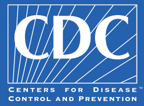
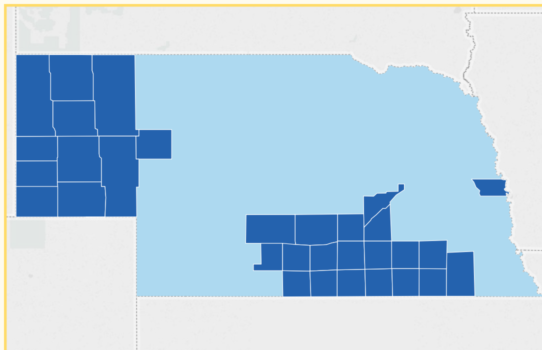
State and Local Public Health Actions 1422 Program

Nebraska | PROGRAM PROFILE



The Nebraska Department of Health and Human Services is a state awardee of the State and Local Public Health Actions 1422 (SLPHA-1422) program, which aims to promote and reinforce healthful behaviors, best practices, and decrease health disparities to prevent and reduce chronic disease.



TARGETED COMMUNITY

AWARD
$2,640,000

AMOUNT TO SUBAWARDEES
$1,727,996

PERCENTAGE OF AWARD TO SUBAWARDEES
65.5%

SUBAWARDEES

- Central District Health Department
- Douglas County Health Department
- Panhandle Public Health District
- Public Health Solutions District Health Department
- South Heartland District Health Department
- Two Rivers Public Health Department

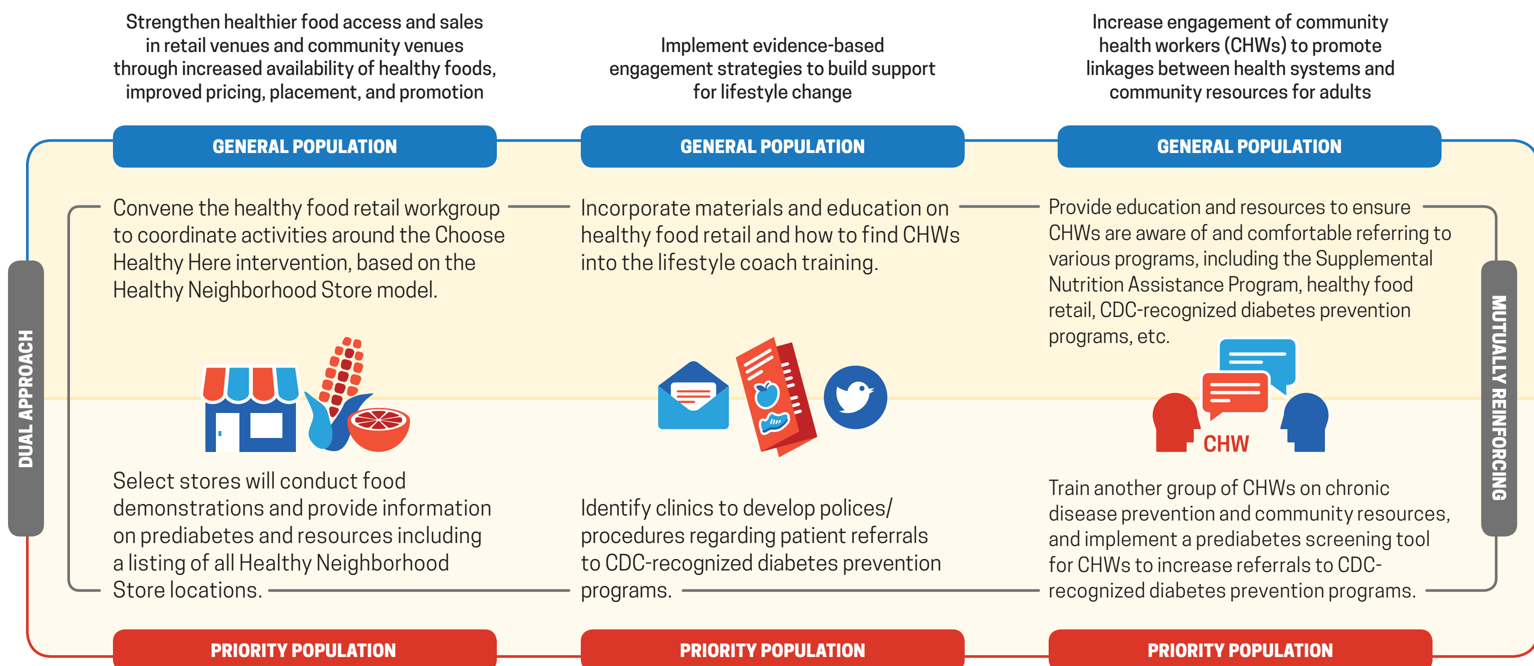
TYPES OF PARTNERS (NO.)

- Nonprofit (12)
- Private Business (11)
- Coalition (5)
- Other local government entity (5)
- University (5)
- Hospital (3)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Adams, Banner, Box Butte, Buffalo, Cheyenne, Clay, Dawes, Dawson, Deuel, Douglas, Fillmore, Franklin, Gage, Garden, Gosper, Grant, Hall, Hamilton, Harlan, Jefferson, Kearney, Kimball, Merrick, Morrill, Nuckolls, Phelps, Saline, Scotts Bluff, Sheridan, Sioux, Thayer, and Webster counties	Low-income including Medicaid-eligible adults	▪ Community capacity/ infrastructure ▪ Disease burden ▪ Sociodemographics

FOCUS ON HEALTH FOR ALL: DUAL APPROACH AND MUTUALLY REINFORCING STRATEGIES

The SLPHA-1422 program aims to reduce health disparities by supporting states, large cities, and local communities working together to implement the Dual Approach using a set of comprehensive environmental, health system, and community-clinical linkage strategies. These strategies aim to reach both the general population at the state or large-city level and priority populations across the state or large city, and within targeted communities. The implementation of each approach supports the other in a mutually reinforcing way that strengthens their combined impact. The graphic below depicts examples of the Dual Approach and mutually reinforcing strategies with three strategies selected by the awardee.

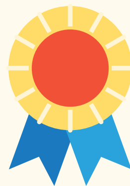


SUCCESS STORIES

In Nebraska, minority and low-income adults experience substantial health and health care inequities. As Nebraska cities grow in population and the prevalence of chronic disease rises, the state and local health departments are approaching these health problems in new ways.

In Grand Island, located in the center of the state, 71% of the population is overweight or obese, which is 4% higher than the state average. Only 69% of the population engages in physical activity during their leisure time. To address this problem, Central District Health Department was selected to receive guidance from the Nebraska Department of Health and Human Services (NDHHS) to ensure that their new **Metropolitan Planning Organization Long Range Transportation Plan** includes walking, biking, and even transit riders (normally not included in a planning process that prioritizes the car). The initiative established a strong steering committee and engaged numerous stakeholders and community members, who are now reviewing the pedestrian/bike plan and working to pass a Complete Streets policy.

In Omaha, an effort to improve the quality of care for low-income residents is underway. To address the high hypertension and prediabetes rates, the NDHHS and Douglas County Health Department partnered with Wide River and South Omaha Medical Associates (SOMA) to improve health care through policy and procedure changes. They developed an **electronic health records (EHR) system** with a patient portal to reduce errors, improve quality of care, and deliver health care more efficiently. With SOMA adopting the use of the health information technology, workflow has improved leading to a 25% increase in patient visits.



50+ participants joined to create a community-driven plan to increase the overall health and safety of the community.

145 patients signed up for the EHR patient portal.

25% increase in patient visits created by workflow improvements.

SUBAWARDEE PERFORMANCE MEASURE HIGHLIGHTS

The Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion funds the SLPHA 1422 program. The following are subawardee performance measure results by division.

DIVISION OF NUTRITION, PHYSICAL ACTIVITY, AND OBESITY

34 (including 13 at baseline) key community locations are implementing nutrition and beverage standards.

165 (including 143 at baseline) retail and community venues are increasing availability, affordability, placement, and/or promotion of healthy foods.

25 community venues are promoting physical activity through signage, joint use agreements, and/or worksite policies.

102,637 adults have access to community venues promoting physical activity.

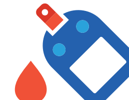
DIVISION FOR HEART DISEASE AND STROKE PREVENTION

482,867 patients are participating in healthcare systems with EHRs appropriate for treating patients with high blood pressure.

33,003 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

6 healthcare systems are engaging CHWs to link patients to community resources that promote self-management of high blood pressure.

8 healthcare systems are implementing a community referral system to evidence-based lifestyle change programs for people with hypertension.



DIVISION OF DIABETES TRANSLATION

289,696 adults reached through evidence-based engagement strategies.

338 adults at high risk for type 2 diabetes enrolled in CDC-recognized diabetes prevention programs.

39,899 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

6 healthcare systems engaged with CHWs to link patients to community resources that promote the prevention of type 2 diabetes.

For more information, please email **1422evaluation@cdc.gov**.

* Targeted community, for the purpose of this funding opportunity announcement (FOA), is defined as a county, metropolitan statistical area, or a group of contiguous counties. These communities must have significant disease burden and sufficient combined populations to allow the strategies supported by this FOA to reach significant numbers of people.

** Priority populations are high-risk, high-burden populations with prediabetes or uncontrolled high blood pressure that experience racial/ethnic or socioeconomic health disparities, including inadequate access to care, poor quality of care, or low income.

LAST UPDATED 11/30/2017