

2017-2019 Minority Health Initiative Project Summaries

Carl T Curtis Health Education Center/Omaha Tribe of Nebraska Thurston

Reduce the disease burden of diabetes mellitus (DM) and improve the quality of life for American Indians who have, or are at risk for Diabetes Mellitus in Thurston County through education and services.

Central District Health Department Hall & Merrick

Improve the health of minority populations in Hall and Merrick Counties using the collective impact model, expanding the current role of Community Health Workers (CHWs), and building a community-based navigator program resulting in integration of CHWs into the clinical care team. CHW's will provide continued education, outreach, and referrals for individuals at risk for obesity, diabetes, and cardiovascular disease. Hard to reach populations will be recruited for coaching, referral, and navigation services. Project will build on past successful initiatives funded through MHI and expand current projects, strengthening the system to sustain improved health of targeted minority populations, with an emphasis on Latino/Hispanic, and Black/African Americans.

Community Action Partnership of Mid-Nebraska Buffalo, Dawson, Phelps, Kearney

Prevent the onset of diabetes by 1) addressing the issue of obesity and pre-diabetes early with pre-diabetic screenings; 2) partnering with local health care providers who can administer diabetes/pre-diabetes testing and provide medical instruction for healthy lifestyle changes; and 3) providing resources and opportunities for participants to act today and reduce the risk of diabetes/pre-diabetes through regular physical exercise, healthy eating information and resources, and diabetes prevention classes.

Community Action Partnership of Western Nebraska Box Butte, Cheyenne, Deuel, Garden, Kimball, Morrill, Sioux, Scotts Bluff

Support clients through the use of Community Health Workers to improve health equity specifically related to cardiovascular disease and diabetes for minority clients. CHW's will provide the Diabetes Education Empowerment Program curriculum to assist minorities in taking control of their disease and reduce the risk of complications. CHW's will engage clients to be knowledgeable of their health in an effort to improve their overall health outcomes.

Dakota County Health Department Dakota

Work in collaboration with local agencies to provide comprehensive chronic disease self-management education following a model of the Diabetes Prevention Program (DPP) to minorities in Dakota County. Utilize facilitated group education, provider referrals and community resources to ensure an impact driven model centered on obesity, cardiovascular disease, specifically hypertension and diabetes prevention and awareness.

East Central District Health Department Colfax, Platte

Implement an evidence based curriculum focused on reducing obesity in minority clients who have a BMI greater than 25. Individuals will be referred from Good Neighbor Community Health Center in Columbus and CHI Health Clinic in Schuyler. Curriculum activities will include implementation of self-management goals, promotion of the consumption of healthy foods, and increasing exercise in order to reduce BMI of greater than 25 by 1-2 points.

Elkhorn Logan Valley Public Health Department Cuming, Madison, Stanton

Implement an evidence-based nutrition and physical activity program for the minority populations in Cuming, Stanton and Madison counties in Nebraska in one-on-one and/or group settings, while utilizing a Community Health Worker as the main mode of delivery. The program is geared towards any minority person who overweight, obese, or has a chronic condition that would benefit from the curriculum content--such as persons with Type II Diabetes or cardiovascular disease. Program referrals will be accepted from a variety of community partners, as well as accepting self-referrals. Midtown Health Center, a federally qualified health center, has committed to serving as a formal and will be instrumental in providing minority referrals to the program for those clinic patients that are overweight or obese. In this partnership, the ELVPHD community health worker will create a setting of multidisciplinary communication and goal setting by improving the communication loop between the members of the health care team and the community health worker.

Mary Lanning HealthCare Foundation Adams, Clay

El Paquete Total (EPT) will serve the Hispanic population of Adams and Clay Counties offering health, wellness, education, nutrition, and exercise components to address and obesity and diabetes. The program focuses on a "total family" wellness concept by offering individual disease management using Diabetes Self-Management Education (DSME) as well as education and support programs to family members. Activities include monthly meetings, diabetes disease management, case management interventions, health risk assessments, and advocacy.

Nebraska Minority Resource Center Cherry, Dawes, Sheridan

The project will focus on the early intervention in the consumption of sugary beverages and to provide early alternative methods for the reduction of sugary beverages in the diet of the youth and the families involved. Families, parents or guardians of the youth group will participate in workshops and activities that will give them ideas and alternatives to fluids consumed at meal times and with snacks, as well as during school. The project will help to educate the parents of the target group and also provide resources and alternatives to sugary drinks in our young children.

Northeast Nebraska Public Health Department Dixon, Wayne

This project is focused on prevention of chronic disease through promotion of healthy living. The activities will include education sessions which provide insight into ways to live healthier, screening to identify risk factors for development of chronic disease, assistance with setting personal goals to

improve healthy living, and one-to-one support with a Community Health Worker to help meet those goals.

OneWorld Community Health Centers, Inc.

Sarpy

Train community health workers known as promotoras to reduce risk factors, improve health outcomes and increase health care access for minorities at risk for obesity, cardiovascular disease, diabetes and pre-diabetes. The promotoras will screen 300 minority individuals in Sarpy County for obesity, cardiovascular disease, diabetes, and pre-diabetes. The 300 minorities will receive education about choosing a healthy lifestyle. The promotoras will connect those individuals to a medical home and other community resources to manage and improve their health conditions. OneWorld will utilize current Minority Health Initiative (MHI) staff and contract with promotoras trained in previous MHI projects to offer provide case management to at-risk persons in need of ongoing health education and services.

Ponca Tribe of Nebraska (on behalf of the Cultural Centers Coalition of Lincoln)

Knox, Lancaster

The Cultural Centers Coalition of Lincoln in partnership with the Ponca Tribe of Nebraska, People's Health Center, Lincoln Lancaster County Health Department, and the University of Nebraska-Lincoln Nutrition & Health Sciences Department will adapt and implement the St. Johnsbury Community Health Team model, augmented with other key evidence-based practice components, to prevent/improve management of obesity, diabetes, and cardiovascular disease through community health worker provided services and coordinated access to a comprehensive range of community resources and medical/dental services. The key components of the St. Johnsbury Community Health Team (CHT) model are: (A) a Community Connections Team consisting of Community Health Workers who improve client health behavior/chronic disease self-management through motivational interviewing/individualized action planning, health education (including the Stanford Chronic Disease Self-Management Program), patient advocacy, and community-clinical linkages; (B) an Extended Community Health Team, which consists of a broad range of community partners who provide a variety of psychosocial and health services to the community; (C) Advanced Primary Care Practices, which provide patient centered medical homes including behavioral health specialists; and (D) an Administrative Core to oversee integration of CHT components. Other evidence-based components to be integrated include: (1) peer support services for clients with behavioral health needs, (2) social support networks for physical activity, (3) oral health management for chronic disease risk reduction, (4) diabetes self-management education

Public Health Solutions

Saline

Provide health screenings to identify pre-diabetics and diabetic clients, and primarily using a community health worker (CHW) to apply evidence-based interventions to improve the health of minorities. The CHW will consult with a public health nurse for higher risk clients. The focus of this effort involves reducing barriers to screening, primary care services, prevention, and self-management. PHS will use the Diabetes Prevention Program and public health-led disease management as its main interventions in order to decrease the risk of developing diabetes in pre-diabetics, reducing obesity, increasing the ability to self-manage chronic disease in those who are already diabetic, and increasing access to primary care through a network of referrals.

Southeast District Health Department Johnson, Otoe, Richardson

Provide health screenings to minority populations to participants at risk for hypertension, cholesterol and high blood glucose. Information regarding healthy living through diet, exercise, and regular monitoring of their health numbers will also be provided with 1:1 education and written educational materials. Evidence-based information and practices will be used to provide participants with accurate screenings and information regarding their health and health risks. Referral to medical homes will ensure consistent monitoring of participant's health will be one goal of the health screenings, along with helping participants understand the importance of regular visits with the same health care provider. SEDHD will partner with local employers, the SEDHD immunization clinic, and other community partners to access minority populations, maintain regular contact, and offer regular screening clinics to provide access to participants.

Southwest Nebraska Public Health Department Chase, Dundy, Keith, Red Willow

Provide health screenings to minority populations and educate participants on their health numbers in blood pressure, cholesterol, and blood glucose. Information regarding healthy living through diet, exercise, and regular monitoring of their health numbers will also be provided both with 1:1 education and written educational materials. SWNPHD will utilize evidence-based information and practices to provide participants with accurate screenings and information regarding their health and health risks. Referrals to medical homes will ensure consistent monitoring of participant's health, and helping participants understand the importance of regular visits with the same health care provider is another. SWNPHD will partner with local employers and other community partners to identify and access minority populations and maintain regular contact with partners and offer screening clinics to provide access for participants.

Three Rivers Public Health Department Dodge

Implement a diabetes prevention program (DPP) for the minority populations in Dodge County Nebraska while utilizing a community health worker as the main mode of delivery of this evidence-based program. The program is geared towards any minority person considered pre-diabetic and the goals are to emphasize the overarching goal of preventing type 2 diabetes and to focus on making lasting lifestyle changes. Two main referral sources will be Good Neighbor Fremont a federally qualified health center and Fremont Health Medical Center. Both organizations will provide minority referrals to the program for patients that are considered pre-diabetic. The community health worker will create a setting of multidisciplinary communication and goal setting by improving the communication loop between the members of the health care team and the community health worker.

West Central District Health Department Arthur, Lincoln

By utilizing a community health worker, the project will educate minority populations on health-related topics which include obesity, cardiovascular disease, and diabetes and support clients to make healthy lifestyle choices. Education will be provided through sessions with the community health worker, as well as in conjunction with client visits with medical providers. The community health

worker will improve access to and utilization of health services by providing interpretation assistance and health literate practices with clients as they attend appointments with medical providers. Advocacy for clients as they navigate the health care system will be a part of the care provided.