

2014 Nebraska Health Care Funding Act Report

**Prepared for the Governor and the
Nebraska Legislature**

**1) USE OF FUNDS APPROPRIATED
UNDER HEALTH CARE FUNDING ACT**

and

2) OUTCOMES ACHIEVED

December 9, 2014

**Submitted by:
Nebraska Department of Health and Human Services**

December 9, 2014

Dave Heineman, Governor
State Capitol
Lincoln, NE 68509

Dear Governor Heineman:

In the 2001 Legislative Session, LB 692 was passed into law. An annual \$50 million endowment for health care programs was created from the principal and investment income of the tobacco settlement fund and the Medicaid intergovernmental transfer (IGT) fund. Currently this endowment has increased to \$59.1 million annually. The purpose of this endowment was to create an ongoing funding mechanism for health care in Nebraska.

In addition, LB 692 requires the Department of Health and Human Services to provide an annual report to the Legislature and the Governor detailing the use of funds appropriated under this act and the outcomes achieved from such use.

The following report fulfills that statutory mandate. We appreciate the opportunity to share with the Governor and the Legislature the important work done as a result of LB 692. Thank you.

Sincerely,



Kerry T. Winterer
Chief Executive Officer
Department of Health and Human Services

December 9, 2014

Patrick O'Donnell
Clerk of the Legislature
State Capitol
Lincoln, NE 68509

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Chief Executive Officer
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EXECUTIVE SUMMARY

LEGISLATIVE BACKGROUND:

LB 692 (2001)

LB 692 was enacted in the 2001 Legislative session. It created an annual \$50 million endowment for health care programs from the principal and investment income from the tobacco settlement fund and the Medicaid intergovernmental transfer (IGT) fund. This \$50 million endowment was transferred to the Nebraska Health Care Cash Fund and initially distributed as follows:

- \$5 million, annually, for grants awarded by the Nebraska Health Care Council; including \$700,000 for grants to improve racial and minority health,
- \$5.6 million in FY (Fiscal Year) 01/02 and FY02/03 to county health departments for local public health services, planning and infrastructure development
- \$100,000 in FY01/02 and FY02/03 for the Office of Public Health Employees
- \$2.8 million in FY01/02 and FY02/03 for minority public health; including \$1.58 million for minority public health services in counties having a minority population equal to or exceeding 5% of the total population of the county in the first and third congressional districts, \$220,000 for satellite minority health offices in the second and third congressional districts and \$1 million to federally qualified health centers that serve primarily African-Americans, Native Americans and Spanish-speaking minorities
- \$3 million in FY01/02 and \$5 million in FY02/03 for services to individuals with developmental disabilities who are on the waiting list for services
- \$1 million in FY01/02 and FY02/03 to Office of Juvenile Services for mental health services to juvenile offenders
- \$1.06 million in FY01/02 and FY02/03 for statewide respite care services
- \$2.4 million in FY01/02 and \$2.6 million in FY02/03 to increase rates paid to providers of inpatient, hospital, or hospital-sponsored residential care services
- \$7.5 million in FY01/02 and FY02/03 to increase rates paid to providers of mental health and substance abuse services
- \$6.5 million in FY01/02 and FY02/03 for community-based mental health and substance abuse services; including intermediate-level residential care
- \$1.5 million in FY01/02 and FY02/03 for the cost of maintenance and treatment of mental health patients under emergency protective custody
- \$10 million in FY01/02 and FY02/03, \$12 million in FY03/04 and FY04/05, \$14 million each FY thereafter, for biomedical research
- \$500,000 in FY01/02 for the study on the Health and Human Services System

LB 692 became effective May 17, 2001.

LB 412 (2003)

LB 412 was enacted in the 2003 Legislative session. This bill changed the funding of public health grants awarded by the Nebraska Health Care Council. Under LB 692, \$5 million of the Nebraska Health Care Cash Fund was to be used for public health grants. At least \$700,000 of the \$5 million was to improve racial and ethnic minority health. LB 412 deleted the specific amounts and inserted the language with "Funds as appropriated by the Legislature" and "fifteen percent of the funds appropriated" respectively. No new funds were appropriated for public health grants. This \$5 million was used to fund the children's health insurance program (See LB 407).

LB 412 also made changes and eliminated provisions relating to minority health offices, the funding of local public health departments, the tobacco prevention and control, the Nebraska Medicaid Intergovernmental Trust Fund and the Nursing Facility Conversion Cash Fund. This bill became operative July 1, 2003.

LB 407 (2003)

LB 407, the 2003 budget bill, appropriated Cash Funds from the Nebraska Health Care Cash Fund to the Department of Health and Human Services and the Department of Health and Humans Services Finance and Support. In addition, LB 407 capped biomedical research funding from the Nebraska Health Care Cash Fund at \$10 million annually. This bill became operative July 1, 2003.

LB 321 (2007):

LB 321, the 2007 budget bill, appropriated Cash Funds from the Nebraska Health Care Cash Fund to the Department of Health and Human Services for compulsive gamblers assistance programs. Also, this bill increased appropriation for biomedical research to \$14 million annually. This bill became operative July 1, 2007.

LB 482A (2007):

LB 482A appropriated Cash Funds from the Nebraska Health Care Cash Fund to the Department of Health and Human Services to carry out the provisions of LB 482, Autism Treatment Program Act. This bill became effective May 25, 2007.

2014 Funding

As amended by LB 195 (2013), as well as past budget bills since 2007, the 2014 funding was appropriated as follows:

Administration (Public Health, Respite, Public Health (Administration)	\$450,331 \$320,000
Juvenile Services Operation	\$1,000,000
Behavioral Health Mental Health and Substance Abuse	\$10,824,660
Public Assistance	\$810,000
Medicaid	\$5,215,896
Public Health Aid	\$200,000
Children's Health Insurance	\$6,835,700
Developmental Disabilities	\$5,000,000
Local Public Health	\$8,280,000
Biomedical Research	\$14,000,000
Other Agencies	\$804,569
Transfer to Tobacco	\$2,370,000
Transfer to Stem Cell	\$437,000
Undistributed Adjusted	(\$182,600)
Child Welfare Aid	\$2,734,444
 Grand Total	 \$59,100,000

Additional Information

DHHS has provided a table which details the amended LB 692 funding accomplishments and outcomes. Additional information is also contained in the Appendix.

2014 LB 692 Report:
Table on Appropriations, Uses and Outcomes

2014 LB 692 Report:
Table on Appropriations, Uses and Outcomes

DHHS Divisions	Program	FY 14 Appropriations	Use Sections are from LB 195 (2013)	Outcomes	Provider Rates
	Program 033				
Division of Public Health	Administration	\$13,688	Sec 93 \$13,688 regulatory support for emergency medical technicians-intermediate and emergency medical technicians-paramedic licensing.	Used for base costs for licensing individual providers of emergency medical services. Base costs include expenses such as salaries, postage, e-commerce, equipment, and communications.	
	Smoking Cessation	\$6,000	Sec 93 - \$6,000 cost related to implementation of smoking cessation.	Continued enhancements to Tobacco Free Nebraska toll free Tobacco Quit line	
	Parkinson's Disease Registry	\$26,000	Sec. 93 (Parkinson's Disease Registry)	DHHS Office of Health Statistics uses these funds to collect, validate, and update the Parkinson's Disease Registry to monitor the incidence and mortality of Parkinson's Disease in Nebraska. Approximately 14,000 cases have been documented since the inception of the Registry. These funds are also used to process and complete data requests as well as promote the use of the registry data and enforce compliance with reporting to the Registry.	
Division of Children & Family Services	Nebraska Lifespan Respite Services Program	\$404,643	Sec 93 Respite Care Program in service areas.	See Attachment A	
	Total Program 033	\$450,331			
	Program 179				
Division of Public Health	Administration	\$100,000	Sec 99 \$100,000 each year for staffing and operating expenses.	Provide technical assistance to 18 local public health departments to provide the 10 essential services.	
	Office of Health Disparities and Health Equity	\$220,000 (*\$110,000 for each office)	Sec 99 for operation a satellite office of minority health in the 2 nd and 3 rd congressional districts.	Two staff in each of the Congressional Districts 2 and 3 satellite offices are supported with these funds. These positions direct the activities necessary to support programs; coordinate services and activities with other community, state, local and federal agencies, health professionals, and service agencies in efforts to reduce health disparities and promote improved health among diverse populations within Congressional District 2 and 3.	
	Total Program 179	\$320,000			

DHHS Divisions	Program	FY 14 Appropriations	Use Sections are from LB 195 (2013)	Outcomes	Provider Rates
				<p>review, - average monthly count 11 - youth served 36 (7/1/13 to 6/30/14).</p> <ul style="list-style-type: none"> • Special needs outcomes working towards release. <ul style="list-style-type: none"> ○ Highlight - more Individual specific programming, more group meetings, more individual/family counseling, more mental health focus/cognitive behavioral therapy in outcome strategies that includes learning, sharing with a goal of promoting change. • Sacajawea – Individual, group, family counseling average youth monthly count of 15, youth contact 38 in individual counseling (7/1/13-6/30/14). 122 with campus wide contact, greenline reviews, MHA, DBT, and classification reports. <p>Highlight – more individual specific programming, more group meetings, more individual/family counseling, more mental health focus/cognitive behavioral therapy in outcome strategies that includes learning, sharing with a goal of promoting change.</p>	
	Total Program 250	\$1,000,000			
	Program 038				
Division of Behavioral Health	Mental Health and Substance Abuse	\$2,599,660	Sec 94 Behavioral Health providers rate increase.	Continued payment of rates to BH providers for treatment and recovery services.	Maintained rate increase established in original LB 692.
		\$6,500,000	Sec 94 to be distributed to SIT Regions based on a formula.	Continued services to consumers in communities (non-state hospital based).	N/A
		\$1,500,000	Sec.94 emergency protective custody.	Crisis Center/hospitals reimbursed for days of service related to Emergency Protected Custody.	N/A
		\$225,000	Sec. 94 for compulsive gambling services.	None. Program transferred to Department of Revenue beginning 7/1/13; funds not expended by DHHS.	N/A
	Total Program 038	\$10,824,660			

DHHS Divisions	Program	FY 14 Appropriations	Use Sections are from LB 195 (2013)	Outcomes	Provider Rates
	Program 347				
Division of Children & Family Services	Nebraska Lifespan Respite Services Program – Respite Subsidy	\$810,000	Sec. 102 Aid in carrying out the NE Lifespan Respite Service payments to caregivers to purchase services.	See Attachment A	
	Total Program 347	\$810,000			
	Program 348				
Division of Medicaid and Long-Term Care	Medical Assistance	\$4,765,896	Sec 103 Continuation of the behavioral health provider rate increase and behavior health provider rate increase for managed care, inpatient and residential treatment.	Continued provision of behavioral health for clients and participation of providers in the program.	Maintain rate increase provided in original LB 692 funding.
	Smoking Cessation	\$450,000	Sec 103 - State Plan Amendment covering tobacco use cessation in compliance to Title XIX of federal Social Security Act smoking cessation.	Clients receive medication and up to four counseling sessions to support up to 2 quit attempts per year. For FY 14, an average of 69 clients utilized 112 counseling sessions per month. An average of 174 prescriptions were filled monthly.	Code 99406-\$13.79- smoking and tobacco use cessation visit; intermediate greater than 3 min. Code 99407-\$23.64 Greater than 10m minutes
	Total Program 348	\$5,215,896			
	Program 344				
Division of Medicaid and Long-Term Care	Child Health Insurance	\$6,835,700	LB 905, Section 101 State Aid	The appropriation for the CHIP program is for state aid, i.e. for the provision of services in the CHIP program, and is used as the state match to earn Federal funds. It is not earmarked for any particular service in the CHIP program; however, the funds cannot be spent for administration costs, only for the provision of services.	N/A
	Total Program 344	\$6,835,700			
	Program 424				
Division of Developmental Disabilities	Developmental Disability Act	\$5,000,000	Sec 106 State Aid/Services to Developmentally Disabled on waiting list.	Continued provision of developmental disability services to participants.	
	Total Program 424	\$5,000,000			
	Program 502				
Division of Public Health	Local Public Health	\$5,405,000	Sec 110 Aid to local public health departments.	Local public health provide the three core functions of public health which include assessment, policy development, and assurance and the 10 essential services (see the attached report).	

DHHS Divisions	Program	FY 14 Appropriations	Use Sections are from LB 195 (2013)	Outcomes	Provider Rates
		\$1,349,000 Cash	Sec 110 to be equally distributed among federally qualified health centers serving a minority population greater than 75,000 inhabitants.	Funding is equally distributed to One World Community Health Center and Charles Drew Health Center in Omaha, Nebraska.	
		\$1,526,000 Cash	Sec 110 for minority health services to be distributed to counties having a minority population equal to or exceeding 5% of the total population in the 1 st and 3 rd congressional districts.	15 Minority Health Initiative (MHI) grants and one contract were awarded in FY 2013 for two years focusing on the priority areas of obesity, cardiovascular, infant mortality, diabetes, cancer, asthma, chronic lung disease and unintentional injury. The 2014 MHI Annual Report has been submitted to the Legislature.	
	Total Program 502	\$8,280,000			
	Program 514				
Division of Public Health	Public Health Aid	\$200,000	Sec 111, Poison Control to UNMC.		
	Program 623				
	623 Biomedical Research	\$14,000,000	Sec 117 Biomedical Research.	Twenty-four percent (24%) of \$14 million of appropriated funds was distributed to the University of Nebraska. Sixteen percent (16%) of these appropriated funds were distributed through contracts with other postsecondary educational institutions having colleges of medicine in Nebraska and their affiliated research hospitals in Nebraska, that being Creighton University, Father Flanagan's Boys Home dba Boys Town Research Hospital and Creighton University – Boys Town Healthcare Foundation. Sixty percent (60%) of these appropriated funds were distributed to the University of Nebraska and to Creighton University, Father Flanagan's Boys Home dba Boys Town Research Hospital and Creighton University – Boys Town Healthcare Foundation with the division of such funds based on the percentage of all funds expended by such institutions from the National Institutes of Health of the United States Department of Health and Human Services in the prior year as contained in a certified report of such expenditures to DHHS from such institutions, excluding such funds expended for research involving the use of human fetal tissue obtained in connection with the performance of an induced abortion or involving the use of human embryonic stem cells. At least seven hundred thousand dollars (\$700,000) of such appropriated funds are to be used for research to improve racial and ethnic minority health.	
	Total Program 623	\$14,000,000			
	Program 030				

DHHS Divisions	Program	FY 14 Appropriations	Use Sections are from LB 195 (2013)	Outcomes	Provider Rates
Division of Public Health	Tobacco Prevention	\$2,370,000	Section 91 Tobacco Prevention and Control	Nebraska statute 71-5714 established a comprehensive statewide tobacco-related public health program administered by the Department of Health and Human Services. The statute established the Tobacco Prevention and Control program including (1) community programs to reduce tobacco use, (2) chronic disease programs, (3) school programs, (4) statewide programs, (5) enforcement, (6) counter marketing, (7) cessation programs, (8) surveillance and evaluation and (9) administration. These CDC best practices components are designed to meet four program goals of reducing adult tobacco use; preventing youth tobacco initiation; reducing exposure to secondhand smoke; and reducing tobacco-related health disparities.	
	Total Program 030	\$2,370,000			
	Program 354				
Division of Children & Family	Child Welfare Aid	\$2,734,444	LB 195 Sec 106	This is for rate increases that occurred when LB 692 was passed in 2001. This is just the continuation of funds. In 2012, LB949 moved the funds from program 347 to Program 354.	
	Total Program 354	\$2,734,444			
	Program 621				
Division of Public Health	Stem Cell Research	\$437,000	LB 195 Sec 115 Biomedical Research	Four research grants were awarded. Two grants were awarded to UNMC, one to Creighton University and one to UNL.	
	Total Program 621	\$437,000			
Other Funds Not Appropriated		(\$182,600)			
Total DHHS		\$58,320,431			
Other Agencies	Legislative Council	\$75,000	Sec 11 Legislative Council.		
	Attorney General	\$395,807	Sec. 38 Attorney General.		
	Department of Revenue	\$308,762 \$25,000	Sec 66 Department of Revenue.		
Total Other Agencies		\$804,569	Sec 3 Department of Revenue LB 464A		
Grand Total		\$59,100,000			

APPENDIX

ATTACHMENT A

RESPIRE PROGRAM ACROSS THE LIFESPAN OUTCOMES

December 2013

INTRODUCTION:

The Nebraska Department of Health and Human Services (DHHS) is responsible for administering the Nebraska Lifespan Respite Services Program in accordance with Nebraska Revised Statutes §§68-1520 through §§68-1528.

The Lifespan Respite Care Act established the Nebraska Lifespan Respite Services Program, which consist of the following:

1. The Lifespan Respite Network designated to coordinate community respite services; and
2. The Lifespan Respite Subsidy Program designated to provide funding for caregivers to purchase respite services. The program is centralized and administered through the Department of Health and Human Service.

The Lifespan Respite Subsidy Program supports Respite Services, which provide short-term relief for primary caregivers from the demands of ongoing care for an individual with special needs. The Lifespan Respite Subsidy Program offers qualified families a maximum of \$125.00 per month to obtain respite services. The program is family focused and encourages each family to choose their own providers, decide how much to pay the providers per hour or per day, and set their own schedule based on the family's needs. This program is limited to those families who do not receive respite services from other governmental program.

The Lifespan Respite Network is a statewide system divided into six service areas. DHHS provides a Lifespan Respite Network grant to one agency in each of the areas, which is responsible for providing the required network activities. The following agencies currently hold the grant in their respective service areas:

1. Central Area - Central Nebraska Community Services, Inc.
2. Eastern Area – Partnerships in Aging
3. Northern Area - Central Nebraska Community Services, Inc.
4. Southeast Area - YWCA - Lincoln
5. Southwest Area – Southwest Nebraska Public Health Department
6. Western Area – Panhandle Partnership for Health and Human Services

The Lifespan Respite Network in each area is responsible for providing the following activities:

1. Recruiting respite providers
2. Offering training for providers, caregivers, and consumers
3. Providing information and referrals regarding respite resources and services
4. Marketing availability and need for respite
5. Matching families with appropriate respite providers and payment resources

LIFESPAN RESPITE SUBSIDY:

The Lifespan Respite Subsidy program is currently serving 546 individuals with special needs. Between July 1, 2012 and June 30, 2013, the Lifespan Respite Subsidy Program served 711 individuals and received 369 new referrals. Clients eligible for other programs providing respite services are referred to those appropriate programs.

The 711 individuals had one or more of the following special needs:

Special Need	Number Served
Behavior Disorders	86
Alzheimer/Dementia	70
Autism	70
Developmental Delay	69
Multiple Impairments	49
Developmental Disabilities	46
Other Health Impairments	41
Brain Injury	39
Neurological Disabilities	39
Visual Impairments	36
Heart Condition	35
Orthopedic Impairments	32
Mental Illness	25
Diabetes	22
Arthritis	20
Seizure Disorder	17
Cerebral Palsy	16
Hearing Impairments	16
Respiratory System Disorder	12
Cancer	11
Parkinson	12
Kidney/Renal Failure	8
Asthma	5
Spinal Disorder/Injury	1

NEBRASKA LIFESPAN RESPITE NETWORK

The Network's goal was to ensure families had increased knowledge and access to quality and inclusive lifespan respite resources to meet their specific respite needs. Currently the Lifespan Respite Network has 1,034 approved agency and individual providers statewide accessible to caregivers through a 1-866-RESPITE phone line that enables access to local Respite Network representatives. When caregivers called 1-866-RESPITE to seek assistance, Respite Coordinators empowered and helped with the following:

- Informed decision-making about respite need;
- Assisted with general resource questions, including questions about available funding, caregiver support groups, access to Medicaid programs, information about special trainings/events;
- Program eligibility and referral, if appropriate;
- Guidance on selecting competent providers to meet their individual needs; and
- When needed, identifying translators and interpreters to help non-English speaking families.

Caregivers were free to choose their respite providers. Caregivers routinely received a caregiver packet with educational information on priority topics that included:

- How to hire, train and provide ongoing supervision of care providers;
- Billing instructions,, available financial assistance, reporting changes of condition or need, and fraud;
- Philosophy of client choice, client direction and family centered services;
- How to identify and report abuse and/or neglect;
- The Nebraska Nurse Practice Act, particularly for providing an understanding of the health maintenance activities a provider is allowed to conduct;
- Handling emergencies, stress relief, positioning and transferring, behavior management, speech pathology, respite goals, limits, confidentiality, and more.

DHHS Program staff, in collaboration with UNL's Center on Children, Families and the Law - Answers4Families and Network Respite Coordinators, created a secure online data management and workspace system. This system is referred to as eLifespan Respite and for use by Network Respite Coordinators and DHHS Program staff. Since the launch of the system on September 24, 2012, there have been several updates enhancing the platform and system functionality to better serve Nebraska's respite infrastructure. Key features of the system:

- Allows real-time provider matching with care recipients that best meet their needs;
- Supports real-time recording of subgrantee activity and financial reporting, including caregiver and provider contacts; and
- Project management functions to support a quality assurance process.

To support statewide access to respite resources, in addition to direct contact with local Respite Coordinators; families, providers, and community partners can access respite resources 24/7 through the Nebraska Resource and Referral System (NRRS) website. This site is supported by Answers4Families. NRRS, on the Answers4Families website, is a statewide database created with input from Nebraska families, service providers and organizations. Public access to Network-approved provider information allows caregivers to match care recipient and caregiver needs as closely as possible. Provider information is exported each evening from the eLifespan Respite system to the NRRS Respite Resource section.

Activities Supported

At every outreach opportunity family caregivers were reminded of the importance of recognizing themselves as caregivers, taking respite and how to access Nebraska Respite Network representatives. In addition, overcoming issues of “trust” and problems of long distance caregiving were addressed. Caregivers were informed of local support groups and respite programs.

Respite support services are available to caregivers not only on a planned basis but also in emergency situations. A uniform statewide crisis respite process was defined, piloted and implemented. Establishing crisis respite resources added to the respite options that met families’ needs. Respite Coordinators gave presentations to emergency response leaders and first responders across the state to educate them about available respite resources and valuable crisis support. First responder education participants included professionals and agencies such as emergency medical personnel, law enforcement agencies, community Fire and Rescue, Health Departments, County Emergency Managers, Directors and Coordinators. Training materials to educate the public and respite providers about crisis response were purchased and disseminated.

Special Projects: The Nebraska Lifespan Respite Network Coordinators in partnership with each of their Advisory Committees have granted \$150,000 (\$25,000 goes to each of the six respite areas) to provide funding to expand or develop programs dedicated to the provision of respite services in each of their areas. These projects continue to enhance respite delivery services in each coverage area. The following are lists of funded projects by service area.

The **Central Service Area** granted 11 organizations funds to expand or develop programs dedicated to the provision of respite services in their area. The following agencies were awarded the funds:

- ARC of Buffalo County, Kearney provided respite to families through Teens & Youth in Action programs, adult recreational classes, Sibshops, monthly KidZone Respite, inclusive recreation, and holiday celebrations;
- Adult Day Care, Grand Island Grand Generation Center provided daycare respite for age 19 and older. They received funds for staff education, salaries, and to develop a public information campaign based on needs assessment results;
- Custer Care Center, Broken Bow completed bathroom renovations to serve an additional five families with respite and to provide respite by accompanying families and their loved ones with special needs to overnight events;
- Families CARE, Kearney offered monthly support group meetings, parents’ day out, and family events;
- Hastings Respite Care was funded to support the “Let’s Take a Break Caregiver Night Out” Support Group, maintaining the caregiver e-mail group and the caregiver newsletter;
- Webster County Senior Citizens Committee, Inc. provided respite by transporting adults with special needs to the Senior Center for activities and lunch, sharing current events and family events while their families took respite;
- Webster Co. Senior Services provided a monthly caregiver support group and special caregiver event;
- Autism Parent Support Group of Grand Island (Autism Society of Nebraska-Grand Island) offered respite care for families with children who have any type of disability,

supported in-home respite care, monthly respite support group activities and respite day camp;

- ALS in the Heartland, Inc. used funds to sustain the respite voucher program and offer an ALS support group in Hastings;
- YWCA of Adams County supported an after school respite program for special needs youth; and
- Grand Island Adult Day Care Used funds for staff training, additional staffing hours, and bilingual aide.

Remaining funds were used for Emergency Respite Services. These funds were utilized when other sources of funding could not be secured.

The **Eastern Service Area** granted 11 organizations funds to expand or develop programs dedicated to the provision of respite services in their area. The following programs received funding:

- Children's Respite Care Center provided weekend respite for families caring for children with special needs;
- ALS in the Heartland for Respite Days to provide respite to families caring for loved ones diagnosed with ALS;
- Girls, Inc. provided respite to families while girls with disabilities participated in agency programs;
- Heartland Therapeutic Riding Academy provided respite activities for youth with special needs and their siblings through their equine therapy program;
- Survivors Raising Kids provided respite care to offer support to families fighting cancer;
- HELP Adult Services for a volunteer respite program pilot to provide respite to families that have difficulty leaving their homes due to the care needs of their loved one;
- Alzheimer's Association Midlands Chapter used funds to provide respite for family members with Alzheimer's to allow caregivers to attend support meetings;
- Bellevue Christian Academy/Royal Family Kids provided camping opportunities for children and youth with disabilities;
- Jewish Family Services for match funding for respite programs that provide individual and group respite for individuals with Developmental Disabilities;
- Lifestyle Innovations for Epilepsy provided respite assistance to people living with epilepsy and their families; and
- Powerful Tools for Caregivers provided a self-care education program for family caregivers.

With remaining funds, the Respite Network provided emergency respite funding assistance to ten families in crisis situations. Training materials were purchased to educate the public, respite providers and first responders about crisis resources.

The **Northern Service Area** granted the following 7 organizations funds to expand or develop programs dedicated to the provision of respite services in their area. The following programs received funding:

- S.M.I.L.E. Inc., Madison expanded the equine and canine therapy for people of all ages with special needs or disabilities to new populations through scholarships and more qualified respite instructors;

- Planning Region Team #29/Early Childhood, Norfolk used funds to connect family caregivers to respite providers at family fun days. They also created a Respite Provider directory for families with children who have special needs;
- ALS in the Heartland, Inc. used the funding to sustain the respite voucher program and offered an ALS support group in Columbus;
- Building Blocks For Community Enrichment used funds for two respite activities inviting respite providers and hosted two summer foster care/respite provider picnics in Norfolk and O'Neill;
- Behavioral Health Services, Norfolk used the funding to support foster parent monthly respite retreats;
- Arc of Platte County, Columbus used the funds to support Pals n Play, special needs camp, Parents for Parents, respite day holiday party, volunteer training, and a family day/open house; and
- Fremont Berean Bible Church used funds for children's respite while parents recovering from substance abuse attended support group.

The remainder of the funds was added to the Emergency Respite/Scholarship program.

The **Southeast Service Area** granted 4 organizations funds to expand or develop programs dedicated to the provision of respite services in their area. The following programs received funding:

- YWCA of Lincoln, Take a Break used funds to help provide respite for families in Lincoln and Lancaster County who have children with disabilities through age 10;
- The Nebraska State Stroke Association used funds to provide the second annual Retreat and Refresh Stroke Camp in Nebraska. This is a camping experience for stroke survivors and their caregivers;
- Lincoln Parks and Recreation used funds to introduce a variety of additional community resources that would increase social and play development to assist families of youth and adults who utilize their adaptive recreation programs as a respite source, but are unable to pay the program fee. Also helped fund field trips for families participating in the developmental play group; and
- ROC Ministries, Ashland helped increase the use of the center as a safe place for respite for parents of youth 13-19 with emotional and/or physical disabilities.

The **Southwest Respite Service Area** utilized the special funds to increase the availability of respite services and caregiver support programs through direct financial support to families.

- Respite Days paid eight hours or up to \$100 dollars of respite care the first weekend of every month; and
- Scholarships were offered to families to help with attending conferences, trainings and camps.

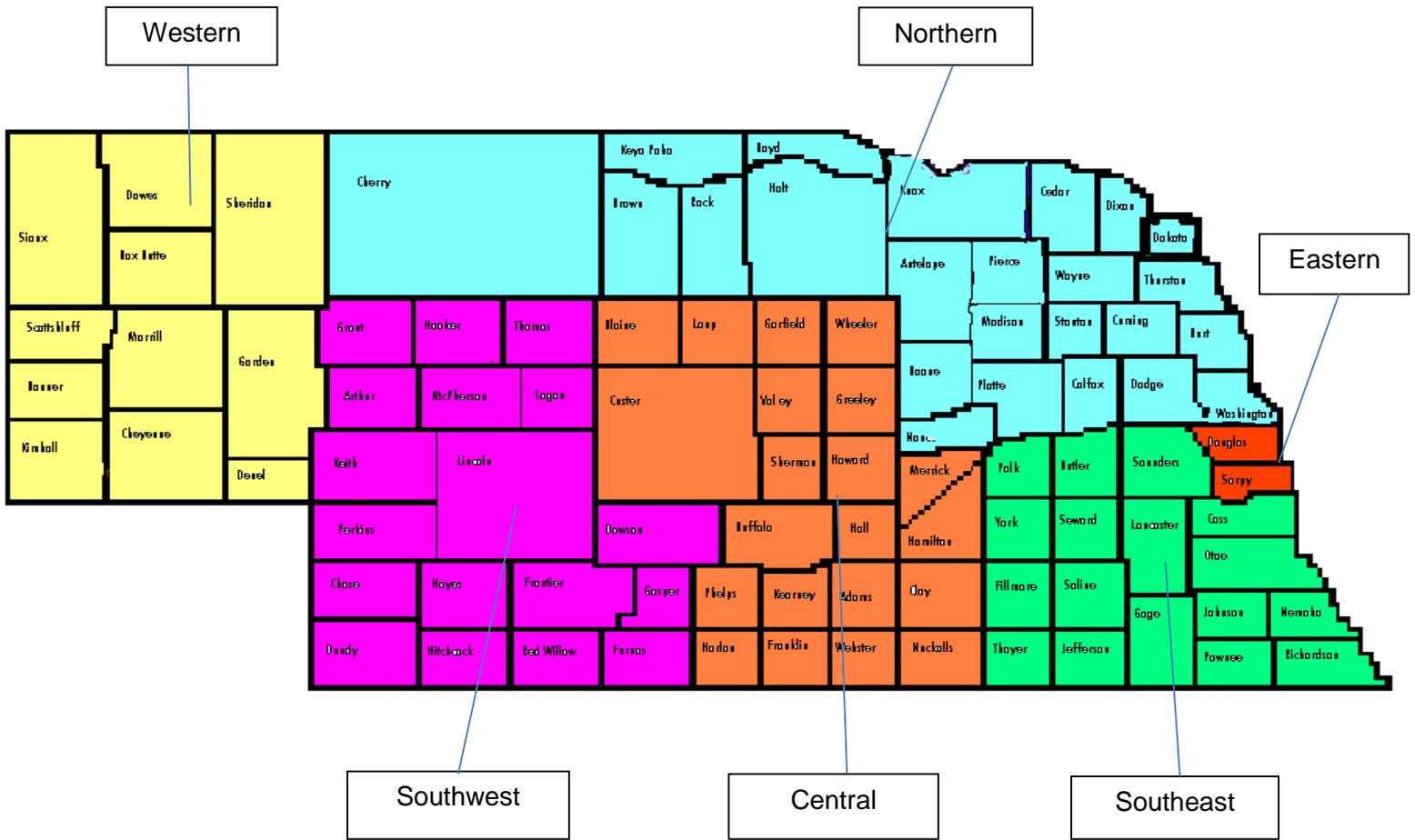
The **Western Respite Service Area** utilized the special funds to increase the availability of respite services and caregiver support programs.

- Respite Days Program offered respite support the second weekend of each month, for eight hours, six times each year. A family maximum of \$100 was allowed each time. Generally Respite Days were scheduled around holidays; and

- FUN Days Program brought children with disabilities and their siblings together for a day of fun.

Remaining funds were used for Emergency Respite Services when other sources of funding could not be secured and typically used as a result of such things as the caregiver being hospitalized.

For more information please contact the Respite Network Coordinator in your area at:



ATTACHMENT B

Department of Health & Human Services



**Annual Report on the Public Health Portion
of the Nebraska Health Care Funding Act (LB 692)**

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

**Office of Community Health and Performance Management
Community and Rural Health Planning Unit
Division of Public Health
Nebraska Department of Health and Human Services**

December 1, 2014

The Nebraska Health Care Funding Act (LB 692) was passed in 2001 by the Nebraska Legislature. This Act provides funding to local public health departments through the County Public Health Aid Program (Neb.Rev.Stat. §§71-1628.08) and assigns the Department of Health and Human Services to assist them in implementing the three core functions of public health and the ten essential public health services. The Act also requires all of the eligible local public health departments to prepare an annual report each fiscal year. These reports identify how the funds were spent to meet the ten essential public health services, including a description of their specific programs and activities.

The Nebraska Department of Health and Human Services (DHHS), Division of Public Health, is responsible for ensuring that eligible local public health departments receive the funding. The Division is also responsible for providing technical assistance and training to the departments in implementing the ten essential services. The annual reports are submitted to the Office in October of each year and staff compile a summary report.

This report provides a summary of the key findings from each of the eighteen local public health departments that have received funding, and covers the period July 1, 2013 to June 30, 2014. The report is divided into three sections. The first section reviews the organizational coverage as well as the funding and spending levels for each local health department. The second section describes the current activities, services, and programs provided by the health departments under each of the ten essential public health services. The final section contains some short stories that describe how the local health departments are improving the lives of Nebraska citizens in their communities.

Organizational Coverage

As of June 30, 2014, a total of eighteen local public health departments covering eighty-six counties were eligible to receive funds under a portion of the Health Care Funding Act, Neb.Rev.Stat. §§71-1626 through 71-1636. The list of eligible public health departments and their affiliated counties is shown in Table 1 and Figure 1. Dakota and Scotts Bluff Counties have single county health departments that do not meet the population requirements of the Health Care Funding Act. In addition, the five counties that comprise the Sandhills District Health Department do not meet the population requirements. Staff from DHHS, Division of Public Health, continue to work toward the goal of having all Nebraska counties covered by a local public health department under the LB 692 umbrella.

Funding and Expenditure Levels

Table 2 depicts the amount of infrastructure and per capita funds distributed to each of the eligible departments under LB 692 as codified in Neb.Rev.Stat. §§71-1628.08. The total amount of funds ranged from \$1,107,698 for the Douglas County Health Department to \$157,672 for the Loup Basin Public Health Department. The table also includes the amount of LB 1060^a funding distributed to each eligible health department, which was \$105,458 per department. The amount of infrastructure funding under Neb.Rev.Stat. §§71-1628.08 was based on the 2000 Census

^a LB 1060 was passed in 2006 with the intent to develop epidemiology and data capacity in local health departments.

because these population estimates were used when the departments were originally established. The health departments with service areas that included a population of 100,000 or more people received \$150,000. If the population was between 50,000 and 99,999, the amount of funding was \$125,000, and departments that had at least 30,000 people but fewer than 50,000 received \$100,000. The amount of per capita funds, which were based on the 2010 Census, was approximately \$1.85 per person.

Table 3 summarizes the expenditures by category for the eighteen local public health departments that were eligible for funding. As expected, expenses for personnel and benefits accounted for approximately 53.8 percent of the total expenses. The next largest spending category was public health programs which represented about 17.2 percent of the total expenses. The line item labeled “Other” includes expenses for mini-grants. The total LB 692 and LB 1060 funds expended during this fiscal year (\$7,941,424) was more than the total funds received (\$7,303,244) because some of the health departments spent carry-over funding from the previous state fiscal year (2012-2013).

Leveraging Other Funds

Although funds from the Nebraska Health Care Funding Act serve as the financial foundation for most the local public health departments, all of the departments have been very successful in leveraging other funding sources. For example, federal grant funds have been passed through the DHHS Division of Public Health to local public health departments for emergency preparedness planning, public education efforts related to West Nile Virus, the Clean Indoor Air Act, Preventive Health block grants, Maternal and Child Health block grants, and radon testing. Some departments have also received grant funds from private foundations and directly from the federal government.

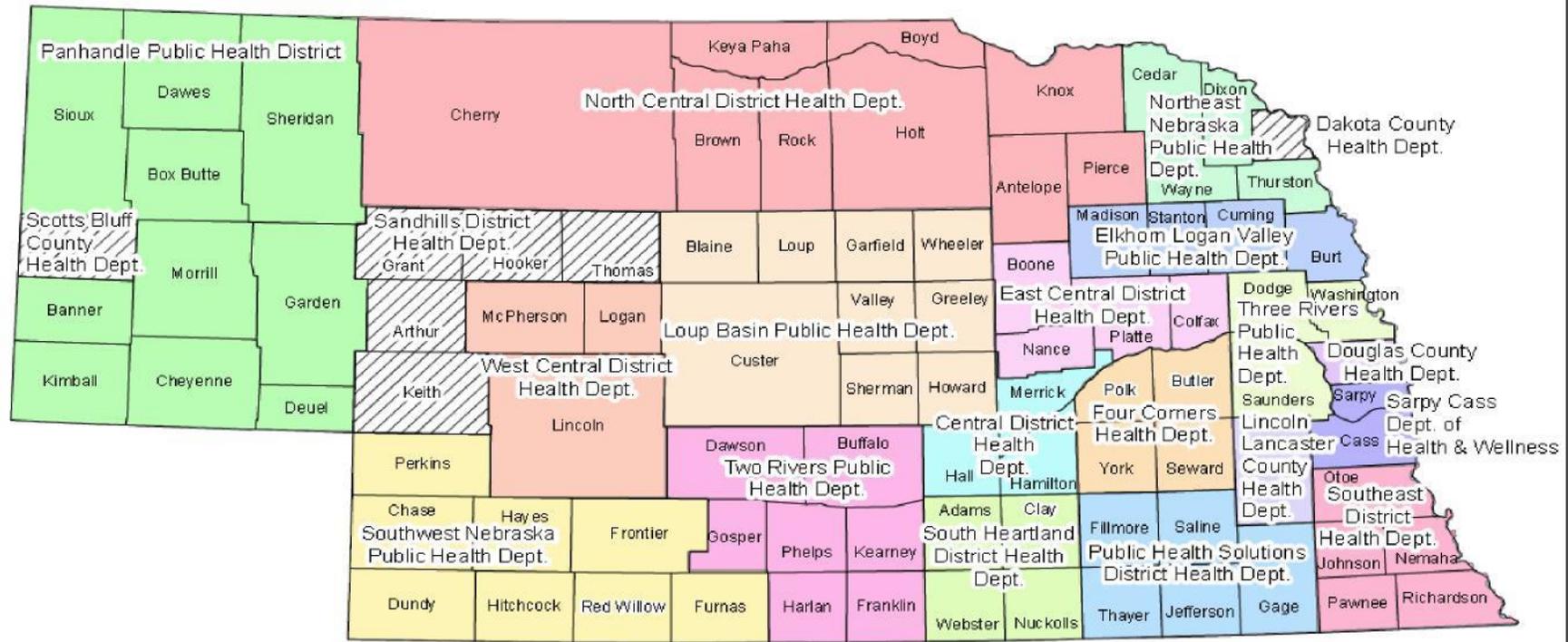
Table 1

**Local Public Health Departments funded under the
Nebraska Health Care Funding Act (LB 692)**

NAME	COUNTIES
Central District Health Department	Hall, Hamilton, Merrick
Douglas County Health Department	Douglas
East Central District Health Department	Boone, Colfax, Nance, Platte
Elkhorn Logan Valley Public Health Department	Burt, Cuming, Madison, Stanton
Four Corners Health Department	Butler, Polk, Seward, York
Lincoln-Lancaster County Health Department	Lancaster
Loup Basin Public Health Department	Blaine, Custer, Garfield, Greeley, Howard, Loup, Sherman, Valley, Wheeler
North Central District Health Department	Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, Rock
Northeast Nebraska Public Health Department	Cedar, Dixon, Thurston, Wayne
Panhandle Public Health District	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Sheridan, Sioux
Public Health Solutions District Health Department	Fillmore, Gage, Jefferson, Saline, Thayer
Sarpy/Cass Department of Health and Wellness	Cass, Sarpy
South Heartland District Health Department	Adams, Clay, Nuckolls, Webster
Southeast District Health Department	Johnson, Nemaha, Otoe, Pawnee, Richardson
Southwest Nebraska Public Health Department	Chase, Dundy, Frontier, Furnas, Hayes, Hitchcock, Perkins, Red Willow
Three Rivers Public Health Department	Dodge, Saunders, Washington
Two Rivers Public Health Department	Buffalo, Dawson, Franklin, Gosper, Harlan, Kearney, Phelps
West Central District Health Department	Lincoln, Logan, McPherson

Figure 1. Map of Nebraska's Local Health Departments

Nebraska Local Health Departments



0 50 100 Miles

Legend

 Local Health Departments that do not Qualify for LB 692* Funding

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

Source: Nebraska Department of Health and Human Services

Department of Health & Human Services
DHHS
 NEBRASKA

Map Created by:
 Public Health GIS Analyst
 DHHS GIS 6/10

Table 2
LB 692 and LB 1060 Health Department Payments
July 1, 2013 - June 30, 2014

District Name	LB 692 Infrastructure	LB 692 Per Capita	LB 1060	Total	2000 Population used for Infrastructure	2010 Population used for Per Capita
Central District	\$125,000	\$139,968	\$105,458	\$370,426	71,141	75,576
Douglas County	\$150,000	\$957,698	\$105,458	\$1,213,156	463,585	517,110
East Central	\$125,000	\$96,290	\$105,458	\$326,748	52,400	51,992
Elkhorn Logan Valley	\$125,000	\$105,569	\$105,458	\$336,027	59,675	57,002
Four Corners	\$100,000	\$81,889	\$105,458	\$287,347	45,500	44,216
Lincoln-Lancaster	\$150,000	\$528,580	\$105,458	\$784,038	250,291	285,407
Loup Basin	\$100,000	\$57,672	\$105,458	\$263,130	33,122	31,140
North Central	\$125,000	\$85,923	\$105,458	\$316,381	51,084	46,394
Northeast Nebraska	\$100,000	\$58,129	\$105,458	\$263,587	32,976	31,387
Panhandle	\$125,000	\$94,118	\$105,458	\$324,576	53,459	50,819
Public Health Solutions	\$125,000	\$102,187	\$105,458	\$332,645	57,858	55,176
Sarpy/Cass	\$150,000	\$340,922	\$105,458	\$596,380	146,929	184,081
South Heartland	\$100,000	\$85,597	\$105,458	\$291,055	47,308	46,218
Southeast District	\$100,000	\$72,860	\$105,458	\$278,318	40,078	39,341
Southwest District	\$100,000	\$58,503	\$105,458	\$263,962	33,610	31,589
Three Rivers	\$125,000	\$143,911	\$105,458	\$374,369	74,770	77,705
Two Rivers	\$125,000	\$175,566	\$105,458	\$406,024	92,756	94,797
West Central	\$100,000	\$69,617	\$105,458	\$275,076	35,939	37,590
Total	\$2,150,000	\$3,255,000	\$1,898,244	\$7,303,244	1,642,481	1,757,540

Table 3

**LB 692 Local Public Health Departments
July 1, 2013 June 30, 2014 Expenses**

Departments:	LB 692 Local Public Health Departments	
Total Funds Received (LB 692):	\$5,405,000	}
Total Funds Received (LB 1060):	\$1,898,244	
		\$7,303,244
Total Funds Expended (LB 692):	\$6,220,790 ^b	}
Total Funds Expended (LB 1060):	\$1,720,634	
		\$7,941,424
Budget Period:	July 1, 2013 - June 30, 2014	
Line Items	Expenditures	
	LB 692	LB 1060
Personnel/Benefits	\$3,242,962	\$1,035,682
Insurance	\$219,628	
Travel	\$124,984	\$24,446
Office Expense/Printing	\$539,135	\$107,982
Communications/Marketing	\$169,413	\$33,480
Equipment/Construction	\$181,483	
Contractual	\$331,575	\$213,389
Public Health Programs	\$1,218,487	\$150,352
Other	\$193,123	\$155,303
Total	\$6,220,790	\$1,720,634
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	\$7,941,424	

^b The total LB 692 funds spent during this fiscal year were slightly greater than the total funds received because departments reported funds that were carried over from the previous fiscal year in their reports.

Current Activities

The activities and programs of the local public health departments are organized under the three core functions of public health: assessment, policy development, and assurance. The assessment function involves the collection and analysis of information to identify important health problems. Policy development focuses on building coalitions that can develop and advocate for local and state health policies to address the high priority health issues. The assurance function makes state and local health agencies as well as health professionals responsible for ensuring that programs and services are available to meet the identified priority needs of the population.

Additionally, the activities and programs of the local public health departments are summarized under the associated ten essential services of public health. The ten essential services of public health provide a working definition of the public health system and a guiding framework for the responsibilities of local public health partners. These functions and services are specifically referenced in the Neb.Rev.Stat. §§71-1628.04. The ten essential services include:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

During the fiscal year July 1, 2013 to June 30, 2014, considerable progress was made in the provision of the three core functions and ten essential services of public health. Every health department receiving funding under LB 692 and LB 1060 demonstrated significant improvement in both number and complexity of activities and programs during this time period. At this juncture, all of these health departments are providing the core functions and all of the ten essential services. Because of the large number of activities and programs, only a few examples from specific health departments are provided within this report. However, the individual reports of the health departments are available upon request.

Core Function Assessment

Essential Service 1: Monitor Health Status to Identify and Solve Community Health Problems

This service includes identification of the community's health problems and emergencies; review of health service needs; attention to health problems of specific groups that are at higher risk than the total population; and collaboration to manage shared information systems with other health care providers.

- Over the past thirteen years, all eighteen local public health departments have conducted a comprehensive community health assessment and have repeated the process at least once every five years. A majority of the departments use the Mobilizing for Action through Planning and Partnerships (MAPP) approach to update their local public health improvement plans approximately every five years. This process involves a thorough review of health needs, community health risks (e.g., tobacco use, obesity levels, and environmental quality), and the ease of access to health services (e.g., insurance coverage status, transportation). This process also involves input from a diverse group of community members and the development of local health priorities.
 - The last update to the East Central District Health Department's (ECDHD) Community Health Assessment was in January of 2012. The department's MAPP core work group meets every three months and oversees the process of the assessment. The core group is made up of the ECDHD Executive and Deputy Director, the four local hospital CEOs and United Way representatives. This team is well into the process of not only gathering data for their next assessment but providing that data to the research firm assisting the assessment. Over 500 written community surveys have been completed. The ECDHD has held seven focus groups in the district (English and Spanish, adult and youth) and currently has the research firm reviewing this data. The ECDHD will be reviewing the draft 2015 Community Health Assessment by the end of the calendar year with the release of the 2015 Community Health Assessment occurring in January of 2015.
 - The North Central District Health Department (NCDHD) partnered with all eleven hospitals throughout their district to complete a community health assessment. The four major focus areas identified for the district are: access to care/cancer prevention and education; behavioral health (mental health and substance abuse); chronic disease, obesity, and related health concerns; and environment/safety. The NCDHD has been working toward strategically developing and processing sustainable programs, services and education that align with their assessment plans.
 - The Northeast Nebraska Public Health Department (NNPHD) built community partnerships through the MAPP process in 2007 and again in 2011-2013. This process includes data collection from every known data set for public health, for hospitals, for community action agencies, for educational institutions, for local and regional governmental entities and other non-governmental organizations. The data are analyzed by an external evaluator and presented to all partners in large group and

small group partner meetings as a component of the MAPP process. The NNPHD and the two Critical Access Hospitals located within the health district, Pender Community Health Center and Providence Medical Center, combined resources, time and efforts to coordinate these work products for the betterment of the community. The progress is posted on the respective websites, shared at Board of Health meetings, and the respective hospital board of directors' meetings. Organizational newsletters and newspaper articles contain the updates on the status of the Community Health Improvement Plan (CHIP) and how it addresses the health priorities identified and featured in the CHIP.

- Most of the local public health departments make local data available to the public on their websites, giving their community partners access to the information (See Appendix A for a list of health departments and their websites).
 - The Loup Basin Public Health Department's (LBPHD) partners and communities are able to access the following from its website: "Network of Care" website, Well@Work presentations and company profiles, the LBPHD's Facebook page and Twitter account, media/press releases, brochures, health fairs, and grant reports.
 - The Lincoln Lancaster County Health Department (LLCHD) supplies data from the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance (YRBS) surveys, Vital Statistics, Hospital Discharge Data (HDD), Cancer Registry and the Census to their partners either upon request or as part of their joint planning efforts where the LLCHD programs share the information. Health data are incorporated into the Mayor's Taking Charge objectives and are updated annually as data become available. In addition, the LLCHD has created data dashboards for the BRFSS data and, most recently, birth and death (Vital Statistics) data that are available to the public from their website. They are also working with the Public Health Association of Nebraska (PHAN) to make vital health statistics available in a dashboard for all local health departments.
- Most of the public health departments use data collected from a variety of sources to help identify significant problems, trends, or gaps in services within their districts.
 - All eighteen local public health departments have contracted with the Department of Health and Human Services (DHHS), Division of Public Health to complete an oversample of the Behavioral Risk Factor Surveillance System (BRFSS) Survey for their districts. These data allow them to continue to monitor health risk factors such as tobacco and alcohol use, levels of physical activity, and seat belt use in their local areas. BRFSS data are essential in determining priorities and measuring success that will lead to a healthier community.
 - The West Central District Health Department (WCDHD) has used data collected from a variety of sources to help identify access to dental care for the underserved as a significant issue within its service area. The WCDHD hired a full time dentist on July 8, 2013. The WCDHD's full-time dentist and 1.5 full-time equivalent

public health hygienists service the vast majority of Medicaid clients in the area. Most local dentists do not accept Medicaid, and for those who do, it is on a limited basis. Having public health hygienists and a full-time dentist has improved access to dental services. However, many continue without access due to a large number of dentists who do not accept Medicaid.

- All of the local health departments worked with staff from the Division of Public Health to track and monitor various diseases such as tuberculosis, West Nile Virus, foodborne illnesses, influenza-like illness (ILI), and pertussis (whooping cough).
 - All departments participate in a statewide school surveillance program to monitor and report absences due to illness (e.g., flu and asthma). This system allows state and local health officials to respond more promptly to disease outbreaks. The departments are also working with the infection control nurses in hospitals to identify patients with influenza-like illnesses. This activity allows them to work with local businesses and the community at large to make appropriate disease prevention recommendations.
- Several local public health departments have formed Colon Cancer Coalitions over the past few years. The coalition members analyzed data obtained from the Division of Public Health on colon cancer occurrence, death, and screening rates. The coalitions then decided on strategies to improve screening rates in their regions. One strategy involved the implementation of Fecal Occult Blood Test (FOBT) kit distribution to pharmacies and other locations across the districts.

Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards in the Community

This essential service includes the identification of emerging health threats; the ability of public health laboratories to conduct rapid screening and high volume testing; and the ability to investigate disease outbreaks and identify patterns of chronic disease and injury.

- All eighteen local health departments conducted numerous disease investigations for a variety of health concerns, including rabies, tuberculosis, sexually transmitted infections, West Nile Virus, and E. coli. Often the health department nurse provided follow-up with case management or appropriate educational information. In addition, the local public health departments continue to participate in the National Electronic Disease Surveillance System (NEDSS). The system is designed so that state and local public health departments as well as the Centers for Disease Control and Prevention can monitor and assess disease trends and guide prevention and intervention programs. Local health department employees are the foundation of the system and can intervene more quickly when there is a communicable disease or foodborne illness outbreak.
 - The Three Rivers Public Health Department's Surveillance Coordinator worked with 43 schools, 17 long term care facilities, and three hospitals to complete weekly reporting during the influenza season to track flu activity levels in their area. These organizations helped to identify when the flu hit the area, which type of virus was

circulating, and how the flu was influencing absenteeism and hospitalization rates. In addition to influenza surveillance, their Disease Surveillance Coordinator investigated five meningitis cases, 11 norovirus cases, 12 pertussis cases, 31 food-borne illnesses, and many other communicable diseases.

- The Panhandle Public Health Department's (PPHD) nurses monitor NEDSS for communicable diseases in the Panhandle. Over the past year there were 120 confirmed, probable, or suspect communicable diseases in the Panhandle from July 1, 2013 through June 30, 2014. By using NEDSS, the health district is able to gain the efficiencies of a statewide reporting system to promote early detection and help prevent the spread of disease. By carefully tracking incidents of communicable disease, the PPHD is able to recommend measures to prevent unnecessary illnesses.
 - The Southeast District Health Department's (SEDHD) immunization clinics include all counties in the region. Last year they gave 1,526 vaccinations to 453 children. This year, they recently have been able to add the state/federal supported vaccination program for uninsured adults. The SEDHD also assists several volunteer agencies in vaccinating personnel. Vaccinations were given to 29 adults.
 - The Public Health Solutions District Health Department (PHSDHD) was able to immunize a total of 2,759 people. This included 2,333 students and 426 staff who took advantage of their on-site school clinic. The PHSDHD worked hard on a new media campaign that helped increase the overall rate of participation. The PHSDHD's highest county had a 43 percent participation rate and the lowest county had an 18 percent participation rate, which is still higher than the national average.
- Many departments investigated a variety of nuisance problems, including mold, property concerns, animals, and garbage.

Spotlight On: The Elkhorn Logan Valley Public Health Department

Responding to the Pilger Tornadoes

On June 16, 2014, several tornadoes went through Stanton and Cuming counties, with two EF-4 tornadoes destroying 80 percent of the village of Pilger. The Elkhorn Logan Valley Public Health Department's (ELVPHD) Emergency Response Coordinator (ERC), Health Director, and Assistant Health Director responded to Pilger approximately one hour after the tornadoes swept through Pilger to receive direction from the Emergency Operations Center (EOC) and begin planning their response efforts. Over the course of approximately two weeks, over 1,300 tetanus shots were given both in Pilger and via mobile units that responded to individual farms that were affected. While the process of coordinating staff, volunteers, and the mobile units had its challenges, the ELVPHD responded effectively and timely.

- Local public health departments are a key element of local emergency response in disaster situations. The departments bring together key stakeholders to hold periodic emergency response exercises to test preparedness plans.
 - The Northeast Nebraska Public Health Department (NNPHD) experienced a year of historically unrivaled disasters as tornadoes hit its district in October 2013 and again in June 2014. The NNPHD was able to respond to these disasters by immunizing tornado victims and volunteers with tetanus booster shots, distributing informational flyers, providing sanitary hand wipes and mosquito wipes with DEET to volunteers, translating important public health messages to Spanish, activating the Behavioral Health Disaster Plan through Region IV Behavioral Health System, and working with City, County, and State Emergency Management Systems to address important public health safety issues. In addition, the NNPHD located seven vulnerable families whose homes were destroyed by the tornado in June 2014 and provided support with interpretation, lodging (both temporary shelter and permanent housing), replacing prescriptions, finding resources for tornado victims, getting volunteers to help sift through and salvage the remains of their belongings, obtain food, replace clothing, transportation, and more.
 - The Two Rivers Public Health Department (TRPHD) staff serves on the TRIMRS (Tri-Cities Medical Response System) Exercise Design Committee. As part of this group, the TRPHD has helped to facilitate five Active Shooter exercises and one tornado/power outage exercise with district hospitals and local law enforcement. The TRPHD participated in a behavioral health table top, a Pan Flu Scramble with the CDC and local partners, and a statewide tornado drill. They also conducted three seminars for staff on emergency response, strategic national stockpile, and incident command.
 - Many of the local health departments contributed to the Pilger tornado response by transferring their stock of adult Tdap vaccine to the Elkhorn Logan Valley Public Health Department which was coordinating tetanus vaccination for responders and residents involved in the cleanup.

Essential Service 3: Inform, Educate, and Empower People about Health Issues

This essential service involves social marketing and targeted media communication; providing health information resources to communities; active cooperation with personal health care providers to reinforce health promotion messages and programs; and joint health education programs with schools, churches, and worksites.

- Nebraska's local public health departments are constantly providing information to the public on ways to become and stay healthy. The departments also help both health professionals and the general public stay informed on how to make healthy choices. In addition, all health departments provide educational information about larger public health issues ranging from radon and hand washing to dental care and the benefits of physical activity to community members and organizations.

- The Panhandle Public Health District is continuing to implement the National Diabetes Prevention Program (NDPP). The NDPP program aims to prevent obesity and type II diabetes. During the program, participants meet weekly for approximately 16 weeks, then monthly for the remainder of the year. Participants keep track of their food intake and physical activity and work with a Lifestyle Coach and the participant group to overcome barriers to a healthy lifestyle. The program is open to anyone with pre-diabetes. Through 24 community partners, the NDPP has served participants from all 11 counties within the panhandle, with 31 Diabetes Prevention classes launched. Almost 7,000 total classroom hours have been taught to the 475 participants from the beginning of the September 2013 to this point. The NDPP is seeing success in partnering with the Panhandle Worksite Wellness Council businesses to offer the classes to their employees through their worksite wellness programs. There have been 18 contracts with local businesses to offer the classes to their employees.
- The Southwest Nebraska Public Health Department (SWNPHD) kicked off their 11th annual Walk to Health program in April 2014 and was completed at the end of June. This program lasts for 12 weeks and is open to residents of all ages in the health district. The 350 participants lost a total of 198.5 pounds, lost 145.3 inches, and walked 450,050 minutes. Overall, participants became more active, sustained a higher level of activity, as well as weight and inches lost for those that had that particular goal.
- The Douglas County community counts on the Douglas County Health Department (DCHD) to provide Sexually Transmitted Disease (STD) prevention and education. The DCHD's STD Program provides STD screenings and compiles data on the diseases that are currently afflicting the most people. Over the past year, 13,188 community members received STD prevention education.
- The Lincoln Lancaster County Health Department has coordinated the Summer Food Service Program (SFSP) in Lincoln for 34 years to provide nutritious meals to children living in the highest poverty areas of Lincoln. This program helps address the health issues of poor nutrition as well as the issue of childhood obesity, especially by the provision of nutritious, low-fat, properly portioned meals and through nutrition education. In 2014, approximately 3,000 children at 37 sites received 88,736 meals over a 10 week period. In addition to the meals, the children receive education on eating healthy and being physically active.
- The Central District Health Department continued to implement their sugar-sweetened beverage campaign designed to increase awareness of the health concerns related to consumption of "empty-calorie" beverages such as soda. The campaign is entitled, "Rethink Your Drink." Accurate information is distributed to the general public through various media outlets in an effort to increase the thought given to beverage choices, thereby reducing empty calories that lead to excess body fat.

- Several local health departments utilize Community Health Workers in an effort to conduct health promotion and outreach activities, and to increase the health knowledge of communities.
- Several departments are working to help local businesses create wellness programs. These departments use a process that includes a review of the health status of their workers, a review of business priorities, a written wellness plan, and implementation of the plan. They provide technical and evaluation assistance to the businesses.

Core Function Policy Development

Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems

This essential service involves bringing community groups and associations together, including those not typically considered to be health-related, to help solve health problems; and building coalitions to draw upon the full range of potential human and material resources.

- All of Nebraska’s local public health departments have organized stakeholders to address local health problems. The departments convene or participate in coalitions addressing topics such as tobacco, colon cancer, suicide, oral health, physical activity, and behavioral health.
 - The Douglas County Health Department (DCHD) successfully worked in close partnership with the Healthy Communities Institute to develop the Health Matters in Douglas County Nebraska website which hosts the Community Health Improvement Plan (CHIP) and quarterly progress reports. The DCHD will continue to administer and update the Healthy Communities Institute platform to enhance capabilities and to effectively tell the story of this initiative. The Health Matters in Douglas County Nebraska website was described as one of the many innovative sites often showcased by the Healthy Communities Institute for how the Douglas County community is making the Community Health Improvement Plan process transparent and easily accessible.
 - The Southwest Nebraska Public Health Department’s (SWNPHD) public health nurse has made an impact with the Department’s Vaccines for Children (VFC) program. VFC clinics are now held on a monthly basis in the following communities: Cambridge, Curtis, Hayes Center, Trenton and McCook. The SWNPHD’s partner is the Community Hospital of McCook with its two clinics in Trenton and Curtis. All of these sites provide vaccines free of charge. These had previously been bimonthly clinics.
 - The Elkhorn Logan Valley Public Health Department’s (ELVPHD) Behavioral/Mental Health initiative is focusing on increasing the access to behavioral/mental health services in the ELVPHD health district. The ELVPHD’s Director is the key organizer of the Northeast Nebraska Mental Health Coalition. This

Coalition has roughly 35 members that represent nearly 20 agencies. As the project grew, the ELVPHD's Director invited three other professionals to join the effort and to become a part of the steering committee. As such, the other agencies involved in the leadership of this project include: Midtown Health Center (FQHC), University of Nebraska Medical Center College of Nursing—Northern Division, and Region IV Behavioral Health System. The three main foci of this coalition have been to 1) Integrate behavioral/mental health services into primary practice clinics and to better coordinate case management duties with other agencies providing similar services, 2) Education—providing continuing education units and continuing education for existing health care providers as well as expansion of the curriculum to allow for advanced practice registered nurses to receive their psych endorsements locally in Norfolk, and 3) General awareness of mental health issues—working on community acceptance of behavioral health needs, standing up to the stigma, and bringing awareness regarding the commonness of mental and behavioral health issues, as well as the risks associated with “ignoring” the problem and encouraging early detection and referral.

- The health departments continue to maintain their preparedness for public health emergencies. Emergency response planning efforts have required the establishment of partnerships between various organizations and agencies. Emergency response planning is inclusive of all foreseeable emergencies, including pandemic influenza. New partnerships with hospitals and health care providers are continually being established.

Spotlight On: The West Central District Health Department

Access to Healthcare (Dental, Mental, and Primary Care)

As identified in the Community Health Improvement process, very few dentists in the West Central District Health Department (WCDHD) district accept Medicaid and those that do only serve on a limited basis. In 2012, data from Great Plains Regional Medical Center confirmed that over 200 patients sought care at the Emergency Room for dental pain that year. Although the WCDHD's Dental Clinic has been in operation since the fall of 2006, there was a period from 2010-2012 when a gap in dental coverage existed. Beginning July 1, 2013, the WCDHD was able to employ a full time dentist to address this access to care issue. The full-time dental staff at the WCDHD has implemented an emergency walk-in hour every day Monday through Friday to provide equal opportunity access to emergency care. Referrals to the WCDHD dental emergency walk-in clinic are received daily from the local hospital and dentist offices from surrounding communities whose dentists do not accept Medicaid insurance. The WCDHD was able to treat approximately 500 walk-in emergency dental patients from July 2013 to June 2014 with an estimated 5,000 total dental visits during the year.

- All local public health departments are involved in their regional medical response systems. The purpose of the medical response systems is to bring together representatives from hospitals, public health, fire, law enforcement, emergency management, behavioral health, EMS, government entities, and community organizations for an integrated medical response

to any disaster that threatens the health and well-being of the public. The systems facilitate communication and cooperation among members to enhance planning, prevention, response, and recovery efforts, whether the disaster is natural, manmade, biological, or terrorist in nature.

- All local health departments continue to implement evidence-based strategies as part of their work with community-based partners across their districts.

Essential Service 5: Develop Policies and Plans that Support Individual and Statewide Health Efforts

This essential service requires leadership development at all levels of public health; regular community-level and state-level planning for health improvement; tracking of measurable health objectives as part of continuous quality improvement strategies; and development of codes, regulations, and legislation to guide the practice of public health.

- All departments are continuously updating their emergency preparedness and pandemic influenza plans. The response plans include guidelines for early detection, response and notification, risk communication, environmental safety, quarantine and isolation, and mass vaccination/dispensing clinics. They conduct exercises to test various components of the plans.
- All departments work with their communities to propose and implement public health policies that improve population health and reduce disparities.
 - The Two Rivers Public Health Department partnered with the Nebraska Department of Education and hosted a school wellness and policy workshop. The workshop educated 26 school employees from eight local schools about the importance of designing specific wellness policies, creation of a policy, and implementation of the new Department of Education wellness policy guidelines. Upon conclusion of the workshop, participants were given ideas for new policies and are given a stipend if they complete a work plan and a policy change narrative. All of these schools provided documentation of specific wellness policies and plans that were adopted by their schools after participation in the workshop.
 - The Panhandle Public Health District (PPHD) continues to work with upwards of 40 businesses reaching one in five employed people in the Panhandle region through the Panhandle Worksite Wellness Council. The department continued to create and enhance council offerings ultimately impacting population-based health through organizational policies, systems, and environments by providing ongoing training and educational opportunities, resources, and technical assistance. The PPHD has provided direct technical assistance in the past year to ten council worksites to build policies and/or environmental supports in the areas of tobacco-free, nutrition, physical activity, or breastfeeding.

- Most local health directors help develop needed health policy changes at the local level by helping to draft ordinances and meeting with the appropriate local government officials.

Spotlight On: The South Heartland District Health Department

The South Heartland Area Drug and Alcohol Policy Team

The South Heartland Area Drug and Alcohol Policy Team completed a policy proposal for the final Health Policy Academy Symposium at UNMC College of Public Health. The team will be recommending that Area Substance and Alcohol Abuse Prevention and the local Community and College Task Force bring a model code of conduct policy to area schools for adoption and implementation using the Life of an Athlete/Pure Performance approach to alcohol and substance abuse prevention.

- Local health departments continue to work to improve outcomes for their public health programs by implementing quality improvement initiatives within their departments. Quality improvement (QI) is an ongoing and continuous effort to achieve measureable improvements in the efficiency, effectiveness, performance, accountability, and outcomes of public health programs to improve the overall health of the community.
 - The Four Corners Health Department's Quality Improvement Team has implemented a QI Plan created in the previous year. The team meets regularly. The first project was to evaluate each program/contract/grant being implemented. The programs were evaluated on their community impact, how they fit within the Community Health Improvement Plan priorities, and sustainability. This gave insight into the need for continuation and the resources required. These assessments will be used for future programmatic planning. The QI Team has worked on policies through the self-assessment process and has begun to put a performance management plan into place.
 - The East Central District Health Department has had a QI plan and process in place for the past 11 years. The plan is updated at a minimum every three years although most recently it has been updated nearly twice every year during the Quality Council meetings which are held monthly. The department's QI efforts are quite robust including over 100 performance measures among the many departments in the agency which requires every department to conduct a QI project at least once a year along with regular metric tracking. The QI process is one of the items that the department is often cited on favorably when undergoing site visits. During the past year select staff have attended QI training and the department continues to drive quality forward in every department.

Core Function Assurance

Essential Service 6: Enforce Laws and Regulations that Protect Health and Ensure Safety

This essential service involves enforcement of clean air standards and sanitary codes; and timely follow-up of hazards, preventable injuries, and medical services.

- Local public health departments continue to educate members of their communities on public health laws, policies, regulations, and ordinances, and how to comply with them. For example, many local public health departments conduct review visits for compliance with Nebraska's Clean Indoor Air law. Along with inspections and review visits, the departments help raise awareness of the requirements by providing educational materials to businesses.
 - The Sarpy Cass Department of Health and Wellness conducted inspections of public swimming pools in Sarpy County. Under the guidance of the DHHS Swimming Pool Program, department staff inspected 48 swimming pools for compliance with Nebraska Regulation Title 178 Chapter 2: Operation and Management of Public Swimming Pools.
 - The Central District Health Department (CDHD) provides food vendor inspections and permits for the Nebraska State Fair, as well as for all food vendors in Hall County. They also provide well and septic inspections for real estate sales. The CDHD inspects and permits garbage trucks, small animal vendors, and swimming pools to assure compliance with state and local laws and regulations.
 - The North Central District Health Department conducts investigation and follow-up on nuisance complaints, provides resources and direction regarding ordinances, and provides information and guidance on issues relating to the Landlord/Tenant Act.
 - The Loup Basin Public Health Department is working with Tobacco Free Nebraska, county officials, law enforcement, and business owners to educate and inform them on how to comply with the Clean Indoor Air Act. Forty-four calls on the topic of tobacco were taken with education and cessation support materials mailed out.
- Local public health departments continue to educate medical providers on adherence to Nebraska's reportable disease requirements. Reporting aggregate disease information back to the local communities is essential for public awareness and safety.
- Many of the eighteen local health departments partner with local law enforcement agencies to address the availability of alcohol and tobacco to minors.
 - The East Central District Health Department (ECDHD) has two programs, the Tobacco Prevention Program and the Youth Substance Abuse Prevention

Program, that work to address this problem. Tobacco compliance checks were conducted in two counties in the ECDHD service area. A total of six businesses had tobacco compliance checks conducted in their facilities from July 2013 through June 2014. These checks resulted in a compliance rate of 86 percent. Five alcohol compliance checks occurred during the year with a 91 percent compliance rate.

- The Panhandle Public Health District contracts with the Nebraska State Patrol and the Scottsbluff Police Department to complete two rounds of tobacco compliance checks throughout their service area. During the twelve months of this report, 192 checks were completed, with a 92 percent compliance rate.
- Many local health departments work with local child care agencies, school systems, and the general public to help ensure adherence to applicable laws and regulations focused on the health and safety of children.
 - The Three Rivers Public Health Department is the lead agency for Safe Kids Three Rivers and focused on the issues of preventing distracted driving, bike helmet use, and car seat safety during the past fiscal year. Through operating car seat inspection sites at both of their clinic locations and by hosting car seat safety events in the community, the department inspected 174 car seats for proper installation. Of these 174 seats, 138 of these seats were provided to low-income families. Parents are also taught that children up to the age of six years old must be in approved child safety seats and that anyone in violation of this law can be cited, even if they get cited for nothing else.

Spotlight On: The Lincoln-Lancaster County Health Department

Health and Safety Training for Child Care Staff

The Lincoln-Lancaster County Health Department and its Child Care Health Consultation Services division is tasked with educating child care centers in the community about the Lincoln Municipal Code 8.14, which requires health and safety training for child care staff every two years. Six hundred eighty-three child care staff attended the Health and Safety Training this year, which included information such as illness prevention and exclusion, diapering, hand washing, food safety, health laws, policies and regulations. The training was redesigned in 2013 to be more of an interactive experience for those attending. The training emulates an actual child care health and safety inspection, which is used to regulate child care facilities.

Essential Service 7: Link People to Needed Medical and Mental Health Services and Assure the Provision of Health Care when Otherwise not Available

This essential service includes assuring that socially disadvantaged people have a coordinated system of clinical care; culturally and linguistically appropriate materials and staff are available to link to services for special population groups; and targeted health information is available for high risk population groups.

- Local health departments are continually working to improve access to medical, dental, and behavioral health care for disadvantaged individuals in their districts.
 - Many local health departments continue to identify the lack of access to dental services in their service areas as a significant issue for the people in their districts. Several departments continue to expand and maintain dental services for residents with lower incomes. The Two Rivers Public Health Department's (TRPHD) Young Children Priority One Dental Program has provided 3,164 fluoride treatments and 1,675 sealants to high risk children and adults. The TRPHD was able to provide services to 2,877 children and 505 adults. The majority of those served are from minority populations, have no insurance or utilize Medicaid. Many of the children are under the age of three and would not be seen in a dental office. The program has maintained a 98 percent approval rating with the clients that it serves.
 - The Public Health Solutions District Health Department's Healthy Pathways consortium is intended to improve patient health outcomes, increase access to quality health care in the most appropriate setting, and reduce inappropriate use of hospital and health resources through working partnerships among health care providers and patients. Healthy Pathways is conducted through a collaborative, enhanced case management program. This case management for clients with complex medical issues is conducted by public health nurses in collaboration with health care providers, social workers, medical clinic staff, nurses, and other community agencies. The goal of case management includes: a) Increasing client self-care; b) Increased use of preventative services; and c) Increased use of a medical home for primary care.
 - The Elkhorn Logan Valley Public Health Department's (ELVPHD) established Colon Cancer Prevention Coalition distributed 321 Fecal Occult Blood Test (FOBT) kits at pharmacies, senior centers, health care clinics, and libraries. The ELVPHD was also recognized by Nebraska DHHS for having the highest FOBT return rate in the state among colon cancer coalitions the previous year at 58 percent.
 - The Sarpy Cass Department of Health and Wellness Senior CARE program offered reduced cost foot care clinics at senior centers throughout Sarpy and Cass counties. A total of 263 clients attended these clinics. An estimated \$11,870 was saved by these clients (based on average co-pay amount at a physician's office).

- The Three Rivers Public Health Department experienced significant growth in the number of patients seen in their Title X reproductive health clinic. The department increased the number of patients by almost 30 percent. Along with providing annual exams, and contraceptive and fertility counseling, the clinic provided 388 Sexually Transmitted Infections (STI) tests and 100 HIV tests. Approximately 74 percent of those served in the clinic do not have health insurance.
- All of the local health departments partner with DHHS on enrolling qualifying women in the “Every Woman Matters Program.” This program assists uninsured or underinsured women in accessing their annual health check-ups if they meet income eligibility guidelines.
- The Central District Health Department (CDHD) was integral in making the Heartland Health Center (federally qualified health center) a reality in February 2014. The CDHD continues to partner with Heartland Health Center and Third City Community Clinic (a free clinic staffed largely by volunteers) to assure gaps are being addressed without duplication of services. The CDHD partners with Third City Community Clinic in providing the public health dental hygiene program that takes place in the department’s Woman, Infants, and Children (WIC) area. The Public Health Dental Hygienist spends time weekly in the CDHD’s WIC clinic, seeing young children and their parents and providing teaching and dental hygiene services.

Spotlight On: The Douglas County Health Department

Direct Observed Therapy for Tuberculosis (TB) Patients

The Douglas County Health Department (DCHD) closely follows, investigates, and provides directly observed therapy (DOT) for active pulmonary and non-pulmonary TB infections. Directly observed therapy is the standard of care and policy of the Nebraska Tuberculosis Control Program. It assures that all TB medications are taken as prescribed. The benefits to DOT visits are: curing disease, preventing transmission, preventing drug resistance, and continued health assessments. Even with those benefits there are challenges and barriers, including intolerance to medication, side effects of medication, patient non-compliance, and the time required to provide quality patient care.

For fiscal year 2013, the DCHD identified 11 foreign-born TB cases of active pulmonary disease and non-pulmonary disease. A total of 833 DOT visits were completed, for the 11 cases, with a quarterly average of 208 DOT visits. Each case was visited daily during the course of his or her treatment to make certain compliance was maintained with treatment requirements. That allowed the DCHD to assist in rendering a patient as non-infectious.

- Several departments either directly provided or contracted with other agencies to expand funding for public immunization programs. They also provided cholesterol and blood pressure screenings. For example, in the West Central District Health Department's (WCDHD) jurisdiction, there are over 20 medical clinics and only four of those medical clinics provide immunizations. Although these medical clinics provide some immunizations, they do not necessarily provide all of the Advisory Committee on Immunization Practices (ACIP) recommended immunizations. The WCDHD is consistently the only clinic in their jurisdiction to offer all of the ACIP recommended immunizations.

Essential Service 8: Assure a Competent Public Health and Personal Health Care Workforce

This essential service includes assessment of workforce to meet community needs for public and personal health services; maintaining public health workforce standards; and adoption of continuous quality improvement and life-long learning programs for all members of the public health workforce, including opportunities for formal and informal public health leadership development.

- Nearly all of the local health departments are preparing for Public Health Accreditation through the Public Health Accreditation Board. Public Health Accreditation provides valuable, measurable feedback to health departments on their strengths and weaknesses. In addition, accreditation provides an opportunity to improve the quality and performance of various programs within the local health departments and requires a workforce development plan.
- Many local health departments are using a variety of techniques to evaluate staff members' public health competencies and to address any deficiencies present.
 - The Two Rivers Public Health Department received their Public Health Core Competency report from the UNMC Office of Public Health Practice training and education survey and will be utilizing these results and the 2014 revised Core Competencies to develop a Workforce Development Plan. This Plan will identify mandatory trainings that all staff must complete such as Incident Command trainings and Health Insurance Portability and Accountability Act (HIPAA); as well as position-specific trainings.
 - The Southeast District Health Department (SEDHD) staff have been trained in Culturally Linguistically Appropriate Services (CLAS) standards this year. Key positions that develop information attended training on health literacy. Health literacy training was also held at the SEDHD facility for staff.
 - In January 2014, staff of the Sarpy Cass Department of Health and Wellness completed the Public Health Foundation's Competency Assessment for Public Health Professionals. The department used these data as a starting point in identifying the professional development needs of the staff. A draft Continuous Quality

Improvement Plan and a Workforce Development Plan were developed in the spring of 2014. Implementation of the plans will begin in the fall of 2014.

- Staff members from local public health departments attended a variety of training sessions and conferences to increase their knowledge of public health in the past year. These included emergency preparedness, chronic disease prevention, and health surveillance. When possible, the Telehealth videoconferencing system or online webinars are used for trainings to save on travel costs.
 - The South Heartland District Health Department's public health risk coordinator attended a Mass Fatality Management Training presented by Nebraska DHHS. It outlined the roles and responsibilities of all governmental agencies and some private companies during a Mass Fatality Event. The public health risk coordinator also attended a course on Mass Antibiotic Dispensing hosted by Nebraska DHHS. The course included coordination of points of dispensing, transport of antibiotics, and calculations needed to insure all people in the district receive medical countermeasures within 48 hours.
 - The East Central District Health Department's (ECDHD) staff take part in an annual training in June. The main focus of the all staff training in June 2014 was customer service. Training also included the topics of: Adult/Child Abuse provided by Health and Human Services, Cultural Competency provided by the Latino American Commission of Nebraska, HIPAA and Ergonomics provided by the local hospital, Drug/Alcohol Abuse provided by law enforcement, Bloodborne Pathogens provided by Good Neighbor Community Health Center staff, Handwashing provided by the ECDHD staff, and Fire Safety, Material Safety Data Sheet, Tornado, and Emergencies provided by the facility manager of the ECDHD.
- Health department staff provided many educational materials, information, and training to other members of the public health workforce.
- Many of the local health departments have participated in the Great Plains Public Health Leadership Institute. The Institute is a one-year program conducted by faculty from the University of Nebraska Medical Center and the public health practice community. The program is designed to strengthen leadership knowledge, skills, and competencies in the public health workforce.
- Health department staff members continue to keep their licenses and certifications updated. They are also pursuing additional educational opportunities for professional development.

Essential Service 9: Evaluate Effectiveness, Accessibility, and Quality of Services within the Health Care Industry and Public Health Departments

This service calls for ongoing evaluation of health programs, based on analysis of health status and service utilization data, to assess program effectiveness and to provide information necessary for allocating resources and shaping programs.

- Almost all of Nebraska’s local public health departments have measured their work against national standards based on the ten essential services of public health. This is an evaluation of the effectiveness and quality of services provided by local public health departments. The departments incorporate the results into their strategic planning efforts in order to improve their performance. This statewide effort involves a partnership between the local public health departments and the Division of Public Health.
- As mentioned previously, many of the local health departments continue to prepare for national accreditation through the Public Health Accreditation Board (PHAB). The purpose of national accreditation is to advance the quality and performance of health departments in order to improve service, value, and accountability to stakeholders. Additionally, the local health departments continue to implement quality improvement initiatives in an effort to improve program efficiency.
 - In July of 2013, the Elkhorn Logan Valley Public Health Department conducted a quality improvement project aimed to increase Fecal Occult Blood Tests (FOBT) kit return rates from the 40 percent baseline to 50 percent. FOBT kits were monitored to determine if kits that had been picked up had been returned. Calls were made to participants who had picked up kits but had not returned them after three weeks. Up to three calling attempts were made and logged. This process continued through September 2013. At the end of the project, the return rate was calculated to be 55 percent, which exceeded the goal.
 - The Two Rivers Public Health Department’s (TRPHD) staff identified school participation in the DHHS School Illness Surveillance program as needing improvement. In 2012-2013, 20 schools participated in the TRPHD school illness surveillance program and none of them reported every week. Before the beginning of the 2013-2014 school year, the TRPHD staff personally visited all of the schools to discuss the program along with providing multiple resources and information that would be helpful to them during the upcoming school year. Each week, during the months of School Surveillance, the TRPHD provided timely and relevant information along with a reporting sheet to each school. DHHS School Illness Surveillance ended the last week of April 2014. Most of the 53 schools that participated in school surveillance did a good job of reporting almost every week. Eight schools sent their school illness reports every week and were awarded certificates of appreciation. This was an improvement of 265 percent on the number of schools participating and a 14 percent improvement on the number of schools that reported every week.
 - The Panhandle Public Health District’s Panhandle Worksite Wellness Council conducts annual evaluations to assess the workplace policies that have been implemented by businesses in the Panhandle and how those policies have impacted the health of employees. To identify workplace policies, they asked individuals responsible for wellness implementation at their respective worksites to complete a wellness survey.

- The South Heartland District Health Department's Quality Improvement team has been leading a project to improve departmental and staff efficiency, with a goal of cost savings and ultimately improving the department's ability to assist partners and the public. Staff have begun naming documents based on new naming conventions proposed by the QI team and have begun reorganizing files on the shared computer drive following a new organizational structure which will make it easier to find documents.
- The local health departments consistently evaluate the evidence-based programs, presentations, and services that they provide to their communities.
 - The Community Health Worker model is strongly supported as an evidence-based practice and many studies have supported its effectiveness in facilitating improvements in health status and quality of life in rural communities. The goals of this program are accomplished by utilizing Community Health Workers (CHW) who are bilingual and will act as a link between health care services and the target minority populations to educate, translate, interpret, and assist families in finding and accessing services available. Currently, the West Central District Health Department (WCDHD) has one CHW dedicated to this initiative. The CHW educates and assists individuals and groups in gaining control over their health and their lives, promotes healthy living by providing education about preventing disease and injury, and helps community residents understand and access formal health and human service systems. The CHW serves as an outreach worker, advocate, translator, educator, mentor, role model, counselor, and community organizer.
 - The Central District Health Department's (CDHD) CHAMP (Choosing Health and Maximizing Prevention) Program, working with an outside evaluator has clearly established measures of outcomes and processes. The CATCH and Discovery Kids Programs are evidence based and evaluation is included in the curricula. The CDHD worked with its evaluator to develop tools to measure effectiveness of the adult portion of the CHAMP Program.
 - The Lincoln Lancaster County Health Department's Information Management and Health Data staff developed reports and tools for supervisory and front-line staff using the evidence-based program – Healthy Families America. The dashboard and data feed from the department's electronic medical records allow supervisors to monitor how their staff are meeting regular benchmarks. It also provides staff with planning tools to improve their ability to schedule activities to meet the benchmarks.

Essential Service 10: Research and Gain New Insights and Innovative Solutions to Health Problems

This essential service includes linking with appropriate institutions of higher learning and research; engaging in economic and epidemiologic analyses to conduct needed health services outreach; and using evidence-based programs and best practices where possible.

- Many of the local public health departments received grants from the Division of Public Health to implement comprehensive evidence-based interventions that address one of their local health priorities. These departments are using innovative evidence-based approaches to address health problems such as poor nutrition practices and low levels of physical activity.
- The Nebraska DHHS Division of Public Health created a Public Health Practice-Based Research Network (PBRN) in partnership with the University of Nebraska Medical Center, College of Public Health. Several local health directors serve on the advisory committee of the PBRN. Additionally, the local public health departments are working with the PBRN to conduct research studies on the public health workforce, quality improvement, and accreditation in Nebraska. They have completed surveys that contribute to the study.
- The Institute of Medicine (IOM) contracted with researchers to do case studies of health literacy in three states: Louisiana, Arkansas, and Nebraska. The Northeast Nebraska Public Health Department's Health Director and the Nebraska Association of Local Health Directors' (NALHD) Executive Director attended a workshop where the case studies were presented to the IOM.
- The Lincoln-Lancaster County Health Department is part of a multi-City Department team that was instrumental in establishing a Complete Streets policy for the City and is now implementing that policy on Lincoln street projects. The Complete Streets strategy is an evidence-based strategy supported by the physical activity section of The Community Guide. The Complete Streets policy was established to direct planners and engineers to design transportation projects that begin with the goal that the street network will be used by drivers, transit users, pedestrians, and bicyclists. Complete Streets policies are intended to incorporate all forms of traffic and to move that traffic safely.
- The South Heartland District Health Department (SHDHD) agreed to provide SHDHD financial and employment data to UNMC College of Public Health researchers so that they may pilot a study on the economic impact of public health. This research is at the request of the Nebraska Practice-Based Research Network steering committee and, once the methods are worked out, would use data from all of the LB 692 health departments to conduct the full study.
- The Four Corners Health Department's (FCHD) Executive Director, Assistant Director, and Public Health Nurses have all participated in interviews for Public Health Students, Community Health Nursing Students, and other scholars to share information about Rural Public Health. The goal is to improve the crossover knowledge of academia and those working in public health.

Conclusion

During the thirteenth year of funding and twelfth full year of operation, continuing progress has been made to strengthen local public health departments throughout the state. All departments (receiving LB 692 and LB 1060 funding) provide all of the three core functions of public health: assessment, policy development, and assurance. In addition, all departments provide all of the ten essential services. They are allocating their funds based on health needs and priorities, as determined through regular comprehensive community health planning processes. The departments have assumed a key leadership role in the coordination and planning of public health services, and have been successful in bringing together local organizations to plan for emergencies such as pandemic influenza. They continue to fill in the gaps with key services. For example, the departments track and monitor infectious disease outbreaks, identify and follow up with individuals who have communicable diseases, and offer a wide variety of health promotion and disease prevention programs. Finally, considerable progress has been made in the areas of evaluation and research as health departments evaluate their own programs and activities and collaborate with research centers to participate in various public health studies. Nebraska's local public health departments are improving their accountability by completing a comparison of their work to national performance standards. The departments identify areas for improvement and make changes that improve the quality of their work and eventually meet the standards of the Public Health Accreditation Board.

Public Health Stories

The following short stories are included in this report to put more of a human face on public health. These stories cover a variety of issues and problems, but the common thread is that they demonstrate how public health agencies have contributed to and improved the quality of life for people in their communities.

Public Health Accreditation - The East Central District Health Department

The East Central District Health Department's (ECDHD) most substantial accomplishment this year was the submission of their documentation to the Public Health Accreditation Board (PHAB). The ECDHD is the first local health department (LHD) in the state that has submitted all of its documentation to the accreditation board, submitting in May 2014 after 12 months of preparation. They are proud of this and all of the work and time it took for this to occur. At this time, PHAB site reviewers have been assigned to the agency and they are reviewing the documentation that the ECDHD uploaded. The department anticipates a site visit early in the first quarter of 2015.

The impact of preparing for PHAB accreditation on the ECDHD staff and ultimately on the work their staff conduct is significant. The process of selecting and preparing documents that best represent what PHAB requests is one that spurs the LHD to assess where they are at and where they want to be with each measure. For example, ECDHD staff have been conducting alcohol and tobacco compliance checks for a number of years and have the data from these checks. They've shared the results of the compliance checks internally with their program managers, quality assurance team, senior leadership and their board of health. After compliance checks they create and publish an article for the largest local newspaper that indicates what the results of the checks were. The ECDHD also tracks the compliance check rates on their quarterly performance measures. These are all fine tasks to do. What the department realized in preparing for PHAB, is that though they do all of the things listed above, what they haven't done is to prepare an Annual Tobacco or Alcohol Compliance Report and provide it to the public, their partners, or their funders. This is an example of only one 'aha' moment that the department experienced through the PHAB readiness process. Though they do many, many things well, there is always room for improvement and PHAB helps LHD's to see this. Preparing for PHAB has helped the ECDHD to see where they can improve, where they have gaps or where they need to set a protocol in place. Ensuring that they take that additional step to provide the best service, the best outcome for their public and those they serve is what PHAB has helped them to visualize. The PHAB process has been well worth the time and effort involved.

The Panhandle Worksite Wellness Council - The Panhandle Public Health District

The Panhandle Public Health District (PPHD), which serves more than 50,000 residents in 10 counties of the rural Nebraska panhandle, collaborated with the Scotts Bluff County Health Department in 2011–2012 to engage more than 760 people in an assessment and community health improvement planning process guided by recommendations from CDC, the National Prevention Strategy, and *Healthy People 2020*. The Community Health Improvement Plan that resulted is aimed at strengthening the regional infrastructure for cross-sector action to increase

the number of Panhandle residents who are healthy at every stage of life. The majority of strategies in the plan focus on creating supportive environments in worksites, schools, and child care centers. Recognizing that workplace conditions have a major impact on physical and mental health, the PPHD has developed extensive programming in collaboration with employers. The Panhandle Worksite Wellness Council, a collaboration of the PPHD and over three dozen employers whose reach ranges from local to National, serves as a conduit to enhance policies, systems, and environmental supports in the workplace so that the healthy choice becomes the easy choice. Members of the Worksite Wellness Council are advancing NPS recommendations in the following areas:

Healthy Eating:

- Offering water and diet drinks in company refrigerators
- Adopting healthy meeting guidelines to increase fruit and veggie offerings
- Providing a room, refrigeration, and time for breastfeeding mothers to express their milk

Physical Activity:

- Using break time for physical activity
- Providing walking workstations

Injury and Violence Free Living:

- Implementing distracted driving policies

Mental and Emotional Well-Being:

- Creating flextime policies to better balance personal and work obligations

Clinical and Community Preventive Services:

- Hosting evidence-based programs like the National Diabetes Prevention Program directly on site

Tobacco Free Living:

- Establishing tobacco-free campuses

One in five employed persons in the Panhandle benefits from the implementation of these worksite wellness initiatives. The PPHD also supports people’s ability to take an active role in improving their health. The National Prevention Strategy’s (NPS) health literacy recommendations prompted the PPHD to participate in the Nebraska Association of Local Health Directors Rural Opportunities Project. This project provides training and technical assistance for area health care and social service providers to implement components of the National Action Plan to Improve Health Literacy.

The PPHD Director, connects the importance of NPS recommendations for Empowered People with the worksite wellness and health literacy initiatives, stating: “PPHD is working to empower Panhandle residents to have the knowledge, ability, resources, and motivation to make healthy choices.”

National Prevention Council, *Annual Status Report*, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2014. Available at <http://www.surgeongeneral.gov/initiatives/prevention/about/annualstatusreports.html>

Responding to a Disaster - The Northeast Nebraska Public Health Department

On the afternoon of June 16, 2014, the second tornado within a year hit the Northeast Nebraska Public Health District (NNPHD). The funnel traveled north on the Thurston-Wayne County line after decimating the town of Pilger in Stanton County, leaving two dead. This tornado traveled north into the southern part of Dixon County and wiped out several farms before leveling a small trailer park east of Wakefield, NE and some businesses. One of the businesses lost 140,000 chickens. At the meeting on Tuesday a.m. the NNPHD asked one of the Emergency Managers and one of the County Commissioners who is also on the NNPHD Board of Health what the status of the residents at the trailer park was. They said that the families were all fine and staying with friends and family members. Later that day, the two NNPHD Community Health Workers came to Wakefield and were able to locate those families who lost their homes in the trailer park. They were not “fine.” Those newly homeless families sought shelter in basements, in the back of a store, and in a garage because in spite of losing most of the few possessions that they had before the tornado hit, they went to work the morning after the storm. The NNPHD requested that a shelter be set up on Tuesday night, Wednesday night, and Thursday night. On Friday, the NNPHD demanded that a shelter be set up and finally the Red Cross was contacted to establish a shelter in the Wakefield school. Twenty-seven people stayed there on Friday night, twenty-seven people stayed there on Saturday night, and thirty people stayed there on Sunday night. The shelter remained open for about a week. There were many more people with needs that were overlooked. The NNPHD made sure that those needs were addressed.

Miles of Smiles - The North Central District Health Department

In 2011, the North Central District Health Department (NCDHD) started laying out a business plan for an oral health program in their district, as a large need was evident based on our prior two community health needs assessments. The NCDHD proceeded, with the assistance of the University of North Carolina College of Public Health, to establish a sustainable business plan. In 2012 an oral health screening and fluoride varnish program for preschool and elementary students living in the health department district was started.

The NCDHD started with very little funding or equity for this program. The department solicited the support of district dental offices and worked towards contracting with dental hygienists, many of whom volunteer some of their time and/or commute time and expenses. In the fall of 2012, the NCDHD was in nine schools and increased to 17 in the spring of 2013. With the assistance of the department’s Legislative funds they have increased to having all but one school participate in their program; jumping up to 37 schools participating in the Fall of 2013 and maintaining all 37 schools during the Spring of 2014. Because of their success with this program, this also lead them to a working relationship with the Nebraska College of Dentistry, providing a Sealant program in Boyd County where they provided 564 sealants to 137 youth, over 200% more than what the College of Dentistry was anticipating or has done before in a school. This program was so successful that the College of Dentistry is working with the NCDHD to provide

another sealant program, in Bassett, this fall, 2014. From there the department's strategic plan will be to accomplish this on their own in one community once per year, which is something the NCDHD never dreamed of two years ago. Some of the highlights from the program are below.

- Consistent averages of 90 percent of those students who receive an oral health screening are also receiving a fluoride varnish application.
- An average of 39 percent of those students receiving a fluoride varnish application are Medicaid Clients. The vast majority of the remaining students is under-dental-insured or have no dental coverage.
- The NDCHD have recorded a dramatic decrease in needed referrals for some type of necessary or urgent dental care, decreasing from 30 percent in fall of 2012 to 19 percent after the completion of spring 2014. This trend data indicates the program is working as youth are referred to dental providers and are receiving more timely intervention.

The NCDHD is currently well ahead of schedule in their business plan of this program, much due to the assistance of Nebraska Legislative funds.

Appendix A. Contact Information for Nebraska's Local Health Departments funded under the Nebraska Health Care Funding Act (LB 692)

North Central District Health Department

Roger Wiese, Director
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O'Neill, NE 68763
Phone: (402) 336-2406
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Northeast Nebraska Public Health Department

Deb Scholten, Director
117 West 3rd Street
Wayne, NE 68787
Phone: (402) 375-2200
Website: www.nnphd.org

Panhandle Public Health District

Kim Engel, Director
808 Box Butte Avenue/Box 337
Hemingford, NE 69348
Phone: (308) 487-3600
Website: www.pphd.org

Public Health Solutions District Health Department

M Jane Ford Witthoff, Health Director
995 East Highway 33, Suite 1
Crete, NE 68333
Phone: (402) 826-3880
Website: www.phsneb.org

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ATTACHMENT C



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.

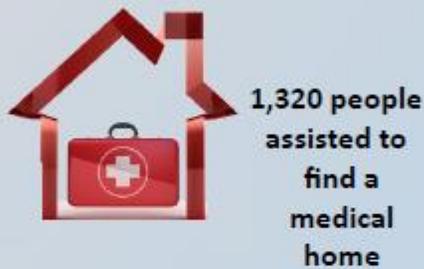
As you will see in this report, the work that is being done by the 2013-2014 MHI projects is fostering positive change and improving the health among minority populations in Nebraska. On behalf of the Office of Health Disparities and Health Equity, the projects funded during this past year, and Nebraska's 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.

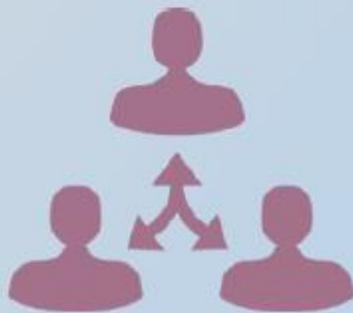
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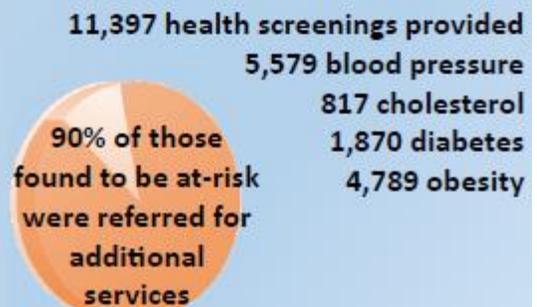
2013-2014 Minority Health Initiative Projects



27,141 interpretation sessions provided



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



2013-2014 Minority Health Initiative Projects



139 Community Health Workers

helped



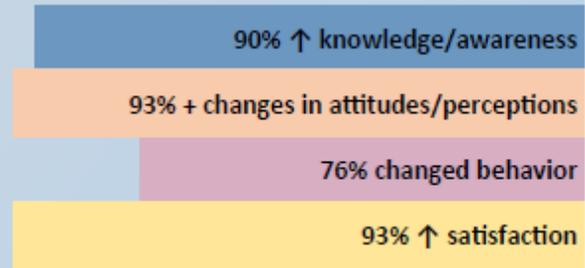
4,661 people

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"

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

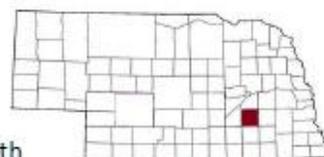
Projects (Congressional Districts 1 & 3)	Amount	County(ies)
Blue Valley Community Action	\$18,126.96	York
Carl T. Curtis Health Center/Omaha Tribe	\$81,012.07	Thurston
Central District Health Department	\$601,024.31	Buffalo, Dawson, Hall, Kearney, Merrick, Phelps
Chadron Native American Center	\$50,254.10	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
Total	\$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

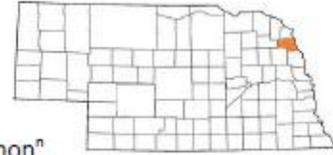
Blue Valley Behavioral Health, Four Corners Health Department

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 Umo^honⁿ 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

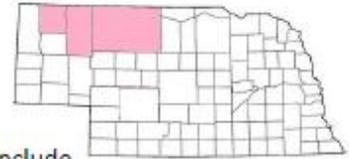
Two Rivers Public Health Department, Central Health Center, Central Nebraska Council on Alcoholism and Addictions, Community Fitness Initiative, Multicultural Coalition of Grand Island, community and cultural centers, employers, faith-based organizations, Lexington Regional Health Center

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

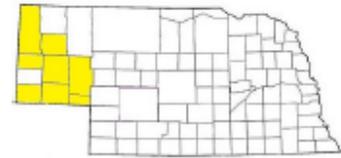
Project partners

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**



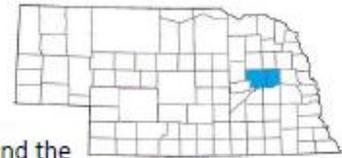
Community Action Partnership of Western Nebraska

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.

<p>Target health issues Obesity, diabetes, cardiovascular disease</p> <p>Dollars \$126,657.29 per year</p> <p>Clients served 338</p> <p>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</p>	<p style="text-align: center;">Activities & Outcomes July 1, 2013—June 30, 2014</p> <ul style="list-style-type: none">• 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
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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

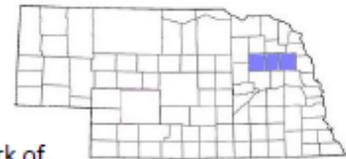
Alegent Creighton Health Clinic, Divine Mercy Church, Good Neighbor Community Health Center, Schuyler Community Resource Center, St. Bonaventure Church

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

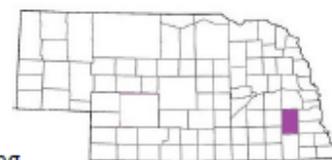


With prevention as the primary priority, this project continues the existing work of reducing obesity and the subsequent chronic disease impact that obesity triggers among all minority populations with a few minor enhancements to the project. Program staff, with the assistance from community health workers, 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.

<p>Target health issues Obesity, diabetes, cardiovascular disease</p> <p>Other health issues As indicated are necessary by the people served</p> <p>Dollars \$68,284.63 per year</p> <p>Clients served 1,212</p> <p>Project partners Norfolk Community Health Care Clinic, Madison Medical Clinic, other local medical providers, Tyson Foods, local schools</p>	<p style="text-align: center;">Activities & Outcomes July 1, 2013—June 30, 2014</p> <p><u>Cardiovascular Group Education:</u></p> <ul style="list-style-type: none">83% of participants increased their knowledge of personal health indicators94% of participants reported increases in exercise/activity72% of participants (with two measures) decreased their weight <p><u>Individual Diabetes Self-Management Sessions:</u></p> <ul style="list-style-type: none">83% of participants increased their knowledge of personal health indicators94% reported increases in exercise/activity <p><u>Physical Activity Classes:</u></p> <ul style="list-style-type: none">Of those identified as overweight/obese, 36% lost weight <p><u>Topic of the Month Sessions:</u></p> <ul style="list-style-type: none">97% of 146 individuals improved knowledge according to pre-/post-test measures <p><u>Referrals:</u></p> <ul style="list-style-type: none">98% of the people reached were provided with access to services and 86% followed through with completing their referral appointment
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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

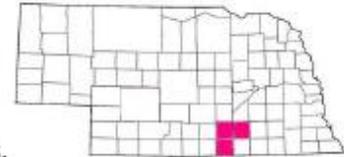
Asian Community & Cultural Center, Clinic with a Heart, Clyde Malone Community Center, El Centro de las Americas, Lancaster County Medical Society, MilkWorks, People's Health Center, UNMC College of Dentistry, Health Hub at Center for People in Need

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

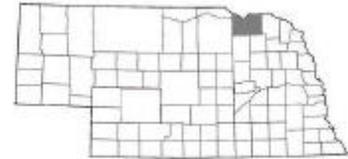
Mary Lanning Diabetes Department, Mary Lanning Healthcare Foundation, YMCA, South Heartland District Health Department

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

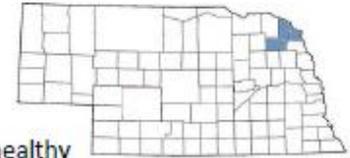
Santee Sioux Nation
(Santee Health
Center)

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

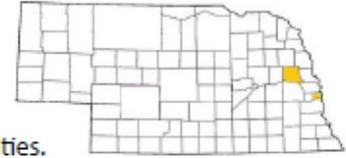
Northeast Nebraska Community Action Partnership, Salem Evangelical Church, Gardner Public Library, local hospitals, medical clinics, city and county governments

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

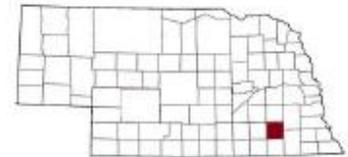
Nebraska Methodist College, Hope Medical Outreach Coalition, Midland University

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

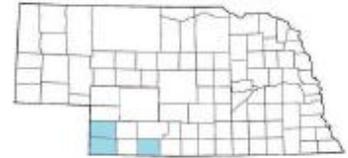
761

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

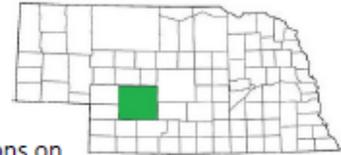
Activities & Outcomes April 1, 2013—June 30, 2014

* 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

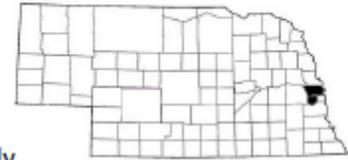
West Central District Health Department



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.

	Activities & Outcomes July 1, 2013—June 30, 2014
Target health issues Obesity, cancer, cardiovascular disease, diabetes	<ul style="list-style-type: none">• 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
Other health issues Mental health	
Dollars \$34,200.94 per year	
Clients served 726	
Project partners Great Plains Regional Medical Center	

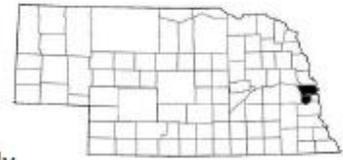
Charles Drew Health Center



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.

Activities & Outcomes July 1, 2013—June 30, 2014	
<p>Target health issues Cardiovascular disease, asthma, diabetes, obesity, infant mortality</p>	<ul style="list-style-type: none"> • 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%
<p>Other health issues Depression, oral health, substance and alcohol use</p>	
<p>Dollars \$714,050.50</p>	
<p>Clients served 10,451 in calendar year 2013</p>	
<p>Minority clients 69.8% or 7,295</p>	

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.

Activities & Outcomes January—June 2014	
Target health issues Diabetes, infant mortality, cardiovascular disease	<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%)
Other health issues Tobacco or alcohol use, depression, asthma, pediatric oral health	<ul style="list-style-type: none">• 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
Dollars \$714,050.50	<ul style="list-style-type: none">• 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
Clients served 27,108 in calendar year 2013	<ul style="list-style-type: none">• 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
Minority clients 85.8% or 23,259	<ul style="list-style-type: none">• Only 4.7% of babies born to OneWorld patients were of low birth weight

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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