

December 1, 2011

**2010-2011**

# **Minority Health Initiative Funding Annual Report**

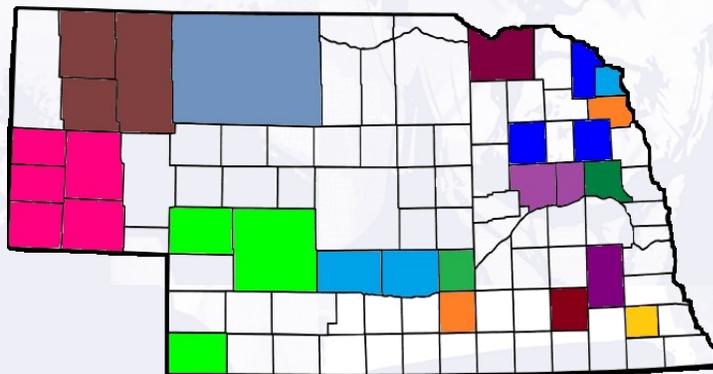
**Office of  
Health  
Disparities and  
Health Equity**

**Division of  
Public Health**

**Nebraska  
Department of  
Health and  
Human  
Services**

**In accordance with Nebraska State Statute 71-1628.07**

**Presented to the  
Health and Human Services Committee  
of the  
Nebraska Legislature**



Department of Health & Human Services

**DHHS**  
NEBRASKA



## Introduction

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

To meet this directive, the Nebraska Office of Health Disparities and Health Equity uses a competitive request for applications process. Minority Health Initiative funds were awarded for two-year project periods, and 17 projects were awarded funding for the 2009-2011 project period.

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

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

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

## Definitions

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

**Body mass index (BMI):** measure of body fat based on height and weight.<sup>2</sup>

**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.<sup>3</sup>

**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.<sup>4</sup>

**Health fair:** event where organizations have an opportunity to disseminate health information to the public at booths and/or to provide health screenings.<sup>5</sup>

**Interpretation:** rendering of oral messages from one language to another.<sup>6</sup>

**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.<sup>4</sup>

**Translation:** rendering of written information from one language to another.<sup>6</sup>

## References

- 1 Health Resources and Services Administration. (n.d.). *Introduction to 340B drug pricing program*. Retrieved from <http://www.hrsa.gov/opa/introduction.htm>
- 2 National Heart, Lung, and Blood Institute. (n.d.). Retrieved from <http://www.nhlbiupport.com/bmi/>
- 3 Case Management Society of America. (2008). Retrieved from <http://www.cmsa.org/>
- 4 National Committee for Quality Assurance. (2011). *NCQA patient-centered medical home: A new model of care delivery*. Retrieved from <http://www.ncqa.org/tabid/631/default.aspx>
- 5 Centers for Disease Control and Prevention. (2009). How to plan a health fair. Retrieved from <http://www.cdc.gov/women/planning/fair.htm>
- 6 Youdelman, M. & Perkins, J. (2005, April). *Providing language services in small health care provider settings: Examples from the field*. Commonwealth Fund Pub. No. 810. Retrieved from <http://www.healthlaw.org>

**Minority Health Initiative two-year grants (7/2009-6/2011)  
were awarded to the following organizations:**

<b>Grantee (CD 1 &amp; 3)</b>	<b>Amount</b>	<b>County(ies)</b>	<b>Page</b>
Mary Lanning Memorial Hospital	\$85,628.09	Adams	2
Community Action Partnership of Western Nebraska	\$318,340.88	Banner, Cheyenne, Kimball, Morrill, Scotts Bluff	4
Chadron Native American Center	\$104,589.61	Box Butte, Dawes, Sheridan	6
Community Action Partnership of Mid-Nebraska	\$339,003.61	Buffalo, Dawson	8
Center for Human Diversity	\$13,033.35	Cherry	10
East Central District Health Department	\$189,969.62	Colfax, Platte	12
Elkhorn Logan Valley Public Health Department	\$183,129.30	Cuming, Dixon, Madison	14
NAF Multicultural Human Development Corporation	\$208,576.72	Dakota	16
Center for Human Diversity	\$72,656.29	Dodge	18
NAF Multicultural Human Development Corporation	\$112,351.43	Dundy, Keith, Lincoln	20
Grand Island Multicultural Coalition	\$308,913.29	Hall	22
Family Health Services	\$11,376.91	Johnson	24
Ponca Tribe of Nebraska	\$5,500.00	Knox	26
Lincoln Lancaster County Health Department	\$993,352.38	Lancaster	28
Blue Valley Community Action	\$47,740.50	Saline	30
Carl T. Curtis Health Center	\$70,277.10	Thurston	32
Winnebago Tribe of NE	\$68,266.04	Thurston	34
<i>Total</i>	\$3,132,705.12		
<b>Federally qualified health center (CD2)</b>			
Charles Drew Health Center	\$714,050.50	Congressional District 2	36
One World Community Health Center	\$714,050.50	Congressional District 2	38

## The Numbers

During the period July 1, 2010 through June 30, 2011, the Minority Health Initiative projects served in nearly 17,000 Nebraskans. Of this number, approximately 16,000 were racial ethnic minority, Native American, refugee, or immigrant. The tables below detail ages and genders for people served by the projects during the last year. Detailed information for the annual funding appropriation for the Community Health Centers in Congressional District 1 is provided on pages 40-43.

**Note:** On the following pages, the Outcomes by Numbers section reflects core participants per project.

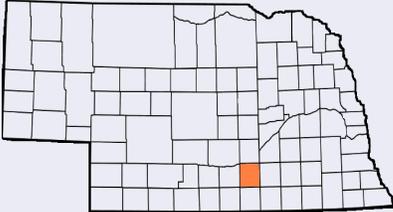
**People served by Minority Health Initiative projects 7/1/10 – 6/30/11,  
by Race and Ethnicity**

Age Group	Total	Unknown Race/ Ethnicity	Non Hispanic							Hispanic
			White	Black	American Indian / Alaska Native	Asian	Native Hawaiian/ Pacific Islander	Two or More Races	Other	
All Ages	16,712	61	1072	831	737	348	19	62	296	13,286
Unknown age	726	16	27	10	1	3	0	0	3	666
1-19 years	5,692	13	630	137	107	56	5	16	34	4,694
20-64 years	9,575	28	343	655	596	262	12	31	237	7,411
65+ years	719	4	72	29	33	27	2	15	22	515

**People served by Minority Health Initiative projects 7/1/10 – 6/30/11,  
by Race, Ethnicity, and Gender**

Age Group	Total	Unknown Race/ Ethnicity	Non Hispanic							Hispanic
			White	Black	American Indian /Alaska Native	Asian	Native Hawaiian/ Pacific Islander	Two or More Races	Other	
All Ages Fe-	10,664	33	594	442	564	197	16	39	189	8,590
Unknown age	625	15	27	5	1	3	0	0	2	572
1-19 years	3,101	3	296	75	75	34	4	10	21	2,583
20-64 years	6,415	12	216	349	464	146	10	21	147	5,050
65+ years	523	3	55	13	24	14	2	8	19	385
All Ages Male	6,048	28	478	389	173	151	3	23	107	4,696
Unknown age	101	1	0	5	0	0	0	0	1	94
1-19 years	2,591	10	334	62	32	22	1	6	13	2,111
20-64 years	3,160	16	127	306	132	116	2	10	90	2,361
65+ years	196	1	17	16	9	13	0	7	3	130

# Adams County



**DOLLARS:**

\$85,628.09 for the two-year project period

**TARGET AREAS:**

Cardiovascular disease, obesity, diabetes

**OTHER AREAS:**

Cancer, translation/interpretation, mental health

**P R O J E C T   G O A L S**

- ◆ Lower health risk factors through participation in structured physical activity, health status awareness, and medication and physician access assistance.
- ◆ Improve total family wellness through familial interaction at educational sessions.
- ◆ Increase awareness of stress and gestational diabetes as risk factors to the Hispanic community.
- ◆ Expand participation in health/insurance resources and community-based support activities.

**O U T C O M E S   B Y   N U M B E R**

114 events/sessions—health fairs, physical activity, nutrition

256 health screenings for body mass index, blood pressure, cholesterol

400 participants/people served

187 results reported—improved diet/nutrition, weight loss, reduced body mass index, reduced blood pressure

## OUTCOMES

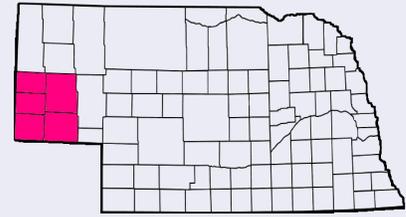
- ◆ Decreased the number of participants with body mass indices (BMI) greater than 30.
- ◆ Participants in the project's exercise group showed greater decreases in blood glucose than did participants not in the exercise group.
- ◆ Home visits conducted by the project coordinator to include interventions to improve or manage health status.
- ◆ Nearly 50% of program participants lost weight and/or decreased body mass index.
- ◆ Significantly increased the numbers of memberships and visits to local exercise programs by project participants.

## S U C C E S S E S

What began in 2002 with a participation of 25 people has now yielded a total program family impact of 375+ people. Instead of reacting to diabetes, our current program incorporates knowledge attained and practiced with diabetes disease management to inspire, energize, and educate the entire family through a variety of structured health, nutrition, exercise, and educational activities.

Mary Lanning Memorial Hospital Project Report, 2009-2011

# Banner, Cheyenne, Kimball, Morrill, & Scotts Bluff Counties



## **DOLLARS:**

\$318,340.88 for  
the two-year  
project period

## **TARGET AREAS:**

Cardiovascular  
disease, obesity,  
diabetes

## **OTHER AREAS:**

Low birth weight,  
HIV/AIDS, STDs,  
prenatal care, teen  
births, Hepatitis B,  
mental health,  
translation/  
interpretation,  
uninsuredness/  
expanding  
insurance coverage

## **P R O J E C T   G O A L S**

- ◆ To reduce health disparities for minorities and target improvement through prevention.
- ◆ To provide health education and information that will assist in overcoming health disparities for minorities.
- ◆ To eliminate barriers that result in disparities in accessing health care for minorities.

## **O U T C O M E S   B Y   N U M B E R**

2 events/sessions—Red Dress and Red Shawl

836 health screenings for blood glucose, blood pressure, body mass index, and cholesterol

1056 participants/people served

306 medical homes found

530 results reported—improvements in diet/nutrition, increases in physical activity, reduced blood glucose, reduced blood pressure, weight loss, improved disease self-management

## OUTCOMES

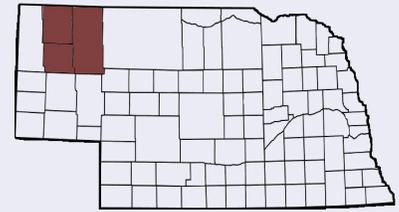
- ◆ Organized Red Dress and Red Shawl events to raise awareness of and encourage screening for cardiovascular disease in Latina and Native American women, respectively.
- ◆ Collaborated with the University of Nebraska Medical College School of Nursing and area hospitals to provide health screenings and referrals for abnormal results.
- ◆ Provided exercise, nutrition, and diabetic information, transportation, and interpretation (Spanish) for diabetic patients.
- ◆ Chronic disease management classes.

## S U C C E S S E S

From the feed back that we received the women were thrilled to have an event that focused on them as Native American Women. An event that was culturally appropriate and geared towards the cardiovascular health of Native American women. We had a very high number of screenings 50 or 73% of the women that attended the event went through all the screenings.

Community Action Partnership of Western Nebraska Project Report, 2009-2011

# Box Butte, Dawes, & Sheridan Counties



## DOLLARS:

\$104,589.61 for the two-year project period

## TARGET AREAS:

Cardiovascular health, obesity, diabetes, asthma

## PROJECT GOALS

- ◆ Provide blood sugar and blood lipid screenings, complete a personal life plan health survey, and assess weight and blood pressure.
- ◆ Periodically review life plan health survey results and set life goals.
- ◆ Educate all participants on physical and mental components of maintaining good health through nutrition, exercise, and stress management.

## OUTCOMES BY NUMBER

13 events/sessions on cardiovascular disease/diabetes, nutrition

513 health screenings for blood glucose, blood pressure, body mass index, cholesterol, stress, physical activity

412 participants/people served

28 medical homes found

112 results reported—improvements in diet/nutrition, increases in physical activity, reduced blood pressure, decreased smoking

## OUTCOMES

- ◆ Weekly meetings with participants.
- ◆ Participants indicated increased intake of water and decreased intake of soda pop.
- ◆ Participants increased their physical activity by counting steps using pedometers received from the program.

## S U C C E S S E S

It is hard for people to take care of their health when they are struggling to obtain the basics of food and shelter. We do make a difference and people are receptive. Success sometimes comes in bits and pieces, but it does come.

Chadron Native American Center Project Report, 2009-2011

# Buffalo & Dawson



## **DOLLARS:**

\$339,003.61 for  
the two-year  
project period

## **TARGET AREAS:**

Infant mortality,  
cardiovascular  
disease, obesity,  
diabetes, asthma

## **OTHER AREAS:**

HIV/AIDS, STDs,  
cancers, low birth  
weight, prenatal  
care, translation/  
interpretation

## **P R O J E C T   G O A L S**

- ◆ Provide minority communities access to diabetes and cardiovascular health care to include prevention/education and treatment.
- ◆ Provide minority communities access to healthcare and education for HIV/AIDS and sexually transmitted diseases.
- ◆ Decrease known language barriers for accessing healthcare.

## **O U T C O M E S   B Y   N U M B E R**

595 health screenings for blood glucose, body mass index, blood pressure, cholesterol, sexually transmitted diseases

827 participants/people served

101 medical homes found

386 results reported—improvements in diet/nutrition, increases in physical activity, lowered blood pressure, reduction in blood cholesterol, weight loss, improved disease self-management

## OUTCOMES

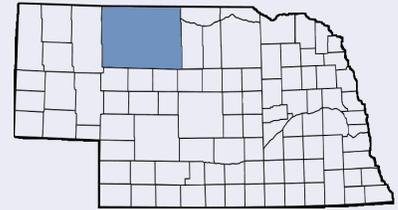
- ◆ Outcomes were based on the relationship between laboratory results and management of chronic disease.
- ◆ Pre- and post tests were performed to evaluate knowledge gained.
- ◆ After-screening phone calls assisted in evaluating of referrals and diagnosis made specifically on asymptomatic individuals with abnormal screening results.
- ◆ Follow-up calls were made to those who participated in the diabetes classes. Thirteen of the 21 people asked were interested in learning more about a diabetes diet.

## S U C C E S S E S

One participant discovered that she was diabetic as a result of our health fair. She had none of the classic symptoms (e.g. thirst, shaking, frequent urination), but did report low energy and attributed this to not sleeping and getting lazy. Her blood glucose reading was well over normal. She stated that, had she not been made aware of this health information she would have had no reason to see her doctor. Eight weeks after her visit she reported that her blood glucose was reduced significantly.

Community Action Partnership of Mid-Nebraska, 2009-2011

# Cherry County



## DOLLARS:

\$13,033.35 for the two-year project period

## TARGET AREAS:

Cardiovascular disease, diabetes

## PROJECT GOALS

- ◆ Implement the Heart Healthy Eating, Activities, Resources, and Training (HHEART) program to include health education, physical activity, and group support to address cardiovascular health and obesity for Native American women.
- ◆ Provide health education to Native Americans about sexually transmitted disease transmission and prevention strategies.

## OUTCOMES BY NUMBER

16 events/sessions—classes on diabetes, overweight/obesity, nutrition, physical activity

24 health screenings for blood glucose and body mass index

12 participants/people served

12 results reported—weight loss, improved diet/nutrition, increased physical activity, improved medication management

## OUTCOMES

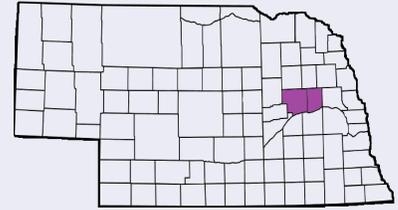
- ◆ HHEART participants demonstrated understanding of ways to improve cardiovascular health through presentations by group members, weight loss/management, biophysical markers, blood pressure decreases/management, blood sugar decreases/management, and improved BMI at monthly meetings.
- ◆ HHEART participants demonstrated understanding of inclusion of heart healthy strategies integrated into daily life through presentations and personal stories.
- ◆ HHEART participants demonstrated understanding of sexually transmitted disease prevention through discussion at meetings.

## S U C C E S S E S

One female participant, an enrolled member of the Ogallala Lakota Tribe, has been a part of the HHEART group from the beginning in 2007. She now speaks of the benefits of exercise and that she is faithful convert. She is now able to maintain better control of several health conditions including diabetes and hypertension as a result of being more physically active. She is also adding hiking and biking to her exercise regime. She is extremely passionate about sharing the message of improved health to others.

Center for Human Diversity Project Report 2009-2011

# Colfax & Platte Counties



## **DOLLARS:**

\$189,969.62 for  
the two-year  
project period

## **TARGET AREAS:**

Cardiovascular  
disease, obesity,  
diabetes

## **P R O J E C T   G O A L S**

- ◆ Through prevention programs, reduce the disease and economic burden of diabetes and improve the quality of life for all minority persons who have or are at-risk for diabetes.
- ◆ Increase the number of minority adults who engage regularly in moderate physical activity.
- ◆ Reduce the proportion of minority adults who are overweight or obese.
- ◆ Increase the number of trained medical interpreters.

## **O U T C O M E S   B Y   N U M B E R**

148 events/sessions—diabetes self-management, weight loss, walking program, aerobic classes

40 health screenings for blood glucose

615 participants/people served

159 results reported—improvements in diet/nutrition, increased physical activity, reductions in body mass index, reduced cholesterol

## OUTCOMES

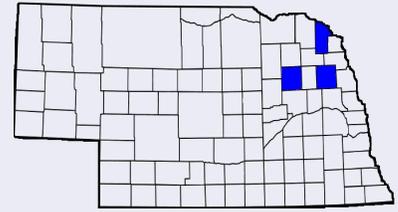
- ◆ Diabetes self-management education provided to participants.
- ◆ Monthly screening events and assistance with connections to medical homes.
- ◆ Health education and promotion about the importance of physical activity.
- ◆ Organization of walking and Tai Chi groups.
- ◆ Presentations on the project to local health care providers, which resulted in increased referrals to and from those providers.
- ◆ Health screenings provided at multiple community events.
- ◆ Health education presentations on diabetes and other chronic diseases.

## S U C C E S S E S

From a participant: “Walking makes me feel healthy and have a long healthy life. In addition to my walking, I’m adding healthy nutrition by eating vegetables, grains, and fruits. I started aerobic classes in September of 2010 and I have lost 8 lbs. I know that is not a lot, but besides losing weight, I get information on nutrition and the support of my class.”

East Central District Health Department Project Report, 2009-2011

# Cuming, Dixon, & Madison Counties



## PROJECT GOALS

Through provision of a culturally appropriate and linguistically competent program:

- ◆ Reduce the incidence and impact of chronic diseases in the minority population through increased knowledge and self-management skills demonstrated by behavior changes.
- ◆ Increase the knowledge of sexually transmitted diseases (STDs) and increase screening for such diseases among minority populations.
- ◆ Increase access to primary care and treatment services through assistive services that increase access to Medicaid and provide opportunities for prescription assistance.

### DOLLARS:

\$183,129.30 for the two-year project period

### TARGET AREAS:

Cardiovascular disease, obesity, diabetes

### OTHER AREAS:

Uninsuredness/ expanding insurance coverage, HIV/AIDS, STDs, translation/ interpretation

## OUTCOMES BY NUMBER

43 events/sessions on diabetes, overweight/obesity, exercise, nutrition, sexually transmitted diseases  
327 health screenings for blood glucose, body mass index, blood pressure, dental health, sexually transmitted diseases  
43 referrals  
351 participants/people served  
54 medical homes found  
43 employer education visits  
112 results reported—reduced cholesterol, weight loss, increased physical activity, improved nutrition

## OUTCOMES

- ◆ Health education on chronic diseases including self-management, monitoring, and medical regimens for diabetes, pre-diabetes, nutrition, exercise, obesity, and cardiovascular disease.
- ◆ Worked with local businesses to encourage adoption of environmental or policy changes to help improve health of employees.
- ◆ Screening and counseling provided for HIV/AIDS and sexually transmitted diseases, provision of follow-up health education.
- ◆ Provision of interpretation and translation services for all who require such assistance, income assessment, insurance assessment, prescription drug needs, provision of low-cost prescriptions as necessary.
- ◆ Successful implementation of American Diabetes Association self-management program.

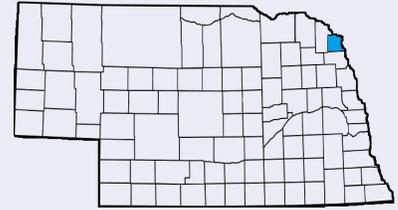
## S U C C E S S E S

The direct assistance (without cost to the project) provided by our partners to the Minority Health Initiative project this year was approximately \$186,000. The success of the grant and help for minorities was an invaluable contribution.

A 49-year-old Hispanic woman came to the clinic to look for answers about her health. She was able to see a doctor who evaluated her condition at a reduced cost. She suffers from high blood pressure, asthma, depression, and obesity. The clinic was able to get asthma inhalers at the reduced cost, representing about \$720.00 in savings for a three-month supply.

Elkorn Logan Valley Project Report, 2009-2011

# Dakota County



## **DOLLARS:**

\$208,576.72 for  
the two-year  
project period

## **TARGET AREAS:**

Diabetes

## **OTHER AREAS:**

Prenatal care,  
translation/  
interpretation

## **P R O J E C T   G O A L S**

- ◆ To promote self-sufficiency and a conscious commitment to wellness so each individual is functioning at their highest potential.
- ◆ To forestall the development of certain chronic diseases and to reduce or delay diabetes and other related diseases.
- ◆ To improve access to and utilization of existing health care services for minority residents.

## **O U T C O M E S   B Y   N U M B E R**

56 events/sessions—health fairs; dance, nutrition, cooking classes; community gardening

448 health screenings for blood glucose, cholesterol, blood pressure, body mass index

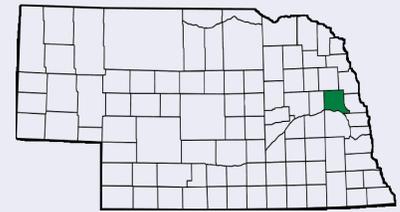
500 participants/people served

213 results reported—weight loss, increased physical activity, improved diet/nutrition, improved medication management

## OUTCOMES

- ◆ 200 women participated in dance classes.
- ◆ 1,500 people attended the multicultural health fair.
- ◆ Diabetes and cholesterol screenings were provided to program participants.
- ◆ Interpretation, transportation, and other enabling services provided to participants.

# Dodge County



## **DOLLARS:**

\$72,656.29 for the two-year project period

## **TARGET AREAS:**

Cardiovascular disease, obesity

## **P R O J E C T   G O A L S**

- ◆ Implement the Heart Healthy Eating, Activities, Resources, and Training (HHEART) program to include health education, physical activity, and group support to address cardiovascular health and obesity for Hispanic, immigrant, and refugee women.

## **O U T C O M E S   B Y   N U M B E R**

36 events/sessions on diabetes, overweight/obesity, exercise, nutrition

44 health screenings for blood glucose and body mass index

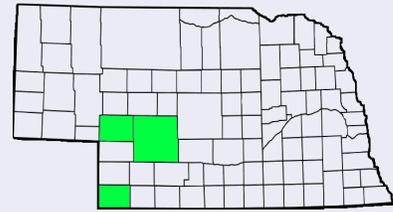
60 participants/people served

49 results reported—weight loss, increased physical activity, improved diet/nutrition, improved medication management

## OUTCOMES

- ◆ Efforts were focused on skills and information. Participants demonstrated proper ingredient usage, identified proper percentages of fats, proteins and carbohydrates and the benefits/detriments of the various types of fats. A follow up of physical metrics showed some significant gains/improvements in the health status of many participants.
- ◆ Pre-screenings identified approximately 30% of the total tested had increased blood sugar levels and 46% were overweight or obese.
- ◆ At the end of the program, only 15% had elevated fasting blood sugar levels.

# Dundy, Keith, & Lincoln Counties



## DOLLARS:

\$112,351.43 for the two-year project period

## TARGET AREAS:

Diabetes

## OTHER AREAS:

Translation/interpretation, uninsuredness/expanding insurance coverage

## PROJECT GOALS

- ◆ To promote self sufficiency and a conscious commitment to wellness so each individual is functioning at their highest potential.
- ◆ To forestall the development of certain chronic diseases and reduce or delay the onset of diabetes and other related conditions.
- ◆ To improve access to and utilization of existing health care services.

## OUTCOMES BY NUMBER

162 events/sessions—health fairs, classes on diabetes, physical activity, nutrition, overweight/obesity

644 health screenings for blood glucose, cholesterol, blood pressure, body mass index

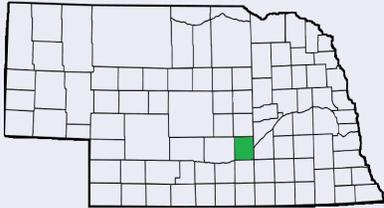
405 participants/people served

150 results reported—weight loss, increased physical activity, improved diet/nutrition, improved medication management

## OUTCOMES

- ◆ Bilingual assistants and *promotoras* worked with all program participants to ensure linguistic competency of all program components.
- ◆ Health education provided on diabetes and obesity to elementary school students.
- ◆ Educational materials and flyers provided to participants, children, and others at health fairs and other community events.

# Hall County



**DOLLARS:**

\$308,913.29 for the two-year project period

**TARGET AREAS:**

Infant mortality, cardiovascular disease, obesity, diabetes, asthma

**OTHER AREAS:**

Low birth weight, prenatal care, teen birth, translation/interpretation

**P R O J E C T   G O A L S**

- ◆ To provide healthcare information and training to empower minority residents to improve lifestyle behaviors and access health care and community resources.
- ◆ Reduce language as a barrier to health care and promote social justice on behalf of minority families, especially those who are limited-English proficient.
- ◆ Provide outreach services and screenings to identify and respond to health problems earlier and improve access to health care for minority residents.
- ◆ Provide the *Teen Parenting Project* to keep students in school, become good parents, and address cultural issues that may contribute to teen pregnancies.

**O U T C O M E S   B Y   N U M B E R**

50 events/sessions on car seat safety, teen parenting, medical interpretation

900 health screenings for blood glucose, dental health, cholesterol, blood pressure, breast cancer

2,219 participants/people served

1,051 results reported—weight loss, decreased body mass index, reduced cholesterol, improved dental health, improved diet/nutrition, increased physical activity

## OUTCOMES

Services provided to participants included:

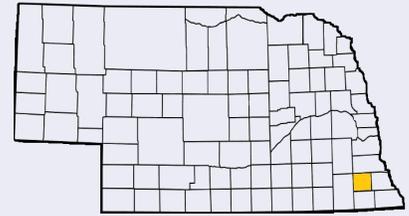
- ◆ Interpretation
- ◆ Cholesterol, blood glucose, and blood pressure screenings and follow up
- ◆ Dental screenings and referrals as necessary
- ◆ Breast examinations
- ◆ Wellness classes
- ◆ Advocacy for families new to the area

## S U C C E S S E S

“During the last year, our project was able to provide interpretation services, cholesterol and glucose screenings, dental screenings, breast exams, blood pressure screenings, HIV testing, and education associated with each of these screenings. We also provided teen parenting sessions, wellness classes, referrals for healthcare, and advocacy for newcomer families, and trained several new medical interpreters.”

Grand Island Multicultural Center Project Report, 2009-2011

# Johnson County



## DOLLARS:

\$11,376.91 for the two-year project period

## TARGET AREAS:

Diabetes

## PROJECT GOALS

- ◆ Reduce the disease and economic burden of diabetes, and improve the quality of life for all minority persons who have or are at risk for diabetes via client health screenings and staff language training.

## OUTCOMES BY NUMBER

18 events/sessions on diabetes

75 health screenings for blood glucose

5 referrals

110 participants/people served

75 results reported—improved diet/nutrition, increased physical activity, reduced blood glucose, completion of Conversational Spanish course by eight staff

## OUTCOMES

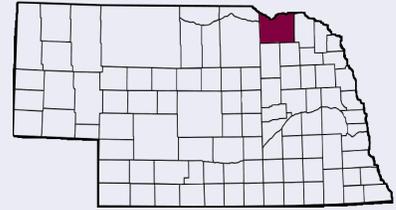
- ◆ Improved the ability of clinic staff to communicate with clients.
- ◆ Health screening events held to address diabetes in Hispanic populations, with referrals for health care provider follow up as necessary.
- ◆ Relationship was developed with the largest employer of Hispanics in the area.

## S U C C E S S E S

“It took us over a year to get into the local plant, but we finally did it. The plant administration felt the project was so successful that they wanted us to replicate the program at their plant in another city. The thing that we feel is most successful about this joint venture is that we were able to build a relationship with the workers at the plant. They should feel a comfort in coming to us for other services.”

Family Health Services Project Report, 2009-2011

# Knox County



## **DOLLARS:**

\$5,500.00 for the two-year project period

## **TARGET AREAS:**

Obesity, diabetes

## **P R O J E C T   G O A L S**

- ◆ Develop a community garden to improve health, physical activity, and youth/elder group involvement and increase knowledge on how to address cardiovascular health, obesity, and overall health for the Native American community.

## **O U T C O M E S   B Y   N U M B E R**

12 events/sessions

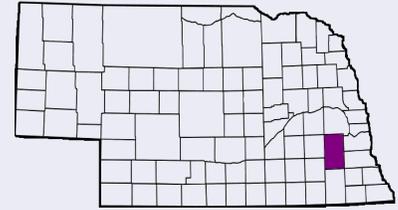
68 participants/people served

68 results reported

## OUTCOMES

- ◆ Created opportunities for youth to work with adults in an educational program to facilitate development of intergenerational learning.
- ◆ Youth and elders in the program increased their knowledge of nutrition and healthy foods significantly.

# Lancaster County



## DOLLARS:

\$993,352.38 for the two-year project period

## TARGET AREAS:

Cardiovascular disease, obesity, diabetes

## OTHER AREAS:

Translation/interpretation, uninsuredness/expanding insurance coverage

## LANGUAGES:

Arabic, Russian, Finnish, German, Kurdish, Farsi, Spanish, Karen, Sudanese, Burmese, Chinese, Vietnamese, Thai, Burmese, French

## PROJECT GOALS

All minority patients served by the grant will have:

- ◆ Cholesterol levels within normal levels.
- ◆ Blood pressure readings within normal levels.
- ◆ Blood glucose levels within an acceptable range (for those diagnosed with pre-diabetes or diabetes).
- ◆ Will take part in at least one lifestyle change (for those diagnosed or at-risk for cardiovascular disease and diabetes).
- ◆ Access to a medical home.
- ◆ Access to prescription medications through the federal 340B program, the \$4 pharmacies, or pharmaceutical company assistance programs.
- ◆ Access to a dental home and specialized dental care; improved understanding of the link between oral health and cardiovascular disease and diabetes.
- ◆ Access to appropriate translation/interpretation services.

## OUTCOMES BY NUMBER

2,006 health screenings for cholesterol, blood pressure, blood glucose

1,085 participants/people served

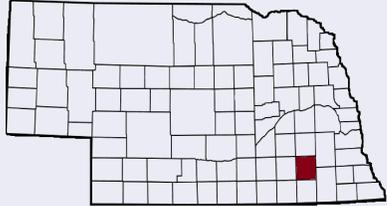
426 medical homes found

255 results reported—weight loss, increased physical activity, improved diet/nutrition, smoking cessation, medication management

## OUTCOMES

- ◆ Individualized follow up, assistance with connection to medical and dental homes, assistance with obtaining prescription medications, referrals, and missed appointment follow up provided to all participants.
- ◆ Developed a partnership with the Health Hub at the Center for People in Need for assistance with advocacy and case management/coordination. Through this program, customers were connected not only with medical and dental homes but also other services.
- ◆ One of the project partners, Clinic with a Heart, was able to move into a permanent space and expand its services. The clinic served more clients during its first two evenings in the new facility than it had in the last several months under the old system.
- ◆ Bilingual, bicultural case managers worked with all clients to ensure services were effective within customers' context. These case managers provided one-to-one and group health education sessions at partner organizations throughout the project.
- ◆ The community and cultural centers served as locations for monthly screening events and provided assistance with connections to medical and dental homes and other services.
- ◆ Personal connections with customers, facilitated by the community and cultural centers, resulted in improved health outcomes and fewer missed appointments.
- ◆ Approximately 1,200 minority customers met one-to-one with a diabetes educator. Of these, approximately 575 lost weight in an effort to address their illness. Another 775 increased their physical activity, 822 improved their nutrition, and 171 worked to stop smoking.
- ◆ Approximately 600 new minority clients established a dental home. This represents a success of 397% over the original goal for this project period.

# Saline County



**DOLLARS:**

\$47,740.50 for the two-year project period

**TARGET AREAS:**

Infant mortality, diabetes

**OTHER AREAS:**

Low birth weight, prenatal care, translation/interpretation, mental health, injury prevention, uninsuredness/expanding insurance coverage

## PROJECT GOALS

- ◆ Reduce risk factors related to infant mortality through education and early access to care.
- ◆ Provide opportunities to attend educational classes to increase knowledge of gestational diabetes, Type II diabetes, and the importance of preconception health.

## OUTCOMES BY NUMBER

467 health screenings for health coverage, smoking cessation, prenatal care, interpretation

142 participants/people served

296 results reported—prenatal care, assistance with WIC, case management, immunizations

## OUTCOMES

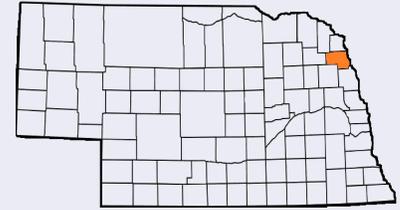
- ◆ Case management services for pregnant women provided to address medical home, health coverage, prenatal care, smoking, enrollment into support programs such as childbirth education and breastfeeding education.
- ◆ Assistance with interpretation, transportation, and related barriers and issues.
- ◆ Educational classes provided addressing diabetes and preconception health.

## S U C C E S S E S

“We have been very successful over the past few years in making significant progress in helping to eliminate disparities in access to and the use of prenatal care, and now rates of women without such services are at an all-time low in our county.”

Blue Valley Community Action Project Report, 2009-2011

# Thurston County



## DOLLARS:

\$70,277.10 for the two-year project period

## TARGET AREAS:

Cardiovascular disease, diabetes

## PROJECT GOALS

Use the National Cancer Institute-tested interventions *Clear Horizons* and *It's Your Life - It's Our Future* to:

- ◆ Reduce the number of patients age 50+ with Type II diabetes who currently smoke.
- ◆ Reduce the number of patients under age 50 with Type II diabetes who currently smoke.
- ◆ Increase the number of diabetic patients who complete exercise instruction as a proactive factor for smoking cessation.

## OUTCOMES BY NUMBER

27 events/sessions on diabetes, overweight/obesity, physical activity, nutrition

55 health screenings for blood glucose, body mass index, smoking cessation, foot issues

55 participants/people served

55 results reported—weight loss, improved medication management, improved foot care, reduced or quit smoking

## OUTCOMES

- ◆ Established an individual and group tobacco cessation consultations during diabetic clinic based on *Clear Horizons* and *Second Wind* interventions.
- ◆ During diabetes clinic, an average of 17 - 32 patients scheduled appointments where nurses were available to provide the patients smoking screenings and providers would consult if needed and refer them back to MHI smoking cessation group classes.
- ◆ Walking activities have been conducted, followed by class discussions. The entire class walked for 20 minutes outside the facility.
- ◆ Other activities completed included chair games, walks, and a scavenger hunt.

## S U C C E S S E S

“One female participant had smoked her entire life. She shares that this is something she never imagined she would quit. However, from the class she learned the facts of smoking and no longer smokes in her home. She is working on this step by step and knows she can stop and will continue to fight this battle. She is thankful for the cessation classes because if it weren’t for them she would still be exposing her children and grandchildren to the dangers of secondhand smoke. She plans to be a part of the group and on battling this addiction with the support of this program. “

Carl T. Cutis Project Report, 2009-2011

# Thurston County



## DOLLARS:

\$68,266.04 project period

## TARGET AREAS:

Obesity, diabetes

## PROJECT GOALS

- ◆ Conduct group nutrition sessions to women at-risk for diabetes.
- ◆ Develop materials and facilitate discussions regarding useable recipes for class.
- ◆ Teach clients how to prepare and modify recipes for healthier meals by creating food logs, goals, and recommendations.
- ◆ Develop a walking program using community trails and high school tracks.

## OUTCOMES BY NUMBER

37 events/sessions on diabetes, overweight/obesity, physical activity, nutrition

137 participants/people served

137 results reported—weight loss, increased physical activity, improved diet/nutrition

## OUTCOMES

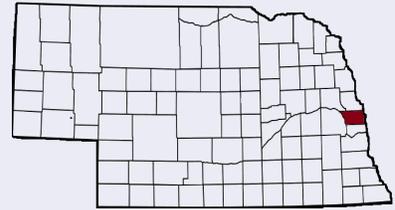
- ◆ Nutrition and fitness classes provided to youth to encourage them to increase daily physical activity.
- ◆ Classes provided on modifying recipes, healthy cooking, nutrition labels, food logs, and setting and following goals.

## S U C C E S S E S

"I have four children, ages four months and two, six, and eight years old. I definitely feel that by attending the nutrition and activity classes that I have learned a lot about healthier cooking and eating and have made changes in my and my family's eating. We are eating more vegetables and using a lot less salt in our home and have decreased the amount of fry bread we eat. I also try and use the recipes we get in class, at home. We are pretty active as a family and try to keep our kids involved in the activities we do, even if it is just going for a walk. I enjoy attending the classes and feel they have benefitted me and my family."

Project Participant, Winnebago Tribe Project Report, 2009-2011

# Charles Drew Health Center



## DOLLARS:

\$700,000.00  
annually

## TARGET AREAS:

Diabetes, asthma,  
cardiovascular  
disease,  
depression

## CLINICAL OUTCOMES

### Diabetes

- ◆ 413 patients in the diabetic registry
- ◆ 7.5 = average blood glucose level of patients in diabetic registry
- ◆ 44% of patients in the diabetic registry have blood glucose levels <7%
- ◆ 50% of patients in the diabetic registry have set self-management goals
- ◆ 80% of patients in the diabetic registry are on cardiac risk reduction via medications
- ◆ 35% of patients in the diabetic registry have had a diabetic eye exam

### Asthma

- ◆ 371 patients in the asthma collaborative registry
- ◆ 43% of patients in the asthma collaborative registry have a current severity assessment
- ◆ 71% patients in the asthma collaborative registry with appropriate treatment with anti-inflammatory medicines

### Depression

- ◆ 338 patients in the depression collaborative
- ◆ 28% of patients in the depression collaborative demonstrated a 50% reduction on the patient health questionnaire
- ◆ 52% of patients in the depression collaborative with a diagnosis of depression have set documented self-management goals during the past year

## CLINICAL OUTCOMES (CONT)

### Cardiovascular disease

- ◆ 1,061 current patients in the cardiovascular collaborative
- ◆ 80% of cardiovascular disease (CVD) patients high blood pressure had two blood pressure screenings recorded in the last 12 months
- ◆ 56% of CVD patients set a documented self-management goal in the last 12 months
- ◆ 69% CVD patients with appropriate lipid profiles

## S U C C E S S E S

“A large number of refugees from Sudan and Somalia, Nepali and Karen/ Burmese continue to settle in the Charles Drew Health Center service area since 2005. More than 5,576 family members have been seen in our health center since January 2005. We have made adjustments to meet their needs.”

Charles Drew Health Center, 2009-2011

# One World Community Health Center



## DOLLARS:

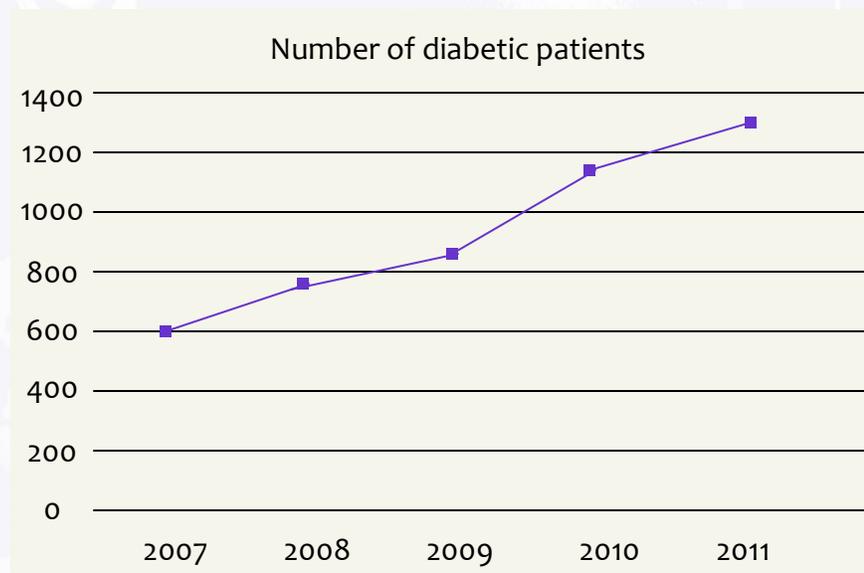
\$700,000.00  
annually

## TARGET AREAS:

Diabetes, asthma,  
cardiovascular  
disease

## CLINICAL OUTCOMES

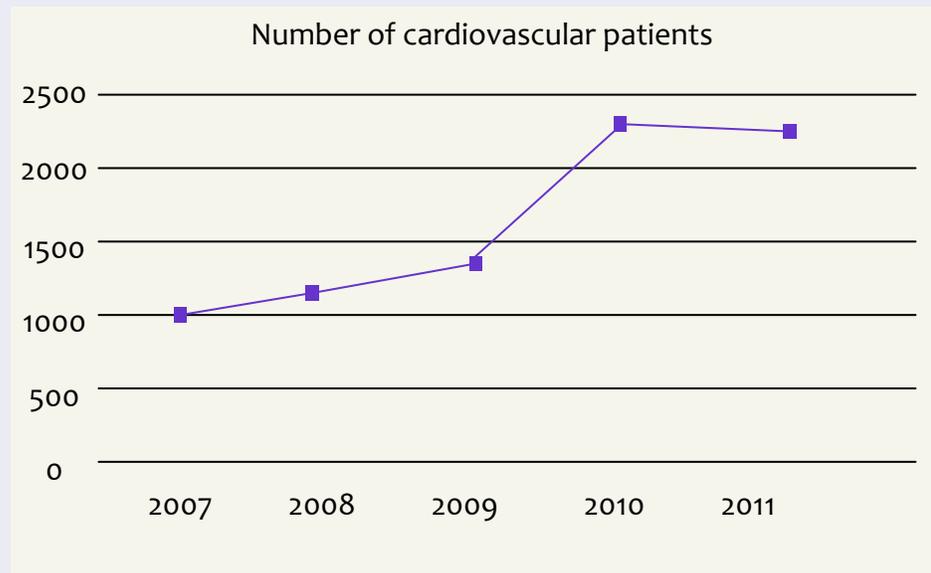
Diabetes	As of 8/1/2011
Registry size	1,289
2+ blood glucose screening in past year	815
Blood glucose $\leq$ 9%	71.7%
Blood pressure < 130/80	55.2%
Yearly foot exam	62.9%
Smoking status documented	74.2%
Received smoking cessation counseling	65%



### Cardiovascular disease

As of 8/1/2011

Registry size	2,268
2+ blood pressure screenings in past year	77.9%
Patients with CVD with blood pressure under control	46%
Patients with CVD with cholesterol under control	49%



### Asthma

As of 8/1/2011

Registry size	981
Patients who had an underlying severity assessment	65.9%

