanic	115.2	76.4	↓
	White	178.5	151.8	↓
Stroke Death rate per 100,000 population	African American	78.8	57.4	↓
	American Indian	51.2	49.2	↓
	Asian	47.8	27.2	↓
	Hispanic	21.5	25.2	↑
	White	46.9	37.5	↓
Diabetes Death rate per 100,000 population	African American	74.1	52.5	↓
	American Indian	51.2	49.2	↓
	Asian	22.0	17.0	↓
	Hispanic	42.5	27.6	↓
	White	20.7	20.5	↓
Infant Mortality Rate per 1,000 live births	African American	14.2	12.2	↓
	American Indian	13.0	7.3	↓
	Asian	5.9	2.3	↓
	Hispanic	6.3	5.7	↓
	White	5.7	5.2	↓

The above is a summary of the mortality rate changes we have seen throughout Nebraska between 2003 and 2012. Progress was made during this period regarding infant mortality, heart disease, diabetes, and stroke mortality. All decreased across all racial and ethnic groups except the Hispanic population, for which the stroke mortality rate increased. The heart disease mortality rate for American Indians decreased from 195.1 deaths per 100,000 population in 2003-2007 to 127.6 death per 100,000 population in 2008-2012. Stroke mortality rates for Asians decreased from 47.8 to 27.2 death per 100,000 population. Diabetes mortality in African Americans decreased from 74.1 to 52.5 death per 100,000 population. Finally, the infant mortality rate for American Indians from 13.0 to 7.3 per 1,000 live births.

Despite this progress, these issues are still challenging to minority populations, especially African Americans.

Data Source: Nebraska DHHS Vital Statistics 2003-2012

Risk Factors Related to Priority Issues, 2001-2005 and 2006-2010

Health Issue	Race/Ethnicity	2001-2005	2006-2010	Change
Obesity Prevalence among adults aged 18+	African American	33.9	39.0	↑
	American Indian	29.6	41.7	↑
	Asian	8.4	10.3	↑
	Hispanic	25.5	32.0	↑
	White	23.1	26.7	↑
High Blood Pressure Prevalence among adults aged 18+	African American	35.8	33.9	↓
	American Indian	36.2	28.2	↓
	Asian	15.7	25.1	↑
	Hispanic	17.1	21.8	↑
	White	22.6	25.3	↑
5+ Daily Servings of Fruits & Vegetables Prevalence among adults aged 18+	African American	15.4	25.5	↑
	American Indian	23.8	19.1	↓
	Asian	18.0	49.6	↑
	Hispanic	19.7	22.4	↑
	White	18.2	22.0	↑
Perceived Health Status: Fair or Poor Prevalence among adults aged 18+	African American	19.7	19.0	↓
	American Indian	24.7	22.9	↓
	Asian	17.0	9.1	↓
	Hispanic	25.2	25.2	↔
	White	11.4	10.9	↓

The table above summarizes the changes in the prevalence of risk factors in Nebraska between 2001 and 2010. Compared to 2001-2005, the percentage of people reporting fair or poor health declined among all racial and ethnic groups except Hispanic. Asians saw a large decrease in fair or poor health reporting, declining from 17% to 9%.

Diets high in fruits and vegetables can reduce the risk for cancer and chronic disease. Nebraska's American Indian population included the smallest proportion of people getting five or more servings of fruits and vegetables (19%), compared to 22% of Whites. Twenty-two percent of Hispanic Nebraskans got five or more servings of fruits and vegetables, a comparable proportion to Whites.

There were also some negative changes. The percentage of people with obesity (a BMI 30 or over) increased across all racial and ethnic groups. In addition, almost 42% of American Indians were obese in 2006-2010.

Data Source: Nebraska Behavioral Risk Surveillance System (BRFSS) 2001-2010

Comments from Participants

"I am eating more healthy and I feel better; my pains are disappearing."

"I liked the classes a lot; I learned a lot about how to eat healthy."

"They teach me the exercises so that I can do them."

"After my class, I have been trying to quit eating all the foods that were making me so sick. I didn't know it was that."

"I feel happy because I have learned how I should take care of my health."

"I want to say thanks to you who have given me help and that the talks helped a lot; I learned how to have better health and how to nurture my health."

"The Community Health Workers helped us better understand our disease."

"The program has changed my life!"

"I have more energy and am healthier."

"I am glad I can get my glucose meter from you because they are so expensive"

"I appreciated the events in the community where I was able to get my glucose checked"

"I don't know what we would have done without you,"

"Thank you for all that you have done for me!"

"I had no idea of the services available, and I cannot tell you how much I appreciate everyone's kindness!"

"All of your staff and volunteers are very kind, patient, and understanding. Thanks you for all of that and for your time."

"Thank you so much for doing this. It's important that my community have access to this type of service, so that my community can be healthier. We don't always get an opportunity for this type of service."

"We're so glad you're here. The services are very needed."

"I liked learning new things that I can apply them in my home and share with new people."

"I learned many things I didn't know before, I made friends, and I don't worry about what to make to eat and to eat well."

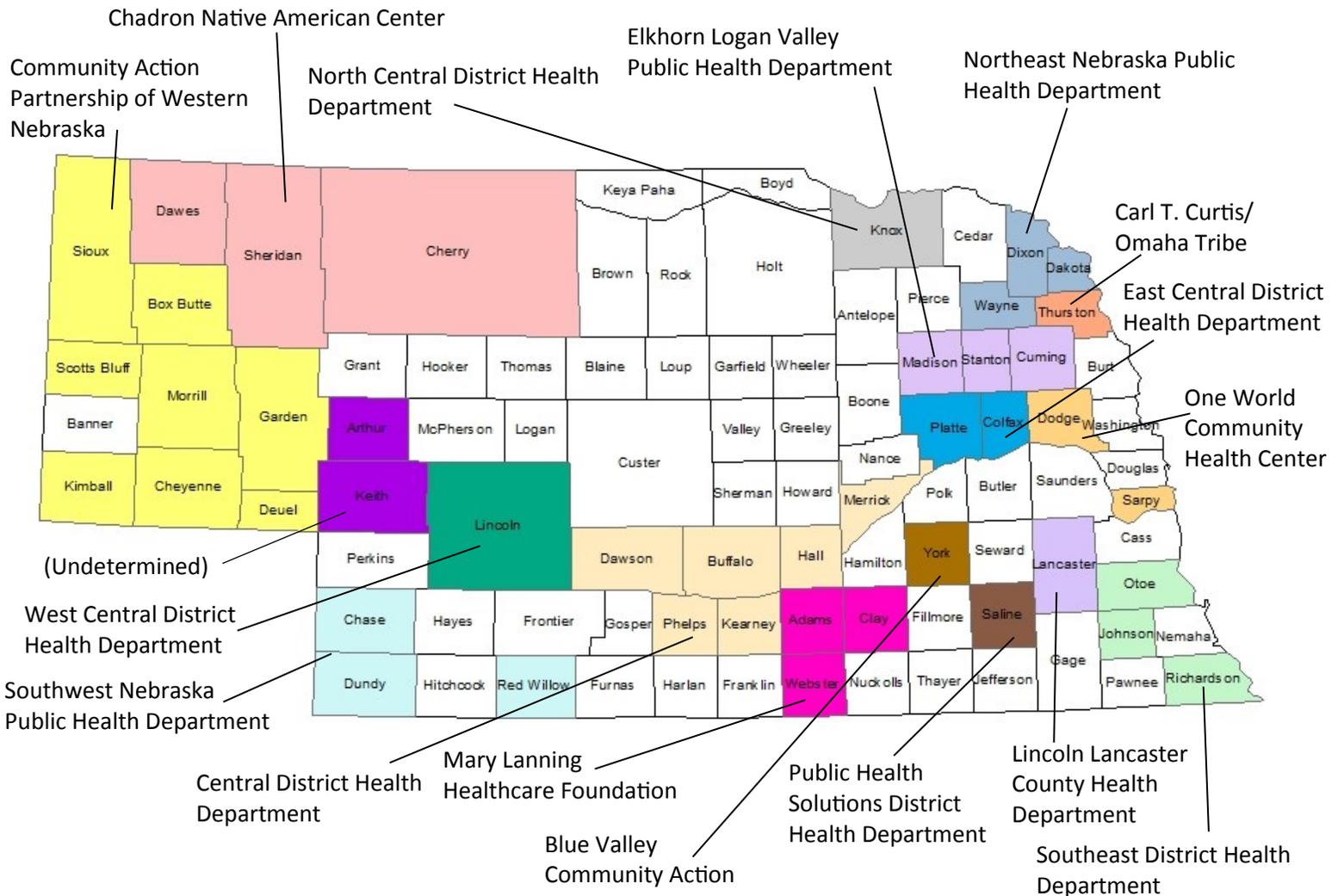
"Thank you so much for helping me. I was so afraid, but having an interpreter come with you to help me made me feel like I could be a better mother and no one would take my baby away."

"Thank you for providing the funding to better serve our minorities."

"This is much needed, and we are very thankful for the help in the community"

Grantee Reports

Page 13 of this document begins summaries of the outcomes of the individual project grants in Congressional Districts 1 and 3 and funding allocated to the Federally Qualified Health Centers in Congressional District 2. The reports are arranged alphabetically by grantee name, and include the county(ies) covered by the project, the funding awarded for the first year of the project period, the funding priority(ies) and other areas targeted, the number of clients served during the first year of the project, and project partners. Funding has not yet been awarded to Arthur or Keith counties, as decisions about the disposition of those counties resulting from the dissolution of Sandhills District Health Department is not yet clear. A brief description of the project is followed by activities implemented and outcomes achieved July 1, 2013 through June 30, 2014.



**Minority Health Initiative two-year projects (7/2013—6/2015)
were awarded to the following organizations:**

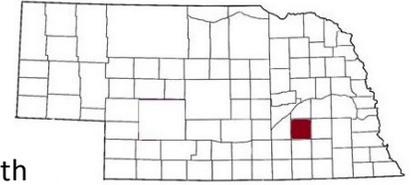
Projects (Congressional Districts 1 & 3)	Amount	County(ies)
Blue Valley Community Action	\$18,126.96	York
Carl T. Curtis Health Center/Omaha Tribe	\$81,012.07	Thurston
Central District Health Department	\$601,024.31	Buffalo, Dawson, Hall, Kearney, Merrick, Phelps
Chadron Native American Center	\$50,254.10	Cherry, Dawes, Sheridan
Community Action Partnership of Western Nebraska	\$253,314.57	Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sioux
East Central District Health Department	\$184,239.30	Colfax, Platte
Elkhorn Logan Valley Public Health Department	\$136,569.26	Cuming, Madison, Stanton
Lincoln-Lancaster County Health Department	\$862,091.05	Lancaster
Mary Lanning Memorial Hospital	\$85,659.51	Adams, Clay, Webster
North Central District Health Department	\$19,534.69	Knox
Northeast Nebraska Public Health Department	\$208,633.56	Dakota, Dixon, Wayne
One World Community Health Center	\$391,812.24	Dodge, Sarpy
Public Health Solutions District Health Department	\$65,237.76	Saline
Southeast District Health Department	\$50,832.61	Johnson, Otoe, Richardson
Southwest Nebraska Public Health Department (contract)	\$25,859.88	Chase, Dundy, Red Willow
West Central District Health Department	\$68,400.33	Lincoln
Undetermined	\$12,823.86	Arthur, Keith
<i>Total</i>	\$3,115,526.06	

Federally qualified health centers (Congressional District 2) For a one-year period:

Charles Drew Health Center	\$714,050.50	CD 2
One World Community Health Center	\$714,050.50	CD 2

York County

Blue Valley Community Action



Through education, guidance and support, this project provides participants with the skills and knowledge to promote chronic disease prevention, maternal and child health promotion, reduce obesity, and improve physical activity among all minority populations in York County. In addition, it raises awareness of post-partum depression and other mental health issues related to challenges facing new immigrants.

Target health issues

Obesity, infant mortality, cancer, cardiovascular disease, diabetes

Other health issues

Mental health

Dollars

\$9,063.48 per year

Clients served

120

Project partners

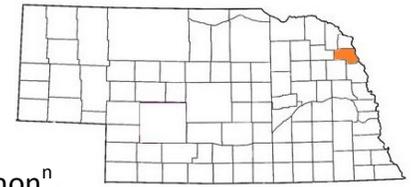
Blue Valley Behavioral Health, Four Corners Health Department

Activities & Outcomes July 1, 2013—June 30, 2014

- 24 women were screened, and all were referred to other services
- 12 participants attended the mental health education session, and 100% demonstrated increased knowledge
- 90% increased knowledge of preventive health measures
- 11 people participated in language focus groups
- 14 people participated in the nutrition sessions
- 12 people participated in a childhood depression education session
- Use of an outside evaluator clarified the need for a different perspective on the process
- Partners are working to provide a more holistic approach to meet the various needs of participants that are not addressed by grant funding
- Partners are working together in building trust among the participants

Thurston County

Carl T. Curtis Health Education Center



This project provides education and services to minority populations on Umoⁿhonⁿ Reservation in Thurston County. It promotes awareness of *Healthy People 2020* leading health indicators of cardiovascular disease prevention and control.

Target health issues

Cardiovascular disease, diabetes

Dollars

\$40,506.04 per year

Clients served

191

Project partners

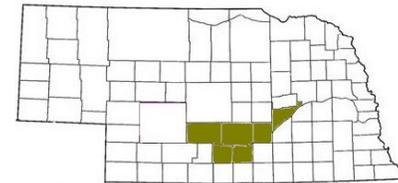
Local programs, education providers, healthcare organizations

Activities & Outcomes July 1, 2013—June 30, 2014

- For the CPR objective, a skills and written test was administered to assess the participants' understanding and knowledge, and about 80% passed the final exam
- Project staff networked extensively with community partners to recruit participants
- Participants received health education regarding cardiovascular disease and diabetes, as well as cardiopulmonary resuscitation (CPR) training and certification
- Participants of the cardiovascular disease and diabetes program earn a wellness score calculated based on a physical screening of body mass index (BMI), blood pressure, A1c, and other measures
- Questionnaires were also developed to measure health literacy, patients' satisfaction, and other measures
- More than 12 health education sessions were provided to over 100 people
- Program staff were able to establish and strengthen relationships with other area programs to help provide education and resources
- Staff of project partner The Wellness Center helped increase participation for the cardiovascular disease and diabetes management program by making referrals for anyone considered to be at-risk
- The Omaha Nation Senior Center, another partner, offered qualifying seniors the diabetes program on-site, eliminating the issue of transportation
- Educational classes were very well attended, and program staff were able to reach the community, generating more inquiries about MHI-funded programs

Buffalo, Dawson, Hall, Kearney, Merrick, Phelps Counties

Central District Health Department



Through a continuum of education and referral care, Choosing Health and Maximizing Prevention (CHAMP) targets obesity, diabetes, cardiovascular disease, and infant mortality in at-risk minority populations. CHAMP uses a life-course educational approach and peer health educators to instill healthy lifestyle behaviors that will improve health status and impact long term health outcomes.

Target health issues

Obesity, diabetes, infant mortality, cardiovascular disease

Other health issues

Sexually transmitted diseases, tobacco or alcohol use, HIV/AIDS

Dollars

\$300,512.16 per year

Clients served

534

Project partners

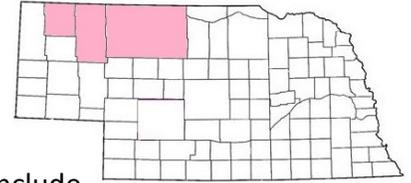
Two Rivers Public Health Department, Central Health Center, Central Nebraska Council on Alcoholism and Addictions, Community Fitness Initiative, Multicultural Coalition of Grand Island, community and cultural centers, employers, faith-based organizations, Lexington Regional Health Center

Activities & Outcomes July 1, 2013—June 30, 2014

- Of the 108 people who participated in interviews at three-months post-intervention, 78 indicated their diets were healthier
- 156 students participated in a CATCH Kids Club series, and all improved their assessment scores on no fewer than seven items
- Discovery Kids served 92 students, and the majority improved on no fewer than eight of the assessment items
- Health education class participants improved their scores by no fewer than nine items included in pre- and post-assessments
- Focus group data indicated that participants in the classes made lifestyle improvements related to healthy eating
- Over 500 adults participated in health fairs and screening events
- 265 adults participated in an eight-week series of nutrition classes
- Participants in classes asked for ongoing opportunities to reconnect and continue their learning

Cherry, Dawes, Sheridan Counties

Chadron Native American Center



This project continues a wellness program in Dawes and Sheridan counties to include wellness checks and the evidence-based National Diabetes Prevention Program (NDPP). In Cherry County, the project focuses on completion of the assessment process in cooperation with the area's Mobilizing for Action through Planning and Partnerships (MAPP) process and begin implementation of NDPP.

Target health issues

Obesity, diabetes, cardiovascular disease

Dollars

\$25,127.05 per year

Clients served

74

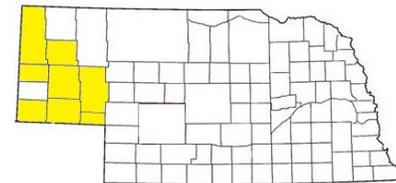
Project partners

Panhandle Public Health District, Western Community Health Resources

Activities & Outcomes July 1, 2013—June 30, 2014

- High levels of satisfaction were documented for each National Diabetes Prevention Program session, with 75% of participants indicating satisfaction with sessions
- Over 85% of participants demonstrated increased knowledge about the importance of physical activity and healthy eating
- Project staff worked with Western Community Health Resources to develop a relationship with a new minority population settling in the area from the Marshall Islands
- With support from Chadron Public Schools, a diabetic program was developed to serve the Marshallese
- Partnership with Chadron Public Schools also resulted in the use of space at the school(s) for health classes, as well as the expressed interest by leadership of that organization to discuss how relationship with minority populations can continue to be fostered through collaboration

Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Sioux, Scotts Bluff Counties



Community Action Partnership of Western Nebraska

This project reduces health disparities by using community health workers to provide intensive case management to racial ethnic minorities, Native American, refugee, and immigrant populations with chronic diseases (diabetes, cardiovascular, and obesity); and uses lay health ambassadors to identify and connect minorities who have diabetes, cardiovascular, and obesity issues with a medical provider.

Target health issues

Obesity, diabetes, cardiovascular disease

Dollars

\$126,657.29 per year

Clients served

338

Project partners

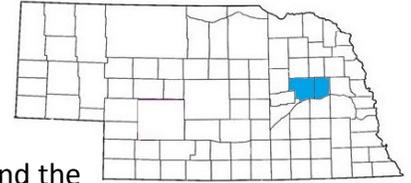
UNMC Western Nebraska Division of College of Nursing, Regional West Medical Center, Lakota Lutheran Center, CAPWN providers, Indian Center Inc, ESU 13, Scotts Bluff County Health Department, Panhandle Public Health District, Nebraska AIDS Project

Activities & Outcomes July 1, 2013—June 30, 2014

- Rate of HbA1C levels lower than 9 achieved by this program: 83% (31 out of 37 patients)
- 70% of health education participants demonstrated increased knowledge
- 100% of participants screened and found to be at-risk were referred to additional services
- Significant activities of the project included outreach to minorities with chronic diseases and culturally and linguistically appropriate case management to each patient through community health workers (CHWs)
- 100% of recruited patients participated in intensive case management
- 100% of participants received education on health care
- 185 glucose screenings were provided, and 27 were found to be abnormal
- 176 blood pressure screenings were provided, and 80 were found to be abnormal
- 100% of people with abnormal screenings received motivational interviewing
- 57% of people who received motivational interviewing were referred for additional follow up
- All participants in the chronic disease self-management program (CDSMP) demonstrated increased knowledge
- 90% of CDSMP attendees were referred for further educational sessions
- CHWs facilitated bridging of the gap in communication among providers and clients, improving timely responses and trust, which will improve health outcomes in the long term

Colfax, Platte Counties

East Central District Health Department



Through prevention programs, this project reduces the incidence of diabetes and the economic burden of diabetes, and improves the quality of life for all racial ethnic minority, Native American, refugee, and immigrant populations who have or are at-risk for diabetes.

Target health issues

Cancers, diabetes, cardiovascular disease

Dollars

\$92,119.65 per year

Clients served

243

Project partners

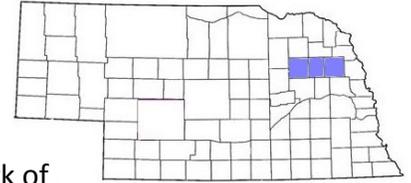
Alegent Creighton Health Clinic, Divine Mercy Church, Good Neighbor Community Health Center, Schuyler Community Resource Center, St. Bonaventure Church

Activities & Outcomes July 1, 2013—June 30, 2014

- The average number of steps per day for 50 program participants increased significantly by the end of the project year
- Survey results indicated that participants reported high levels of satisfaction with the program
- 70 individuals received blood glucose screenings to determine the presence of undiagnosed diabetes, and 56 of them received follow-up services to improve their glycemic control
- 95% of patients who received follow-up care reduced their A1c levels
- 20 patients received fecal occult blood test (FOBT) kits to screen for colorectal cancer

Cuming, Madison, Stanton Counties

Elkhorn Logan Valley Public Health Department



With prevention as the primary priority, this project continues the existing work of reducing obesity and the subsequent chronic disease impact that obesity triggers among all minority populations with a few minor enhancements to the project. Program staff, with the assistance from community health workers, implement evidence-based strategies that align with *Healthy People 2020*, the DHHS OHDHE strategic plan, as well as the *National Partnership for Action* to reach program goals, objectives, and outcomes.

Target health issues

Obesity, diabetes, cardiovascular disease

Other health issues

As indicated are necessary by the people served

Dollars

\$68,284.63 per year

Clients served

1,212

Project partners

Norfolk Community Health Care Clinic, Madison Medical Clinic, other local medical providers, Tyson Foods, local schools

Activities & Outcomes July 1, 2013—June 30, 2014

Cardiovascular Group Education:

- 83% of participants increased their knowledge of personal health indicators
- 94% of participants reported increases in exercise/activity
- 72% of participants (with two measures) decreased their weight

Individual Diabetes Self-Management Sessions:

- 83% of participants increased their knowledge of personal health indicators
- 94% reported increases in exercise/activity

Physical Activity Classes:

- Of those identified as overweight/obese, 36% lost weight

Topic of the Month Sessions:

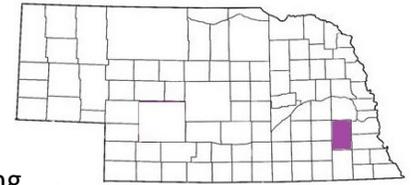
- 97% of 146 individuals improved knowledge according to pre-/post-test measures

Referrals:

- 98% of the people reached were provided with access to services and 86% followed through with completing their referral appointment

Lancaster County

Lincoln-Lancaster County Health Department



This project focuses on decreasing health risk from chronic disease and reducing the associated health disparities often experienced by minority populations. Partners of the Minority Health Community Collaborative continue to play a significant role with the health safety net in the community. Partners provide services such as outreach, education, help in applying for assistance programs, health screening and health risk assessments, health care navigation, breastfeeding consultation, help to establish a medical and dental home, specialty health care referral, medication assistance, and interpretation services for minority populations in Lancaster County.

Target health issues

Obesity, diabetes, cardiovascular disease, cancers

Other health issues

Oral health, tobacco or alcohol use

Dollars

\$431,045.53 per year

Clients served

12,873

Project partners

Asian Community & Cultural Center, Clinic with a Heart, Clyde Malone Community Center, El Centro de las Americas, Lancaster County Medical Society, MilkWorks, People's Health Center, UNMC College of Dentistry, Health Hub at Center for People in Need

Activities & Outcomes July 1, 2013—June 30, 2014

- 260 patients with cholesterol levels over 200 mg/dl were successful in lowering their levels
- 141 people were successful in losing weight
- 255 increased their levels of physical activity to meet recommendations
- 256 people were successful in improving their diets/nutrition
- 891 people were assisted to establish medical homes at People's Health Center
- 51 people were assisted to establish medical homes with private providers
- 836 people were assisted to establish a dental home at Lincoln-Lancaster County Health Department and People's Health Center
- 90 people with complex dental needs were referred to the UNMC College of Dentistry, which provided services at reduced cost
- 550 (all) people found to be at-risk for chronic or other conditions were referred for additional services
- Almost 10,000 interpretation sessions were provided by project partners
- 68 minority mother/baby pairs received breastfeeding education and consultation via 217 encounters
- 1,863 minorities received health education (155% of the two-year goal)
- 297 people received health risk assessments or screenings
- More than 750 people were assisted by staff of the Health Hub to access interpretation or transportation services, or to complete aid applications
- A Native American needs assessment was completed, and used to create project components for year two of the project
- MHI funds were leveraged to gain administrative support from every partner agency and in-kind services; and secure additional funding to help cover medication, translation, and specialty services

Adams, Clay, Webster Counties

Mary Lanning Healthcare Foundation



El Paquete Total (EPT) serves the Hispanic population, offering health, wellness, education, nutrition, and exercise components to address diabetes. The program focuses on one individual experiencing diabetes using a “total family” program. EPT offers individual disease management using the American Association of Diabetes Educators’ (AADE) seven self-care behaviors as well as offering educational and support programs to family members, including YMCA memberships, family garden plots, volunteer activities, home visits, and advocacy.

Target health issues

Obesity, diabetes, cardiovascular disease

Other health issues

Mental health

Dollars

\$42,829.76 per year

Clients served

698

Project partners

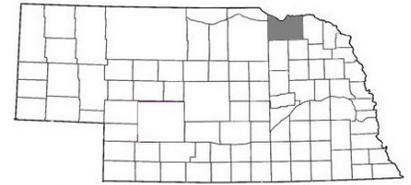
Mary Lanning Diabetes Department, Mary Lanning Healthcare Foundation, YMCA, South Heartland District Health Department

Activities & Outcomes July 1, 2013—June 30, 2014

- 73% of home visit participants maintained or improved their body mass index (BMI), blood pressure, or cholesterol
- Of the 260 participants of educational programs, 97% learned the importance of food groups, 94% learned how to limit intake, 79% ate two or more servings of fruit per day, and 60% exercised three or more days per week
- 99% of participants monitored for weight learned the benefits of weight management and the relationship to health
- 48% of the Adams County participants decreased their BMI over the past 12 months
- 30 case management participants increased their physical activity level
- Two outdoor family activities were provided, after which 99% of participants expressed increased knowledge of local options for physical activity
- 112 (Adams) and 25 (Clay) program participants were connected to a primary care provider or assistance program
- 87% have a trusted medical home
- 97% indicated satisfaction with their healthcare
- 85% of home visit participants maintained or improved home health habits
- 100% achieved access with medication compliance
- 6 sessions of CATCH Kids Club were offered, with participation of 30 kids per session; of those, 70% demonstrated increased knowledge, and 60% of families changed their behavior related to physical activity and healthy eating and decrease of snacking
- 263 home visits were provided
- 100% of home visit participants at risk were referred to other services
- Health risk assessments were provided to 70 (Adams) and 25 (Clay) participants
- Education was provided to 10 healthcare providers on secure health literacy curriculum in Adams and Clay counties

Knox County

North Central District Health Department



This project focuses efforts to improve the quality of life for all racial ethnic minorities, Native American, refugee, and immigrant populations will be served in Knox County who have diabetes, by increasing education, prevention efforts, and community capacity. Sexually transmitted diseases are also addressed through increasing access to quality health services through education and prevention efforts.

Target health issues

Diabetes

Other health issues

Sexually transmitted diseases

Dollars

\$9,767.35 per year

Clients served

757

Project partners

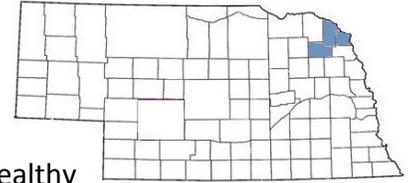
Santee Sioux Nation
(Santee Health Center)

Activities & Outcomes July 1, 2013—June 30, 2014

- 67% of people who attended diabetes health education sessions demonstrated increased knowledge
- Of the 225 people who participated in sexually transmitted disease (STD) education, all indicated increased understanding and awareness
- All (100%) of the 82 people screened for high blood pressure were subsequently referred, exceeding the goal of 85%
- 5 participants effectively managed their chronic health conditions, and had blood pressure readings and HgbA1c within normal limits
- About 12% of participants (10 of 81 screened) were found to be at risk for diabetes
- All diabetics with a diagnosis of hypertension were referred to wellness to receive instruction on exercise and education from a dietician
- Of the 30 people whose were screened in quarter 3 and found to have a diagnosis of hypertension, 18 (60%) had it adequately controlled (<140/90)
- In Year 1, a total of 77 participants received foot examinations
- The relationship between the grantee and its project partner, the Santee Sioux Nation, was strengthened through the relationship fostered with the Public Health Nurse and the Health Educator at the Santee Health and Wellness Center
- The Santee Sioux Nation's Wellness Center staff used creativity to provide health education, screenings, and activities to the people of Santee where they lived, worked, and played

Dakota, Dixon, Wayne Counties

Northeast Nebraska Public Health Department



This program focuses on the prevention of chronic disease and promotion of healthy lifestyles. Community health workers are integral to the success of this project. Both a focus on health literacy and collaboration with community health workers provides the evidence-based approach necessary to ensure accomplishing the goals of the project.

Target health issues

Cardiovascular disease, diabetes

Other health issues

Access to care

Dollars

\$104,316.78 per year

Clients served

146

Project partners

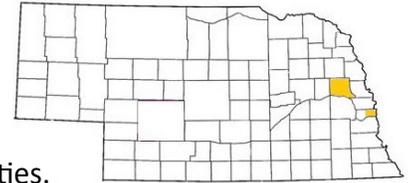
Northeast Nebraska Community Action Partnership, Salem Evangelical Church, Gardner Public Library, local hospitals, medical clinics, city and county governments

Activities & Outcomes July 1, 2013—June 30, 2014

- This was the first year for this project in Dakota County, and successes achieved included establishment of office locations and building relationships with leaders of local minority communities (Somali and Hispanic)
- 71 minorities in Dakota County were screened for chronic diseases
- An assessment of barriers to health care in Dakota County was completed, and results indicated that they included lack of transportation, work hours, lack of time, language barriers, clinic hours that did not work with participants' schedules, lack of money, lack of health insurance, and lack of phones
- 64 people in Wayne and Dixon Counties received health screenings
- 93 participants received referrals to additional services, which included interpretation, screenings, assistance with forms, and others
- 30 people received assistance accessing dental care or medications

Dodge, Sarpy Counties

One World Community Health Center



Funds are used to continue the *promotora* programs in Sarpy and Dodge Counties.

The goal of the project is to train 150 additional *promotoras*, provide additional training to *promotoras* already trained through the previous grant cycle, and by June 30, 2015, the *promotoras* will screen at least 1,800 individuals for diabetes, hypertension, and obesity in Sarpy and Dodge Counties. Individuals who have high test results will be connected to the One World outreach lead and individually connected to One World as a medical home to manage and improve their health condition.

Target health issues

Obesity, diabetes, cardiovascular disease

Dollars

\$104,316.78
per year

Clients served

1,027

Project partners

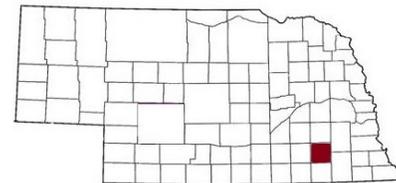
Nebraska Methodist
College, Hope
Medical Outreach
Coalition, Midland
University

Activities & Outcomes July 1, 2013—June 30, 2014

- The percentage of participants who correctly responded to questionnaire items was much higher at the post-test as compared to the pre-test
- The percentage of persons who performed correctly the specific behaviors they were taught was either always or almost always higher for post-test measures when compared to pre-test measures
- A total of 80 participants completed the *Promotora* program
- A majority of the trainees responded positively about the benefit of the *Promotora* educational program and its various program components
- There was a substantial increase in the number of persons reporting that they felt comfortable with performing most/all of the skills in the analysis (delivering education programs and conducting community events)

Saline County

Public Health Solutions District Health Department



The primary goal of the My Life, My Health (*Mi Vida, Mi Salud*) Program is to minimize the detrimental impact diabetes has on the local racial ethnic minorities, American Indian, refugee, and immigrant populations through educating community members about ways to prevent and/or manage diabetes through healthy eating and physical activity.

Target health issues

Obesity, diabetes, cardiovascular disease

Dollars

\$32,618.88 per year

Clients served

118

Project partners

Saline Medical Specialties, Crete Area Medical Center, Gage County and Saline County Extension, Saline Eldercare, El Paraiso, Crete Community Gardens; Bruce Kennedy, DDS

Activities & Outcomes July 1, 2013—June 30, 2014

- 95% of participants who completed pre- and post-testing demonstrated positive changes in knowledge of their personal health risks
- 94% of people who completed *Road to Health* (an evidence-based program from the Centers for Disease Control and Prevention) classes demonstrated positive changes in knowledge
- 75% of participants who completed *Road to Health* classes changed their behavior to include healthier choices
- All participants who completed *Journey for Control* classes indicated they had changed their behavior to include healthier foods and increased levels of physical activity
- 96% of participants found to be at-risk for diabetes, obesity, or cardiovascular disease were referred for additional services
- 24 screening events were held, and 138 people were screened for diabetes
- 34 people at risk for type 2 diabetes participated in health education classes designed to prevent the condition
- 46% of people diagnosed diabetic participated in health education regarding their conditions
- Efforts of the Community Health Worker hired under this funding resulted in an increase from 30% to 56% in the proportion of people who learned about available services via word-of-mouth from other clients
- Relationships with local partners (employers, businesses, medical community), both existing and new, were strengthened
- Funding was leveraged to hire additional staff, add exercise classes, and purchase for low or no cost supplies and educational materials for the program

Johnson, Otoe, Richardson Counties

Southeast District Health Department



This project improves access for all racial/ethnic minorities, Native American, refugee, and immigrant populations to three existing programs: Growing Great Kids, Every Woman Matters, and the Nebraska Colon Cancer Program (NCP). Community-based lay health ambassadors serve as liaisons between the public health system and minority communities and provide health education, outreach and community education. Communitywide cultural competency training workshops also increase awareness of health disparities and advance cultural intelligence.

Target health issues

Infant mortality,
cancers

Dollars

\$25,416.31
per year

Clients served

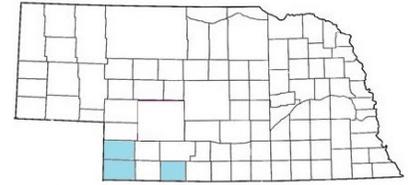
761

Activities & Outcomes July 1, 2013—June 30, 2014

- 54 clients reported positive satisfaction with program services
- The cultural competence training (*People are People are People*) was delivered to 13 staff/service providers, with 58% demonstrating knowledge gains in most topic areas between pre- and post-test comparisons
- Spanish interpretation was provided for 87 clients
- 88 individuals received lead screening services at immunization clinics
- 89 clients participated in the Growing Great Kids curriculum (addresses infant mortality risk factors and supports the development of nurturing parent-child relationships age 0-3 years old)
- 36 home visits were conducted
- A health fair reached 76 people with prevention information
- 21 health-risk cancer (breast, cervical, colon) screenings were performed for medically underserved adults between the ages of 40-64

Chase, Dundy, Red Willow Counties

Southwest Nebraska Public Health Department



This project aims to increase access to preventive healthcare services that are offered through Southwest Nebraska Public Health Department.

Target health issues

Obesity, cancer, cardiovascular disease

Other health issues

Tobacco or alcohol use, access to preventive healthcare services

Dollars

\$12,929.94 per year

Clients served

15

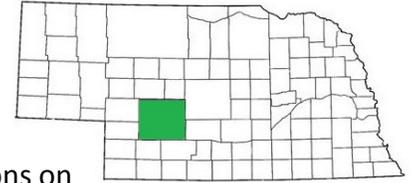
Activities & Outcomes April 1, 2013—June 30, 2014

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

- The job description for the program assistant was developed and implemented
- Hired a Spanish-speaking program assistant
- Registration forms, service flyers and brochures were translated into Spanish
- Outlying clinics have been established
- An increase of Spanish-speaking clients has begun to be apparent

Lincoln County

West Central District Health Department



By utilizing community health workers, continue to educate minority populations on health-related topics which include obesity, cancer, cardiovascular disease, diabetes, and mental health issues. Additionally, the community health worker serves as a member of the care delivery team by serving as an advocate for the clients. The community health worker collaborates with a team comprised of a physician, nurse or allied health worker, and assistant to deliver health education or basic screening services while the providers conduct medical exams and will also serve as an interpreter when needed.

Target health issues

Obesity, cancer, cardiovascular disease, diabetes

Other health issues

Mental health

Dollars

\$34,200.94 per year

Clients served

726

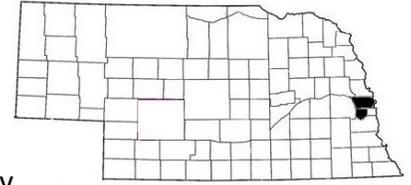
Project partners

Great Plains Regional Medical Center

Activities & Outcomes July 1, 2013—June 30, 2014

- 8 education sessions were completed, with an average of 18 participants per session
- The project provided 550 encounters during this first year
- 331 referrals were made
- As of June 30, the case management component of the project was providing services for twice as many individuals as intended in the original, two-year grant proposal
- Many participants return on a regular basis for each health education session, and based on attendance tracking, the regular participants attended an average of 5 of the 8 sessions
- Monthly mailings were sent out to participants and community partners with information regarding the educational sessions.
- A flyer was created in English/Spanish to provide basic information for the general public about this program

Charles Drew Health Center



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

Target health issues

Cardiovascular disease, asthma, diabetes, obesity, infant mortality

Other health issues

Depression, oral health, substance and alcohol use

Dollars

\$714,050.50

Clients served

10,451 in calendar year 2013

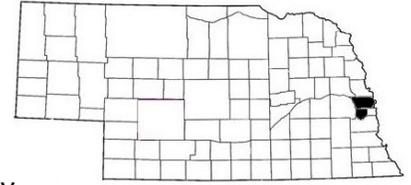
Minority clients

69.8% or 7,295

Activities & Outcomes July 1, 2013—June 30, 2014

- Interpretation/translation services were provided for 912 encounters, including Mai Mai/ Somali (602) and Karen/Burmese (310)
- 94% of patients screened and diagnosed with depression received the appropriate follow up
- Of the 331 adult diabetic patients, 73% had a HbA1c less than 9%
- There were 61 patients ages 5-40 with asthma, and 89% of them were treated with an accepted inhaled corticosteroid or an accepted alternative medicine
- 1,221 patients ages 18-85 were hypertensive, and the proportion of them with controlled hypertension increased from 53% in 2012 to 56% during this period
- The proportion of adult patients with a diagnosis of coronary artery disease (CAD) who were prescribed a lipid-lowering therapy was 80%
- The percent of adult patients with ischemic vascular disease or who were discharged after acute health events (e.g., heart attack) with documentation of aspirin use or another antithrombotic was 81%
- 978 obstetrical and 67 post-partum appointments were provided
- The proportion of women initiating their prenatal care during the first trimester was 66%
- The percentage of births <2500 grams (underweight) was 9%
- The proportion of patients 2-17 years with weight assessment and counseling for nutrition and physical activity increased from 41% in 2012 to 47% in 2014
- The percentage of adult patients with weight screening and follow up increased from 33% in 2012 to 37%
- From January 2014 to June 2014, the percentage of patients with documented tobacco use who had cessation interventions was 60%
- The proportion of children who were fully immunized by their 3rd birthday was 70%

One World Community Health Center



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

<p>Target health issues Diabetes, infant mortality, cardiovascular disease</p> <p>Other health issues Tobacco or alcohol use, depression, asthma, pediatric oral health</p> <p>Dollars \$714,050.50</p> <p>Clients served 27,108 in calendar year 2013</p> <p>Minority clients 85.8% or 23,259</p>	<p style="text-align: center;">Activities & Outcomes January—June 2014</p> <ul style="list-style-type: none"> ▪ Of the 27,108 patients served in calendar year 2013, 85.8% or 23,259 were racial ethnic minority ▪ 93.9% of adult patients were screened for tobacco use, compared to the <i>Healthy People 2020</i> goal of 30%, the national average (59%), and Nebraska average (60%) ▪ Since 2008, over 80% of diabetic patients treated have their conditions under control ▪ 80.4% of diabetic patients had HbA1c results less than 9 mg/dl ▪ One World cared for 1,038 hypertensive patients ▪ In the last year, 87% of cardiovascular patients received cholesterol treatment and lipid therapy ▪ 1,516 patients were treated for depression, which is 70% of the number seen for this condition in all of 2013 ▪ Over 91% of patients screened for and diagnosed with depression received the necessary follow up in 2013 and 2014 ▪ 175 patients were treated for asthma ▪ 929 prenatal visits were provided ▪ Over 88% of prenatal patients began their care in the first trimester, which is higher than the national community health center average and the <i>Healthy People 2020</i> benchmark ▪ Only 4.7% of babies born to OneWorld patients were of low birth weight
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Success Stories

Blue Valley Community Action Partnership

In March of 2014, a Hispanic family that was new to the community came into the Women, Infant and Children (WIC) clinic seeking services for their 6-month old baby. The family (father and mother), were also non-English speaking, so the Hispanic healthcare case manager completed an assessment to determine whether they had any additional needs with which she could help. The father shared with her that the baby had been very sick, and although the baby had been seen by a medical provider, the baby still did not seem well. The case manager contacted the medical provider, giving information about the WIC staff's assessment and status of the baby, and was instructed by the physician to have the parents take the child to a Lincoln hospital emergency room for evaluation. The case manager provided a map and directions for the parents, and her cell phone number in case they had any problems getting there.

The baby was placed in intensive care with respiratory syncytial virus (RSV). Over the next few days, the father remained in contact with the case manager, and reported that the baby was improving and thanked the staff for the support and action they took, feeling that it saved the baby's life.

Several weeks later, the case manager contacted the family and made referrals and appointments for assistance due to additional identified needs. A follow up with the family in June found the father was gainfully employed, they had moved into a low-income rental, the children were healthy, the children's application for Medicaid was approved, they had a medical home, and continued to receive services through the WIC program. The family expressed how thankful they were for all the support services that the case manager and the project provided.

Carl T. Curtis Health Education Center

A patient who had signed up for our project's service was demonstrating good initial participation, but over time, she discontinued attending any project events. We thought maybe she had given up on the program. In June of 2014, this individual was seen in our clinic with a blood sugar of 700 and an A1c of 12.8. The patient stated her vision was getting worse and that she always felt ill. After seeing these results, I knew that we needed to step in and help.

We incorporated her back into our program and performed follow-up phone calls and office visits, and offered encouragement at each opportunity with this individual. The patient acknowledged that she needed to make some changes and wanted to work with us. Subsequent to in-depth diabetes education services and providing a glucometer to the patient, we set a goal: the patient committed to taking blood sugar readings at least three times a day and to decrease her consumption of soda; she also agreed to utilize our fitness center in Macy.

After a recent visit back to our clinic, our patient was rescreened. I think we were all astonished when we realized that her blood glucose was 115 and her A1c result was a remarkable 7.7. That represents a 5.1 drop in her A1c in 4 months. The patient eliminated soda from her diet, and reduced her weight by almost 10 pounds. She has incorporated a walking regimen into her weekly routine. Her vision has improved, and she uses fewer sick days from work. In addition, she has attended our events consistently and was elated when asked if we could use her as our success story. She is proud of herself, which is a testament to all the hard work and time she put in to make a positive change in her own life.

Central District Health Department

In June, Alfredo was hospitalized after he became very ill, disoriented, and then unconscious. At the hospital, the doctor diagnosed him with type 2 diabetes and prescribed medication to control his condition.

Both of Alfredo's parents had type 2 diabetes and completed the CHAMP program last winter. They recommended to Alfredo that he should attend the CHAMP program to learn about eating healthier and increasing his physical activity. He took his family's advice and joined CHAMP in July, stating that he wanted to change his lifestyle and learn about eating healthier to better manage his diabetes.

Alfredo reported that CHAMP has helped him understand the importance of physical activity, and he currently walks/runs every day for 30-60 minutes. He says he now understands how to make healthier choices by consuming smaller portions and incorporating more fruits and vegetables into his diet.

Alfredo did not see any weight changes, but feels he is able to better control his diabetes by eating healthier and by getting more exercise. He stated that his blood sugars have been in a healthy range such that his doctor has changed his medication. Alfredo expressed that he loved the program and hopes it will continue and help more people.

Chadron Native American Center

After learning about our program from other community members, a 45-year-old female client came into the office to access our services in August 2013. She had a family history of diabetes and heart disease. In addition, her personal risk factors included being overweight and tobacco use (smoking). She informed us that she was interested in learning about overall prevention of diabetes by incorporating healthier eating and exercise into her daily habits.

We enrolled her into our MHI program and arranged for her to come in monthly for one-on-one education using the National Diabetes Prevention Program curriculum. We conducted baseline checks her blood pressure and weight and documented the level of exercise she was getting per week.

Upon repeating measures after utilizing our program, we discovered this client had benefitted from our program - she had lost a total of 14 pounds despite an interval of not being able to participate in the program due to some illness. However, she is getting back on track with the program and is always so positive about wanting to be healthy. She continues to walk an hour each day and is mindful of eating healthy foods. Due to applying what she learned from the program and then adopting the recommended behavioral changes, her post-evaluation measures have remained positive and she has conveyed to others within the community that the class has been very effective for her health.

Community Action Partnership of Western Nebraska

A 40 year-old female patient presented in February 2014 to be checked for diabetes due to a strong family history of the disease. She was subsequently diagnosed with diabetes and referred to the minority health program for diabetes education; she also received an annual exam. During that exam, our provider found a lump in the patient's breast. It was learned that the patient had history of breast cancer, and she received a lumpectomy of the left breast.

The patient was referred to receive a mammogram, and with the help of the minority health program, she applied for the FAST program (The FAST application is used for people who do not have insurance, but have a qualified need to participate in a hospital study. Eligibility for discounted services is determined by income and dependents).

At the time of her referral, Regional West Medical Center's FAST department did not provide language access services, so the minority health program was utilized to help with the medical interpretation process.

The patient underwent a mammography and a biopsy of the mass in the breast. The minority health program staff continued to support the patient who was very distressed to receive the news for a second

time that she had breast cancer. The patient was assisted to arrange the appointments with the surgeons, oncologists, and surgeon.

The patient continues to undergo chemotherapy and radiation therapy and will soon receive plastic surgery for breast reconstruction. Fortunately, all services have been covered by the FAST program.

These results demonstrate how, by fulfilling the minority health program goals, we can reach people with diabetes who are also suffering from chronic illnesses and change the course of their health outcomes.

East Central District Health Department

In December 2013, Jose, age 40, was referred to a community health worker (CHW) by his primary care doctor due to a high A1c level. The CHW contacted Jose several times by phone; after not following through with the first two appointments scheduled, Jose did arrive for the third appointment during which the CHW reviewed with him the A1c levels and provided him with educational materials. He was also informed of the importance of taking the medication as prescribed. Jose agreed to set a goal of increasing physical activity by exercising three times a week and also to eat appropriate portions and increase vegetables and fruits in his diet, following the My Plate serving guide.

At the one-month follow-up appointment, Jose revealed that he met his goal of exercising three times per week, and had increased the amounts of fruits and vegetables in his diet. Although Jose had received information that his subsequent A1c levels had decreased, he admitted to the CHW that he did not know how to understand the results. The CHW reviewed the documents with Jose and showed him where to find A1c results, then explained to him how to interpret the findings. Jose departed with an increased understanding of his own health and committed to the next goal set for him: to discontinue the diabetes medications and control his diabetes with nutrition and exercise.

Elkhorn Logan Valley Public Health Department

Ma Ji is a Latino male with a history of three family members who were diagnosed of type 2 diabetes in their late 50s. When Ma Ji was hospitalized for chest pains and an elevated blood glucose level of 1106, he, too, was diagnosed with type 2 diabetes and enrolled into the diabetes self-management classes offered by the Elkhorn Logan Valley Public Health Department's MHI project.

Ma Ji has committed to making healthier choices to better control his diabetes. He has been exercising regularly and making healthy nutrition choices; he also checks his blood sugar levels consistently to ensure proper insulin usage. Since participating in our diabetes self-management education and self-care, Ma Ji's blood glucose has remained within the normal range.

Lancaster County Minority Health Initiative

One example of the many collaborative success stories...

A woman recently came to the program in dire need of help. She had initially come in contact with the Asian Community and Cultural Center through the weekly senior group meetings. She was elderly and had a number of serious health issues, including heart disease, high blood pressure, and diabetes. She was also unemployed and had been paying out of pocket for her blood pressure medication and doctor's visits, but it was too much of a burden. She did not have the money to continue to afford her medication.

She visited the Asian Center and asked about the options available to her. With the assistance of minority health staff, she made an appointment at the People's Health Center, where their sliding fee scale has helped her to pay less for her visits. She was able to see a doctor for her chronic disease conditions, as well as a visit with a registered dietician, who helped her to learn the value of diet in controlling diabetes.

Currently, her diabetes is under control and she is receiving medication at an affordable cost.

She continues to attend the weekly senior meetings at the Asian Center, and often uses her time at the Asian Center to talk with staff about the questions she has or any further resources she needs. She is doing much better and is now able to go to the doctor and take medication regularly.

Mary Lanning HealthCare Foundation

MG is a 60-year-old female who is a long-term participant in our MHI project. She has diabetes and currently takes insulin. Over the past 10 years, MG has had poor diabetes care and has struggled to maintain good blood glucose control. Her HbA1c lab work has consistently been elevated and she has struggled to obtain the supplies needed to adequately control her diabetes. Finances are a concern, and obtaining insulin therapy and glucose monitoring supplies has been a hardship.

In the spring of 2014, MG had surgery for a mitral valve replacement and our project staff were involved in her care. Our project coordinator provided interpretation and translation services while MG completed cardiac rehabilitation. The need for improved blood glucose control was again emphasized with the patient following surgery. MG had received education on diabetes complications as part of the MHI project and knew it was important for wound healing and prevention of further complications.

A few months later, MG contacted our project coordinator with an update that she now had an area on her right foot that was sore and not healing. Our project coordinator promptly facilitated an appointment with her primary care provider (PCP). Initially, MG stated the sore began from wearing shoes that were too small, but she later shared that she had trimmed a callused area on her right foot that quickly developed into an ulcerated area.

Within a week, MG was admitted to the hospital for IV antibiotic therapy. Eventually the 5th digit (or small toe) on her right foot was removed. The project coordinator attended all follow-up appointments with the primary care physician and was present during the hospital stay and surgery to provide interpretation and translation services. The coordinator also made home visits to help assess the dressing change following surgery and to make sure the new incision on her right foot was healing.

MG is now doing extremely well. She has spoken twice at our support group, sharing with other participants the need for good diabetes care and how fortunate she was to reach out for help and receive the services she needed before the complication became worse. MG has already changed her health behavior as a result of the foot surgery and is working to improve her diabetes care. She is sharing her story not only to help herself but to help other participants in our MHI project change their health behaviors and improve their diabetes health.

North Central District Health Department

A story that I would like to share is from Dava, one of our MHI project staff. She put together and held a diabetic awareness health fair at the Santee Health and Wellness Center. She took blood pressure and blood sugars and provided information about diabetes. An employee from the Santee Health and Wellness Center provided a demonstration on gentle yoga. During the time of their diabetic awareness health fair, Santee was holding an election at the community center. Following the Health Fair, Dava packed up her equipment and went to the community center to catch people who were not able to make it to the fair and got blood pressures and blood sugar measurements on more people.

Northeast Nebraska Public Health Department

Our community health worker (CHW) performs a vital service when Hispanic people need assistance with medical services paperwork such as applications or letters that come to them in English. He connects them with Spanish-speaking personnel from clinics or agencies, and follows up with them to find the right services and programs that will help them be healthier.

One example was during the 2014 tornado response in our health district. Our CHW was approached by a young girl who had been without her medicine for a couple of days due to the tornado destroying their home. This medicine was needed daily and in emergencies for a chronic illness. She was seeking the CHW because she needed someone who was bilingual, and other people within the community had suggested that the CHW might be able to help with the problem.

The CHW consulted with our health department's public health nurse. They worked together with other health department staff to get questions answered to assist the client with getting the needed medicines. After about an hour and a half, they were able to get the medicine to the girl. The parents were very happy with how we worked together to obtain their daughter's crucial medication.

OneWorld Community Health Center

Nelly arrived from Guadalajara, Mexico 11 years ago looking for better opportunities in life to help her family and to study. She has been working for the past seven years in packaging at a bread making plant, and it was there just over a year ago where she discovered that she had been able to succeed economically. However, this success, which came from working 12-hour shifts, sometimes six days a week had diverted her from her goal of continuing her studies.

She requested two days a week off in order to re-start her education. In this pursuit, Nelly began studying for her GED, basic ESL course, and enrolled in the training of community health workers offered by the Minority Health Initiative. She successfully completed training as a CHW in December of 2013.

She recalls that she enrolled in the MHI trainings in order to understand more about diabetes, which affects her sisters and her mother. She said, "I also learned about additional topics, while diabetes was the main focus, I also learned to test blood glucose levels, take blood pressure, and especially how to improve nutrition."

What she learned really paid off when she made her most recent trip to Mexico, because during the three weeks she spent with her family, she dedicated herself to offering coaching about diabetes and nutrition to such an extent that now her family has made important life-style changes such as improving nutrition habits and periodically checking their blood glucose levels. Also, Nelly continues to follow up from a distance on a weekly basis.

Nelly continues to maintain a healthy lifestyle. At the community level, Nelly has dedicated herself to spreading the word about the importance of making changes to improve nutrition. She takes advantage of every opportunity in her workplace to talk with her coworkers especially during breaks, about the importance of nutrition and controlling and preventing chronic diseases. Nelly said, "It was from person to person that I found out about the MHI training, and now when I talk with people, I can help some of them make changes, and this is my main motivation."

Nelly says that her expectations have changed and now she has decided to further her studies in the health field, at the same time not losing the opportunity to continue advancing her English language skills and taking classes related to health. So, she is taking the online health navigation training offered by the Nebraska DHHS women's health program.

Public Health Solutions

Melissa, a mother of six children, came into Public Health Solutions District Health Department one day as a direct result of her primary care provider referring her. It was learned the provider had become frustrated with Melissa, as she was not making the changes the provider had hoped for regarding her diabetes.

Melissa is a type 1 diabetic, and she is just over 35 years of age with six children. She has health coverage through Medicaid, however the coverage is intermittent. Her doctor was very concerned about her long-term prognosis if she did not deal with her type 1 diabetes. He wanted her to get her diabetes under control or she would not live long enough to see her children grow up. Needless to say, that scared Melissa. She had previously said that she wanted to make changes in her life to better manage her situation, but now she was willing to actually make those changes.

To compound the situation, Melissa is not able to read or write. When she met with the community health worker, they instantly hit it off and a program was laid out. Since child care was provided during the educational classes, Melissa knew her children were being cared for in a safe environment and she was able to fully focus on learning the skills she needed to address her life as a diabetic. Melissa took the Road to Health class series and the Journey for Control classes. She has not missed any Live Fit classes. All in all, she is happier and has a positive attitude when she comes to the office for her weekly visits.

Melissa laughs with the staff and is eager to show off her children. She reports that she is a better mom and is very pleased that she has lost 40 pounds. Her doctor is very pleased with her and states that the community health worker has opened up the door for change that he was never able to open after 10 years. The doctor is very pleased that PHS staff have been able to make strides with his patient and after only a few months. At her last check, Melissa's A1C results were within normal limits for the first time ever! She is happier, the kids have a healthy mom, and the physician is pleased with Melissa's results, too.

Southeast District Health Department

By incorporating interpreters into our Growing Great Kids (GGK) Program, we have been able to admit more parents to our program. We currently are serving people who have no comprehension of English and one who has English as a second language (ESL), but her English is very limited. By being able to communicate with them, we have a new trust factor in the community – one of our admissions was a referral from one of our current case load.

Our new interpreter works part-time at the library and has developed a story hour for Spanish-speaking parents/children. We attend this function to become more visible and known in the community. We have given attendees information about community resources, and worked with the library to communicate needs for back-to-school admission. We have also spent time talking about GGK and have gained some trust. We have started doing outreach in the Women, Infants, and Children (WIC) clinics, and this has offered some additional referrals through a trusted resource.

Southwest Nebraska Public Health Department

A client was searching for services for their child. They only spoke and wrote in Spanish, and wanted to communicate with a provider who speaks Spanish.

In September 2013, we hired a Spanish-speaking translator/interpreter for the health department with the emphasis on immunization services. All clinic forms have been translated into Spanish. This staff member works 32 hours a week and interprets as needed. In this specific situation, our staff member was able to successfully communicate with the family.

This client is now current on their immunizations. The parents will continue to utilize our services in the future and have referred other clients seeking Spanish translation or interpretation to our office.

The father was very grateful that these services were offered, as the whole family has limited English

speaking skills. He told our interpreter that, if it had not been for her, “they would have no idea what was needed to be done or what was being done for their child.” They were initially very nervous about coming in to see us. This family left with confidence, knowing that their child was taken care of, could go to school and they had a partner to help them with future services.

West Central District Health Department

A 44-year old female client moved from Scottsbluff to North Platte in May 2014. She has three children—an 18-year-old and 12-year-old twins. Her husband is the financial supporter of the family; he is employed at a cattle ranch.

The client was referred to the Minority Health program at West Central District Health Department in North Platte by a friend who is also a MHI client. The client came to MHI seeking help to get medical attention and medical interpretation assistance. After she enrolled in our program, we referred her to a doctor who then referred her to an oncologist. Maria L., the community health worker, accompanied her to the initial doctor appointments to serve as an interpreter. The oncologist performed a biopsy on her breast and found a malignant tumor. A surgery was scheduled for removal of the tumor and the resulting surgery was successful.

The client received prompt and successful medical attention. The family didn’t have medical insurance or the finances to pay the bills and for this reason had been very concerned about their ability to pay for the expenses of the doctor visits and surgery. Maria L. referred her to the financial assistance program offered by the North Platte hospital, Great Plains Health, and she was approved. In addition, Maria assisted the family in talking with the doctor, who agreed to reduce the total cost of the bill if they would continue to make payments.

At present, the family is very grateful for the assistance they received and continue to receive through the MHI program at West Central District Health Department.

Definitions of Key Terms

Body mass index (BMI): measure of body fat based on height and weight.¹

Case management: advocacy and guidance activities that help patients understand their current health status, what they can do about it, and why those treatments are important; and guide patients and provide cohesion to other health care professionals, enabling individuals to achieve health goals effectively and efficiently.²

Community health workers: an umbrella term used to define other professional titles; an individual who serves as a liaison/link between public health, health care, behavioral health services, social services, and the community to assist individuals and communities in adopting healthy behaviors; conducts outreach that promotes and improves individual and community health; facilitates access to services, decreases health disparities, and improves the quality and cultural competence of service delivery in Nebraska; a trusted member of, or has a good understanding of, the community they serve; able to build trusting relationships and link individuals with the systems of care in the communities they serve; builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

Dental home: model of care characterized by provision and coordination of dental health care at a single location that takes responsibility for the patient's health care needs and arranging for appropriate care with other clinicians; includes a high level of accessibility, excellent communication, and full use of technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.³

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

Interpretation: rendering of oral messages from one language to another.⁴

Medical home: model of care characterized by provision and coordination of health care at a single location that takes responsibility for the patient's health care needs and arranging for appropriate care with other clinicians; includes a high level of accessibility, excellent communication, and full use of technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.³

Outcome: the statement of an intended result.

Translation: rendering of written information from one language to another.⁴

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