Proceedings of the Conference

Addressing Health Disparities: Policy, Systems, and Environments in Preventing and Improving Chronic Disease

Conference Summary

Center for Promoting Health and Health Equality
Health Sciences-Multicultural and Community
Affairs Health Sciences' Continuing Education

April 29, 2017

Conference Summary

Addressing Health Disparities Seminar
Effects of Policies, Systems, and Environment in Preventing and Improving Chronic Disease

Creighton University Sponsors
Center for Promoting Health and Health Equity
Health Science-Multicultural and Community Affairs
Health Science-Continuing Education

April 29, 2017
Creighton University
Omaha, NE

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Preface

Policy, Systems, and Environmental (PSE) Improvements*

What is PSE Improvements?

The health of an individual is influenced by three basic factors: biology, behavior, and environment. When determining how to create changing in health, we know that changing an individual's biology is not feasible and changing an individual's behavior is challenging. This leaves addressing the environment in which an individual lives, works, learns, and plays (CDC, 2013). We know that where you live affects how you live. Policy, systems, and environmental improvements is a way to modify the environment that defaults to the healthier choice for all which has more of an impact on the health of the population. We will begin this section by determining what are policy, systems, and environmental improvements and then we will move on the why PSE Improvements are important.

- Policy Improvement: Policy improvement may be formal in the form of a law, ordinance, resolution, mandate, regulation, and rules or informal in the form of the codes of operations that are not drafted. This type of improvement greatly influences the daily decision we make about our health. Examples of policy improvement would be tax on unhealthy goods or school policy prohibiting junk food in vending machines.
- Systems Improvement: Systems improvement refers to altering rules and regulations that impact all elements within an organization, institution, or system. This type of improvement often focuses on infrastructure within a setting and generally works closely with policy change. Types of systems include schools, parks, and transportation. An example of systems improvement would be creating a plan that links time off during work hours to physical activity.
- Environmental Improvements: Environmental improvement is material adjustments made to the social, economic, or physical environment. Examples of environmental change can be installing sidewalks, signage, and recreation areas into community design.

Major health problems will not be solved solely by individual actions or choices. Health problems are influenced by societal policies and environments that in some way maintain behavior or fail to foster healthier options. By being preventative in improving environments, we can prevent individuals from becoming chronically ill. With PSE improvements, practical health choices are made available to all community members.

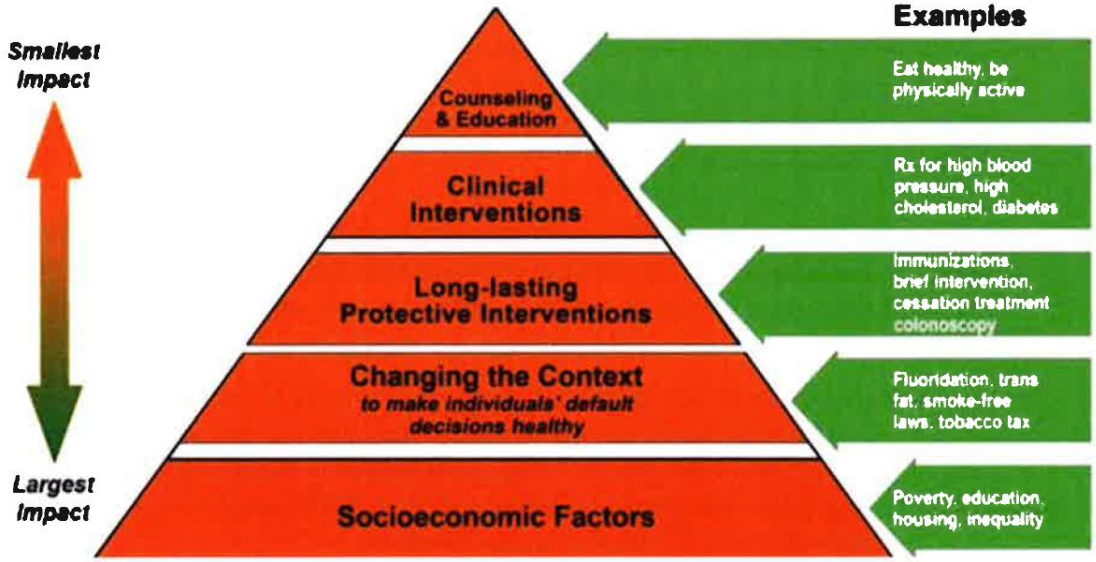
Why is PSE Improvements Important?

As stated earlier, PSE improvements create a default choice for healthy behaviors. These healthier choices created through policy, systems, and environmental improvements create real and feasible choices for individuals in the community that will impact their behavior. This in turn impacts the health of the community and decreases the rates of individuals with chronic illnesses. PSE improvements are instrumental in creating and fostering the desired health behaviors in communities (NACCHO, 2011).

When we look at the three basic factors that influence the health of an individual, the environmental factor can be broken down into social determinates of health. According to the World Health Organization (2015), social determinates of health are circumstances an individual is born into which are influenced by economics, social policies, and politics. An individual's education, housing, and access to healthcare services influence their health. Decades of research has provided us with information on how we can intervene to improve health.

Dr. Thomas R. Frieden (2010) constructed the health impact pyramid (Figure 1) which offers guidance in determining what strategies will have the greatest impact. This pyramid shows that the strategies that are located towards the bottom have the greatest population impact. Since we are addressing policy, systems, and environmental improvements, we will focus on strategies that change the context to make an individual's default decisions healthy. An example of a strategy that changes the context is fluoridation of the water supply. This policy was put in place to have fluoride added to public water supplies to reduce tooth decay.

FIGURE 1. The health impact pyramid.



Programs vs. PSE Improvements

Programs and events have been the main strategies implements over the years to address health outcomes in individuals. Decades of research have provided us with enough information to know that programs and events alone do not create a great enough impact on the health or behaviors of individuals or on the health of the community. Here are the characteristics of programs in contrast to characteristics of PSE improvements.

Characteristics of Programs

- One time
- Additive: often results in only short-term behavior
- Individual level
- Not integrated into ongoing plan
- Short term
- Non-sustaining

Characteristics of PSE Improvements

- Ongoing
- Foundational: often produces behavior changes over time
- Population level
- Part of an ongoing plan
- Long term
- Sustaining

Programs and events can be used in comprehensive approach with PSE improvements as long as they are appropriate for the concerted efforts. Although programs can sometimes result in behavior changes for an individual or community, if the efforts are not paired with PSE improvements, the program may not be sustainable and will cease to exist (Minnesota Department of Health, 2014). Below is a chart (Figure 2) provided by Communities in Putting Prevention to Work (CPPW) that gives us examples of programs and events in certain settings and how those programs align with PSE improvements.

FIGURE 2. Difference between PSE improvements and programs.

What's the Difference Between Policy, Systems and Environmental Change and Programs?

Setting	Programs/Events	Policy, Systems and Environmental Change
School	Celebrate national nutrition month	Add fruits and vegetables to the a la carte options in schools
Community	Host a community bike ride and parade	Implement a Complete Streets policy to ensure community roads are constructed for safe biking, walking and driving
Worksite	Hold health screenings for staff	Implement a healthy vending machine policy that offers healthy snacks at an affordable price
Hospital	Hold free breastfeeding courses for new moms	Implement the WHO 10 Steps to Successful Breastfeeding and become a baby friendly hospital

Barriers to PSE Improvements

When creating policy, systems, and environmental improvements we must be aware of potential barriers. Some barriers include not knowing the level of change you can expect, not balancing programming with policy efforts, locations may not be suitable, and change takes time. Another serious barrier to PSE improvements are the fears and misconceptions that arise when policy changes are proposed (Lyn, et. Al, 2013).

Knowing and addressing barriers to PSE improvements beforehand will help with its success. For example, many groups across the United States work to improve the quality of indoor air and reduce exposure to secondhand smoke for their community members by proposing policies that would prohibit smoking indoors in work sites, restaurants, bars, and public shared spaces. These groups have to know what level of change their

communities are ready for and the fears and misconceptions people have. To address these barriers, one thing the groups do is conduct focus groups with community members to find out exactly what dears they have and what policy would be feasible in their community. Moving forward with this policy change, the groups need to know exactly what programs and events would be put into place to help the policy become a success. One program would be to make smoking cessation services available. There must be a balance between programs and PSE improvements because programs may not be sustainable by themselves and policy improvements can be reinforced.

One thing to always remember is that change takes time. Success will not happen overnight and people will not accept all PSE improvements right away. Eventually, the improvement becomes the normal behavior and we can see the impact that it has on the health of the community.

*Adapted from the Creighton University REACH Health Ambassador Training Manual, pages 23-27 2016

Purpose and Objectives

The Center for Promoting Health and Health Equality (CPHHE) and Health Science-Multicultural and Community Affairs (HS-MACA) collaborated to discuss policy, systems, and environments in preventing and improving chronic disease. The Health Science's Continuing Education department coordinated and approved the seminar for the award of CME credits.

At the end of the seminar, the participants were able to achieve the following objectives:

- Recognize what Policies, Systems, and Environmental (PSE) changes mean,
- Discuss how to evaluate, develop, and implements new PSEs,
- Recognize PSE outcomes after changes have been made, and
- Discuss policies for Nebraska Medicaid coverage, its process, and sustainability.

Meeting Sponsors and Host

Creighton University
Founded in 1878, Creighton is one of 28 Jesuit colleges and universities in the U.S. More than 8,000 undergraduate, graduate, and professional students come to Creighton each year to find their place in the world through lives of leadership and service. As members of the Society of Jesus, the more than 17,000 Jesuits serving around the world continue the Ignatian tradition by advancing education. Creighton University, located in Omaha, NE, offers a top-ranked education in the Jesuit tradition for people who want to contribute something meaningful to the world. At Creighton students, faculty, and staff thrive in a supportive community committed to Jesuit, Catholic values and traditions. Here students learn to become leaders through service to others.

Center for Promoting Health and Health Equality
The Center for Promoting Health and Health Equality (CPHHE) is a community-campus collaboration that promotes health and health equality through research, education and intervention. Community members and Creighton University health sciences faculty comprise a partnership of equal parity using funding from Nebraska Tobacco LB-692 monies. The partnership develops, evaluates, and disseminates multidisciplinary culturally competent research methodologies and health promotion education, behavior interventions to improve the health of vulnerable populations and reduce health disparities. Community health is the primary focus.

Health Sciences-Multicultural and Community Affairs
Founded in 2000, Creighton's office of Health Sciences Multicultural and Community Affairs (HS-MACA) is recognized as an innovative department that pioneers and synthesizes community, education and research in the development of future healthcare professionals who are culturally aware and work toward the elimination of health disparities. Health Sciences Multicultural and Community Affairs work to recruit and retain qualified disadvantaged students. The department offers academic and professional development through health careers seminars, summer research programs, financial counseling, academic counseling, scholarships, social and cultural activities, and pre-health advising.

Health Sciences' Continuing Education
Creighton University's Health Sciences Continuing Education Division provides top-quality interprofessional continuing education programs -- for the team by the team. Creighton offers programs that help you as a physician, dentist, dental assistant, pharmacist, nurse, physical therapist, occupational therapist or other healthcare professional enhance the quality of your clinical practices and provide comprehensive and compassionate care for diverse populations. Additionally, Creighton sponsors over 100 conferences annually, attracting attendees from the local, national, and international healthcare communities.

Conference Agenda

8:00 a.m. **Welcome/Opening Remarks**
Sade Kosoko–Lasaki, M.D., M.S.P.H., M.B.A., FAASS
Thomas F. Murray, Ph.D.
Doris Lassiter, B.S

8:10 a.m. **Agenda Overview, Logistics, Charge to Audience**
Mervin Vasser, M.P.A.

8:25 a.m. **Present Dr. Frank T. Peak Memorial Health Disparities Essay Award to Contest Winner**
Sade Kosoko-Lasaki, M.D., M.S.P.H., M.B.A., FAASS
John R. Stone, M.D., Ph.D.
Mrs. Lyris Peak

8:55 a.m. **Overview of Success of the Center for Promoting Health and Health Equality (CPHHE)**
Speaker: Doris Lassiter, B.S.

9:05 a.m. **Changing Policy, System, Environment (PSE): National Best Practices**
Speaker: Ali S. Khan, M.D., M.P.H.

9:35 a.m. **Changing Policy, System, Environment (PSE): REACH Program in Omaha**
Speaker: Richard L. Brown, Ph.D., FACHE

9:50 a.m. **Panel Discussions 1: Development of Policies: Local and National Focus**
Moderator: Stephen B. Jackson, M.P.H.
Speakers: Willie Barney, B.A.
Deb Esser, M.D.
Sherri Nared-Brooks, M.A.
Brenda Council, J.D.

11:00 a.m. **Panel Discussions 2: Policy, System, Environment (PSE) Changes in the REACH Program**
Moderator: Doris Lassiter, B.S.
Speakers: Evelyn Gould, M.F.A, M.B.A.
Eric Burgin
Jeffrey Williams, M.B.A.
Rev. Portia Cavitt
Jeffrey Smith, Ph.D., N.C.C.

12:00 p.m. **Practical Ethics for Health Policy**
John R. Stone, M.D., Ph.D.

1:00 p.m. **Keynote Address – Achieving Health and Well-being for All**
Keynote Speaker: Denise Koo, M.D., M.P.H.

2:00 p.m. **Panel Discussions 3: Measuring Policy, System, Environment (PSE) and Sustainability in Nebraska: Medicaid Approach**

Moderator: Kenny McMorris, M.P.A., FACHE, CHCEF
Speakers: Kathleen A. Mallatt
Ryan Sadler, M.B.A.
Melanie Surber, M.N.S, RN
Lisa White, M.D.

3:30 p.m. **Case Studies Breakout** - **Solutions**

Group 1: Lead Contamination in Omaha
Facilitator: Tom Warren, M.S.
Recorder: Joel Dougherty

Group 2: Sexually Transmitted Diseases (STDs):
Facilitator: Stephen B. Jackson, M.P.H.
Recorder: D. Roselyn Cerutis, Ph.D.

Group 3: Tobacco in Omaha
Facilitator: Martha Nunn, M.S., D.D.S., Ph.D.
Recorder: Jeanne Burke, MLIS, M.Ed.

4:15 p.m. **Q & A / Closing** – Sade Kosoko-Lasaki, M.D., M.S.P.H., M.B.A., FAASS

Proceeds

Opening Remarks

Dr. Sade Kosoko-Lasaki, Associate Vice Provost, Professor in Creighton's School of Medicine, Co-Founder and Co-Director of CPHHE started the seminar by welcoming all participants to the 10th annual seminar Addressing Health Disparities: Effects of Policies, Systems, and Environments in Preventing Chronic Disease.

The primary purpose and use of the Nebraska Tobacco Settlement Biomedical Research Development Fund (NTSBRDF) program at Creighton University is to increase funding from federal health agencies and institutes with a concentration in two areas: Research Program and Infrastructure Development and Minority Health Research Grants.

With the support of the NTSBRDF, Creighton University continues to address some of the world's most complex and perplexing healthcare challenges. Researchers play a fundamental role in enhancing the quality of life for individuals and in expanding the research community in Nebraska and the region.

In 2015-2016, the collective efforts of the research investigators at CU produced significant results: Creighton University received approximately $26.1 million in extramural funding and investigators were awarded federal grants from the Department of Defense, National Institutes of Health, National Science Foundation, and Centers for Disease Control and Prevention, as well as many other non-federal grants from corporations and foundations. Below are the grants individuals have received through the infrastructure support from.

- From 2009-2017 total over $1.3 million
- 2015-2016: $178,268 for minority health research
- Since 2009:
    - To: Principal Investigator Sade Kosoko-Lasaki, M.D.
    - Through: Health Science Multicultural and Community Affairs (HS-MACA)
    - And the Center for Promoting Health and Health Equality (CPHHE)
    - Current Year Funding Yield: $697,339.00.

- Department of Defense
    - Prostate Cancer Genetics in African Americans
    - Value: $731,278 for 3 years

- Center for Disease Control
    - Center for Promoting Health and Health Equality – Racial and Ethnic Approaches to Community Health (CPHHE-REACH)
    - Value: $1,478,778 for 3 years

Frank Peak Memorial Health Disparities Award

The first annual Frank Peak Memorial Health Disparities Essay Award was then launched. Dr. Frank Peak was one of the founders of CPHHE. The essay award is in recognition of his work in addressing health disparities at Creighton University and in Nebraska. The essay award is open to all students at Creighton University (undergraduate, graduate, and professional) who are required to choose and write on one of the following topics on health disparities:

- Employing a social justice lens, analyze relationships between social determinants and health inequities or health disparities. Argue for at least one remediation that social justice would support.
- Employing a social justice lens, analyze how culture, class, and other social factors influence healthcare inequities/disparities. Argue for at least one way that healthcare professionals or institutions should respond.

In the inaugural year of the award, there were eight entries which were reviewed by a CPHHE committee. First prize was awarded to Morgan Murphy, 1st year medical student. Ms. Murphy was awarded $500 and a plaque presented by Mrs. Lyric Peak and Drs. Kosoko-Lasaki and Stone. Below is the abstract written by Morgan Murphey.

Smudged Glasses: Considering Healthcare in the Context of Bias
By: Morgan Murphey

The construct of individual bias is deeply ingrained in the human psyche. Every person has a distinct perspective, shaped by genetic predispositions, life experiences and education. While some suggest the world might be a better place if bias did not exist, there is in fact an evolutionary advantage to having and employing biases. In a world where individuals are faced with an overwhelming amount of information, having predefined constructs and templates can aid in organization and management of information. For example, by recognizing that a foul smell may indicate rotting, one can quickly judge food as safe to eat based on smell alone. In contrast, when it comes to healthcare, there is no place for bias.

When medical professionals look at patients through the framework of personal biases, critical decisions may be confused or clouded by individual perceptions. Recent studies have shown that certain patient populations are treated differently in the face of shared medical conditions. One study demonstrated that, even after controlling for demographics, comorbidities, income status and geographic variation, eligible black men, black women and white women were less likely to receive coronary revascularization versus white men (Freund, Jacobs et al. 2012). This research indicates that racial and gender prejudices result in disparities in medical care. Medical decision-making should be based on clinical evidence and should not be swayed by personal viewpoints. For those

professionals that are unable to put aside personal beliefs, patient care should be deferred to a different provider without conflicting values or biases.

While it may seem logical to conclude that personal biases should not influence healthcare decision-making, an often overlooked problem is implicit bias. Research has shown that many people hold subconscious, or implicit, biases (Buchs and Mulitalo 2016). Like smudges on reading glasses, many are not acutely aware of their implicit biases, yet they still affect an individual's view of the world. These beliefs and frameworks are often unrecognized or unrealized, yet still affect behavior and treatment decisions. Given the role of implicit bias, healthcare professionals should employ implicit association tests to identify those prejudices that are yet unrealized. Tools, such as Project Implicit, should be utilized to identify and increase awareness of implicit beliefs. Given improved awareness and understanding, there is an opportunity to mitigate the effect of bias in healthcare practices.

Community Academic Partnerships

Mrs. Doris Lassiter, Center for Promoting Health and Health Equality (CPHHE) Chair and a community partner, discussed CPHHE and its role in Omaha and the region. At the foundation, CPHHE is a community/academic partnership that plans to eliminate health disparities in Nebraska based on a triple core approach that rests on a foundation of robust community and academic intersectorial partnering and collection.

The guiding values of CPHHE are respect, justice, care, and other ethical values that inform this collaborative-partnering endeavor. Because CPHHE values good health, it champions enhancing quality of life and eliminating disparities that lead to negative health outcomes. CPHHE promotes partnerships that balances power and shares resources among equitably among partners to support three core areas:

Intervention & Awareness Core
Objective: Strengthen the core intervention of the Center through programs that have been developed and implemented in educating and serving community members based on their health care priorities as determined by the community

Training & Development Core
Objective: To expand and sustain career development opportunities for faculty and students who are interested in minority health.

Research Core
Objective: To develop and promote research that targets elimination of health disparities

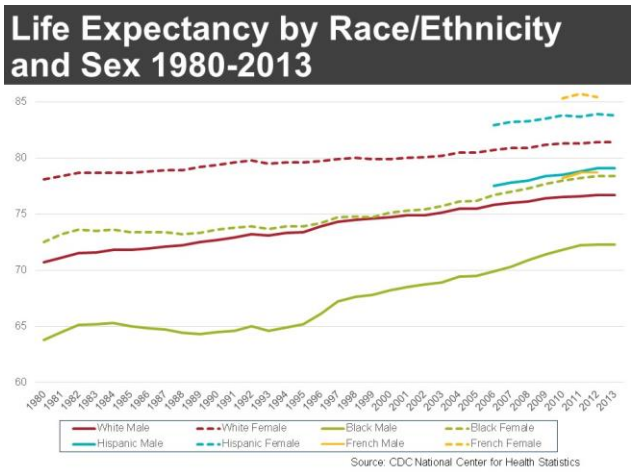
CPHHE's mission is to identify health disparities and effectively promote health equality and health improvement in a collaborative community-Creighton partnership in accord with Ignatian values. CPHHE significantly contributes to the elimination of ethnic, racial, and other health disparities in Nebraska and the region. The vision is that CPHHE is valued and respected by communities and academia.

CPHHE has had many successes throughout its years. Notable programs are: Inspiring Change, a chronic disease education and prevention program held in churches and public housing; and CPHHE-REACH, Racial and Ethnic Approaches to Community Health, a three year, ~$1.5M award from the Centers for Disease Prevention and Control (CDC). REACH aims to educate, develop, and implement policy, systems, and environmental (PSE) improvements that promote physical activities, resulting in an ultimate reduction in chronic disease within the African-American/Black community in Omaha Nebraska.

National Best Practices of PSE

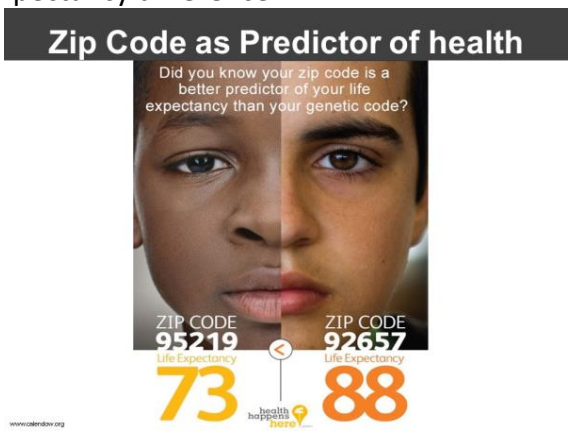
Dr. Ali Khan, Dean of College of Public Health, University of Nebraska Medical Center delivered a presentation on Changing Policy, System, Environment (PSE): National Best Practice.

In 1985, Department of Human Services (DHHS) published Secretary's Task Force on Black and Minority Health, also known as the Heckler Report. This was the first time DHHS had consolidated minority health issues into one report and Americans were seeing improvements in their life expectancy and overall health status. It was also one of the first times we were able to see that African Americans, Hispanics, Native Americans, and other minorities were not seeing the same improvements in their health and life expectancy that non-minorities were.



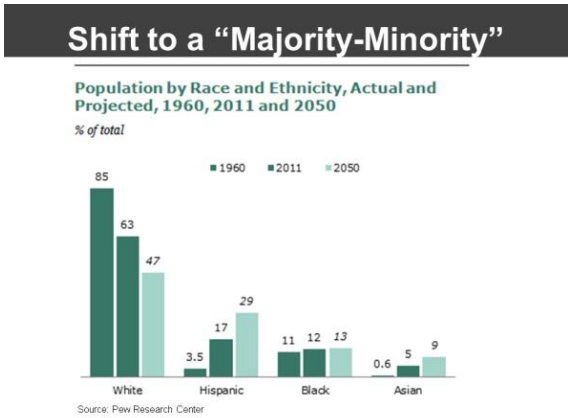
Closely examining life expectancy rates, we notice the differences between Whites, Hispanics, and Blacks. The United States focuses on disparities within its borders, but there are significant global disparities we should understand. Hispanic males/females have the highest life expectancy in US at 77 and then you go to France and its population is doing better than Americans at an average life expectancy of 82.

Your zip codes are another predictor of your health and it's often better than your genetic code. For example, Creighton University's zip code is 68178 and the zip code of a west Omaha area is 68154. If you go from 68178 to 68154 (about a 20-mile difference), there is a 12 year life expectancy difference.

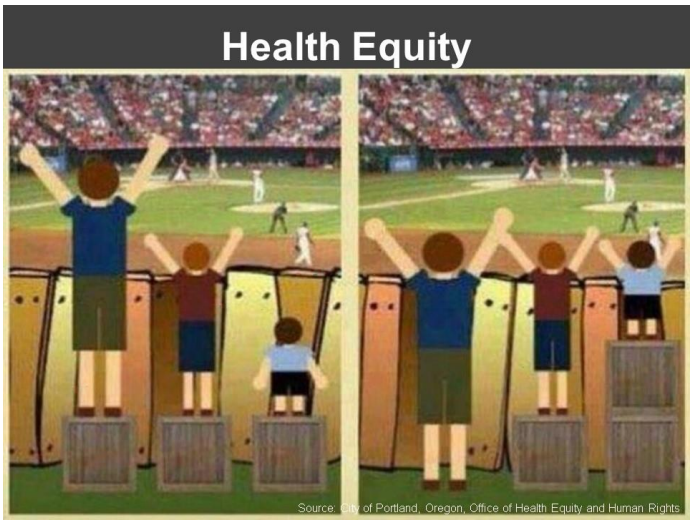


When taking a closer look at Nebraska, we have made some progress in such categories as infant mortality rates: 5.2 deaths per 1,000 live births compared to 5.9 for the overall US rate. However, Massachusetts is 4.3. While Nebraska does well in some areas, others are still areas for improvement.

It is projected that by 2050 the majority of Americans will be minorities, with over ¼ of the population Hispanic. The U.S. population younger than five years stood at 49.9% minority in 2012 and 11% of U.S. counties are now "majority-minority."



There is still an issue of health equity in our communities and who has access to insurance. Implicit bias can influence clinic participation among patients, such as with obesity. Obese doctors are less likely to give weight management advice to those that suffer from obesity and we see that in our health outcomes. These are some of the problems within our health care system that lead to disparities. In order to address them, we need to broaden our thinking with questions such as "Where do we see disparities and how do we get health equity?" Health equity is when everyone has the opportunity to "attain their full health potential" and no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance." Equality is the process, Equity is the outcome. The image on the left represents equality and the image on the right represents equity.



One way to get to health equity is through is Policy, Systems, and Environmental (PSE) changes. We need to tie all organizations together if we want to see change happen in our community. A national example was the Putting Prevention to Work Program by CDC. A local example is Partners for a Healthy City and City Sprouts.

What is next? How do we integrate and combine the community component and not just think about community health, but public health to combine all these initiatives to make people healthier? We talk about the concept of accountable healthy community and align partners to get them together. This involves getting each person involved in system reform, shared responsibilities, focusing on social determinates of health where we can start thinking about that whole person.

Question and Answer from the Audience

- All answers were from Dr. Khan unless otherwise noted.

Question 1: **Why can you say kids that live 20 miles West of Creighton University, will live an average of 12 years longer?**

Answer: There are many reasons why. To name a few, are Omaha's understanding difference between Millard and North Omaha? This leads to discussion on the difference between access to jobs/resources and poverty. Many reasons why, we see differences between Millard and north Omaha. Understanding jobs, poverty, access.

Question 2: **How is the longer life expectancy in Hispanic women explained**?

Answer: I haven't looked at the literature extensively to give you a concreate answer, however it's not just about health care, it's about culture and social determinates of health.

Question 3: **Please provide clarification of value of insurance and its impact on value of health.**

Answer: Access does not equate to equality. If we said tomorrow morning, everybody has access to healthcare that does not mean we have instantly addressed healthcare. We have to address health equity in the US. It's not just a function in the system but across the system.

Question 4: **How can you promote an accountable community without promoting an accountable College of Public Health (COPH) and University of Nebraska Medical Center (UNMC)?**

Answer: UNMC does this every day. UNMC COPH is committed to make Nebraska healthier and healthiest state in the union.

Question 5: **What does Norway do that we don't do?**

Answer: Norway has healthcare access for everyone and they spend a lot of money on social programs to address social determinates of health. Europe has a different approach. For example, 35% of youth in Madrid are unemployed but they are not rotting in place because they have social systems in place to stop that.

Question 6: **Should health communities align with school systems?**

Answer: Yes, align all of the efforts within the community of teachers and schools to bring better social determinates of health.

Question 7: **What can you tell us about politics and what the US is currently doing for healthcare?**

Answer: What our current administration tells us, is that your vote matters. If you want to change your communities it starts with you. You can't look for a political party, friends, etc. to make all the changes, it must start with you.

REACH Program in Omaha

Dr. Richard Brown is the Executive Director of CPHHE-REACH, a coalition to reduce health disparities. Dr. Brown's presentation was on Changing Policy, System, and Environment (PSE): The REACH program in Omaha.

CPHHE-REACH is the Center for Promoting Health and Health Equality's Racial and Ethnic Approaches to Community Health Program. The purpose of CPHHE-REACH is to align a partnership constituted for the purpose of improving the health-related quality of life of racial/ethnic minorities through culturally appropriate and competent community-based participatory healthcare research, health promotion/education and clinical services.

The Center for Disease Control (CDC) started funding community-based participatory research (CBPR) REACH programs in 1999. CPHHE received the grant in 2015 for a three year time period to increase physical activity among African American's in Douglas County, Nebraska. To monitor the effectiveness of the program, a Community Action Plan (CAP) was created to periodically review the grant's programs/goals of the program. The evaluation for CPHHE-REACH has been done via questionnaires that identify and assess impact of messages, behavior change, and physical activity types. Focus Groups were created to assess and identify impact on behavior changes and their health status and user opinions of strategies. The Evaluation team then collects and analyzes the data for progress reports and recommend future strategies.

CPHHE-REACH has trained Health Ambassadors who are lay people, but frontline public-health workers promoting the CPHHE-REACH objectives. To date, there has been 48 health ambassadors who have been trained however only 39 have received certification. The breakdown of those certified: 12 from faith based organizations, 11 within the Omaha Housing Authority and 2 within Community-Based Organizations.

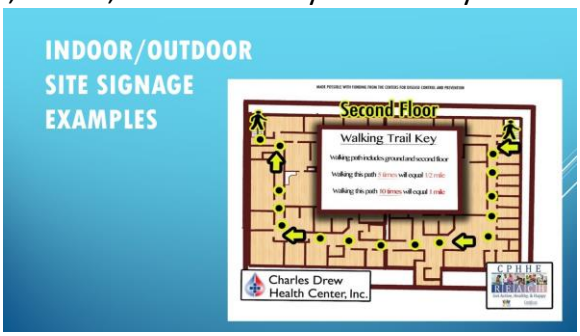
CPHHE-REACH created a communication effort to have a media impressions which impacted over 14 million people. The communication efforts have included bus ads, social media, magazine/newspaper ads, billboards, newsletters, and jingles: 2 Hip-Hop, 1 Gospel, and 1 Slow-Drag Ballad.

CPHHE-REACH is comprised of six partners each with their own role and responsibility during the grant period. To sustain the community partners, CPHHE-REACH meets regularly, provides encouraging messages on physical activity, develops communication

plans, establishes philanthropic activities, and provides incentives. Below is a list of the organizations with their responsibilities with pictures identifying what they have done to achieve the goals of CPHHE-REACH.

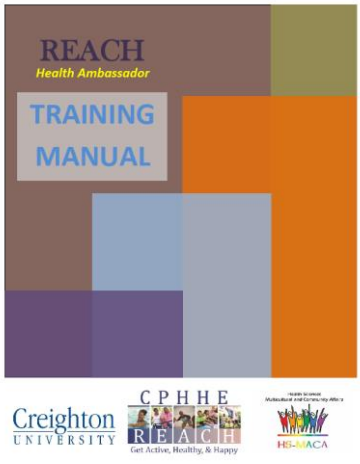
Douglas County Health Department: works in collaboration with the REACH Advisory Board and all CPHHE-REACH community partners in terms of personnel support.

Charles Drew Health Center: Implement Policy, Systems, and Environment (PSE) improvements for staff, clients, and the nearby community.



Creighton HS-MACA/Collective for Youth: Implemented PSE improvements for after-school programs.

Creighton University School of Medicine: School of Medicine created a curriculum for the health-ambassador training program.



Nebraska Center for Healthy Families: Implement PSE improvements of 12 African-American/Black Faith-Based Organizations.

Omaha Housing Authority: Implement PSE improvements for the public housing residents.

CPHHE-REACH has put on several activities within the Omaha community to promote the goal of increased physical activity with the African American community in Douglas County.

Development of Policies: Panel Discussion

Local and National Focus on Policies was the topic of the first panel discussion. Led by moderator Stephen Jackson, Douglas County Health Department, former chair of the CPHHE Partnership and current member of the Community Partnership. The panel included the following individuals: Willie Barney, Empowerment Network; Deb Esser, Blue Cross Blue Shield of Nebraska; Sherri Nared-Brooks, Douglas County Health Department; Brenda Council, Women's Fund. See panelist biosketches in Appendix II of the program book.

The panelists gave opening remarks regarding their organizations, then took questions from the audience, and finally gave their thoughts for the future.

Empowerment Network: The Empowerment Network is a collaboration of residents, elected officials, neighborhood groups, community organizations, philanthropists, educational institutions, faith communities, governmental agencies, and businesses, working together to transform Omaha. As the Empowerment Network began in 2010, organizers investigated programs across the U.S. to identify best practices that the Omaha effort could emulate. In 2007, the Empowerment Network was ready to launch effective gun violence strategies in Omaha. In 2008, Omaha 360 was born out of The Empowerment Network's Violence and Prevention Team. Every Wednesday, Omaha 360 meets to discuss how to reduce city-wide homicides in targeted areas, reduce gun violence (gun assaults), reduce youth violence and gang violence, and provide positive alternatives and activities. In 2012, Step-up Omaha was created—a summer jobs programs for individuals ages 14-21 aimed at closing the employment gap by investing in tomorrow's workforce.

Blue Cross Blue Shield of Nebraska (BSBC): When looking up medical policies to shape your community you need to ask questions. Will it be a big or small policy? Who is your audience? Is it patients/business owners? In making a policy deciding who will win and who loses becomes important as well as addressing previous success and failures by other organizations. Lastly, decide if a policy is necessary or if there are other avenues to explore for people to understand the message.

Douglas County Health Department (DCHD): STD/HIV Prevention starts on the ground floor, every day, by meeting people where they are at to change their behavior. For example: Mark Foxall, Director of County Corrections (Douglas County, NE), was asked to give condoms for people when leaving jails. After years of discussion, a policy was made and now condoms are distributed when they leave the jail.

Adolescent Health Project (AHP): AHP seeks to create sustainable community-wide changes through a research-based, results focused, comprehensive approach that will: (1) increase the sexual knowledge and health of youth and, thereby, (2) decrease the number of youth engaging in risky sexual behavior and the rates of STDs and teen pregnancy. African American women are nearly six times more likely to contract chlamydia and Latina women two times more likely.

Question and Answer from the Audience

Question 1: **When you discuss sex, do you specify what kind of sex you have. A lot of times they don't count oral and anal sex as sex. Why don't we do dental damns, finger condoms, etc., instead of just giving out condoms.**

Brenda Council: That is the reason why you need comprehensive sex education that teaches anal and oral sex are sex and encourage them engage in safer sex activities. We are trying to address a public health issue around sex and giving out condoms is not promoting sex, its promoting healthy behavior. We encourage parents to have ongoing open honest conversation with their kids.

Sherri Nared-Brooks: To understand kids and to have kids want to talk to you, you really have to meet them where they are at and not expect them to come to you. You must also learn their language because not everyone knows the correct terminology. Music, marketing, and media affect STD rates because young kids want to perform the lyrics. Anal and oral sex. And they want to perform the lyrics. You must also meet the parents and encourage them to speak to their kids. It takes a village.

Question 2: **What policy changes occurred to increase African American own businesses and a decrease in African Americans with degrees?**

Willie Barney: City of Omaha created policies to increase contracts going to those in high poverty areas in north and south Omaha. Employment related funding to increase dollars for youth and fund more opportunity.

Question 3: **What is BCBS doing with health systems for reimbursements?**

Deb Esser: We are looking at value based contracting as opportunities to collaborate with partners and preventive care and health outcomes instead of fee for service healthcare. Fee for service, the more I do the more I get paid mentality, is going away as it is setting the wrong incentives for providers. Healthcare is now looking at value-based contracting were we will partner with providers so we encourage look at quality indicators (e.g.: cervical cancer screening) based on quality outcomes they will get reimbursed more than just providing service to patient. Bundle payments, providers in hospital collaborate in hospital for the entire patient.

Question 4: **Teen birth rates are on the decline, but not teen pregnancies rates when you include abortions.**

Brenda Council: Decreases in teen birth rates are due largely to contraception availability. For example: Colorado provides free contraception to females.

Question 5: **Do school-based health centers test for STDs?**

Brenda Council: Yes, they test and treat. They cannot distribute condoms, provide referral, or counseling around contraception.

Question 6: **Where do we draw the line on younger generations on sex and making contraception easily available at an inappropriate age?**

Sherri Nared-Brooks: I believe parents should be talking to the youth about STDs. Parents should discuss with their kids what they think regarding STDs. Sexual education starts at home first and foremost but that isn't happening. You may preach abstinence only, but when they step outside it is a war zone and kids are coming talking about sexual messages all the time at school. Every household is different. If you aren't going to teach your kids about sex, someone will.

Brenda Council: The American Academy of Pediatrics recommends talking about sex at age 9.

Question 7: **How do you combat cultural explanations within putting policies in place and how long does it take before you see change?**

Willie Barney: Behavior/education/hope/employment. Increase opportunities for youth, more jobs and violence goes down.

Question 8: **How can we completely eliminate smoking when powerful bodies depend on cigarette tax? How much tax dollars are generated by cigarette tax.**

Deb Esser: We still do federal subsidies to tobacco growers. We can't lose focus on smoking because we have to strive for national policy to combat and do away with. We are now seeing a rise in young folks based on social messages, think it's cool. It's not glamorous with wrinkle skin, terrible cough.

Changes in the REACH Program: Panel Discussion

Policy changes in the Racial and Ethnic Approaches to Community Health (REACH) Program was the topic of the second panel discussion. Led by moderator Doris Lassiter, Doris Lassiter Consulting LLC and current chair of the CPHHE Partnership. The panel included the following individuals: Evelyn Gould, Zion Baptist Church; Eric Burgin, Crown Tower; Jeffrey Williams, Nebraska Urban League; Rev. Portia Cavitt, Clair Memorial United Methodist Church; Jeffrey Smith, REACH Program Evaluator. Panelist biosketches are in Appendix II in the program book.

The panelists gave opening remarks regarding their organizations, then took questions from the audience, and finally gave their thoughts for the future.

Zion Baptist Church: At Zion, we are have walking maps, walking club and a Zumba class that many people attend. During Sunday school we have activity time and sing songs that allow us to move about the room. We get happy, healthy, and active.

Nebraska Urban League: February 2017 our management team met to put together an action plan on how to be active within our organization. Starting in April 2017, we put our new policies into effect. We have designated walking areas within the building and outside, we take five minutes every hour to stand up from the desk to get oxygen throughout the body. Our goal was to keep it simple, but effective.

Crown Tower: Crown Tower is public housing operated by Omaha Housing Authority. At Crown we have put up signage about taking the stairs instead of the elevator. We encourage group walking activities and get people involved even if they are disabled.

Clair Memorial United Methodist Church (CMUMC): The mission of CMUMC is impacting lives and inspiring life which we do each and every day. CMUMC has updated the messaging on the website to reflect our health moment. During Sunday morning services, when we greet visitors we do exercises. CMUMC has also started a walking club and are providing pedometers. We have partnered with Visiting Nursing Association (VNA) and Nebraska Extension for cooking classes. The children also have health classes during the summer months.

REACH Evaluation: There are no path deviations in evaluations. In order to evaluate the program correctly, we always have to go back to the project goal and then go to our community action plan. REACH goal is to increase physical activity opportunities in the north Omaha community from 0 to 46,000 people over a 3 year period. Prior to the start of the program, RACH conducted an environmental scan and determined each partner's project period objectives for the duration of the grant.

Question and Answer from the Audience

Question 1: **What is SOPARC?**

Jeffrey Smith: SOPARC is the System for Observing Play and Recreation in Communities. It is the tool used assess a recreational area, activities in area, assess people in that area, and assess people and their physical activity level in a particular area.

Question 2: **How do ambassadors increase motivation for the public to increase physical activity?**

Jeffrey Williams: What that exercise taught me was that it took less to ride the bike. We have more women than men. You can present to meetings like I did yesterday. We have former athletes, so coming up with activities to benefit them is necessary.

Evelyn Gould: Talking to the people and find out what they like to do. Letting different people do activities they want to do to get them more involved which helps motivate them.

Portia Cavitt: Consistency, giving the message over and over again to remind them and tell them they are a healthy temple 24hrs a day and they have to get up and move. Encourage them.

Question 3: **In 7th grade recess is reduced, it is nonexistent in high schools. What can be done?**

Eric Burgin: Each school will have to access the policies. I go to different schools and know recess is important for brain stimulation as well as physical activity. I would tell them to implement it as bet as possible. There has to be a point where people measure we need recess.

Question 4: **How can individuals implement these with grant funding in their community?**

Sade Kosoko-Lasaki: At Creighton, we first partnered with Redeemed Christian Church and asked the question, how we can help you help your congregation. We would go and provide talking about healthy eating, healthy living. We found money for weight measurement scales and blood pressure measurement equipment which gave us data to work with and to use to apply for the REACH grant.

Question 5: **Do you have young health ambassadors?**

Doris Lassiter: We only have one because our project requires ambassadors to be at least 18.

Question 6: **Why do you think the REACH program is successful and think it can be sustained when it goes away?**

Doris Lassiter: We had to write policies which state when the money goes away we will sustain the effort.

Practical Ethics for Health Policy

Dr. John Stone is Co-Founder and Co-Director of CPHHE and a Professor in The Center for Health Policy and Ethics at Creighton University. Stone's presentation was on Ethics of Violence Prevention in Omaha.

Working together, concreate outcomes, and evidence are part of the ethical framework we use to guide us with the general idea that we have background ideas, principles, and values. If we use frameworks to guide our policies, they become more likely to be effective.

The personal framework policy is one that doesn't matter how old we are or where we are at in our lives. We can set our own policies and make them a priority, aligning with our core values. We can use exercise as an example. If we are 15 or 50 we will exercise, even if it's just strength training or light walking. When we meet our family for holidays we will want to discuss our activities and hopefully get them involved because exercise is part of our core values. Another example of extending policies is the Maya Community Health Collaborative in Omaha, Nebraska. This is a collaboration between Creighton University's health professional students, CPHHE and the Maya Community. The students get together with the Maya community members to promote healthy living and activities.

Fair equality of opportunity. As a matter of equity or fairness, we must work to ensure communities and organizations are developing their capacity for creating and implementing projects. Respect involves giving people a voice and allowing for different modes of expression. We should use democratic deliberation where we will deliberate about issues and stake out our positions so everyone can understand. We don't want and can't have experts coming in and using technical language and argue for a position that we can't understand.

What kind of principals/guidelines should we develop to make sure we have fair exchange? What does fairness look like and how should be achieve that? Collaboration is one answer to the question of fairness. Think about fairness in a certain neighborhood: it

had deplorable sidewalk conditions that correlated with obesity and other conditions associated with low physical activity. Presented with this information, the city council gave high priority to constructing sidewalks in these neighborhoods.

Question and Answer

- All answers were from Dr. Stone unless otherwise noted.

Question 1: **As we look at future program as associated with our current REACH project, I think out moral anchors are in place, are you suggesting we use this as a guideline as future policy implementations that we look at all of this?**

Answer: In terms of any work we do with policy, we ought to be able to look back and meet these four and ensure we are following the principles as we proceed, and if we aren't we need to question. Broad general ideas that will hold up.

Question 2: **In learning we are focused on getting the input of residents, community, stakeholders, and one of the learnings is keeping residents actively engaged through the entire process and that we are not going to city council/school boards and speaking on their behalf they are going to do that. It is a critical point going forward.**

Answer: How do we fulfill them? That's a matter of looking at what we do and see if it works. Then actually we need to go back and think of our guidelines and see how it all fits together.

Question 3: **Where do you see the most funding for community based participatory research (CBPR)?**

Answer: If you look at the funding opportunities that come out, we are seeing CPBR from all major funding agencies, NIH, Center for Disease Control, Robert Woods Johnson Foundation, and other major funders

Question 4: **How do you suggest institutions with no capital get involved?**

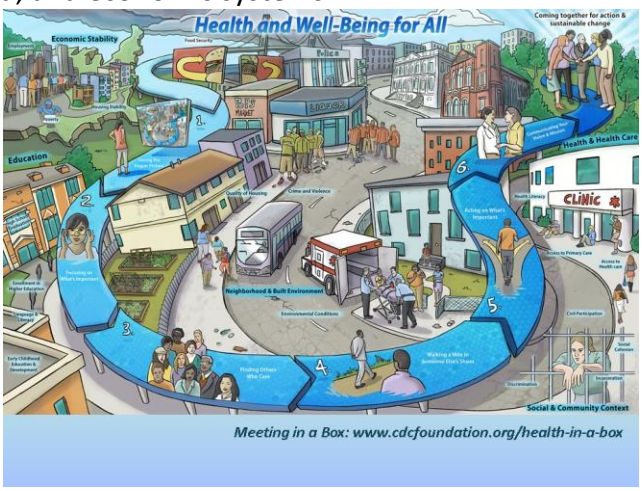
Answer: In the early 1990s University of Alabama-Birmingham (UAB), addressed cancer from bench research to what's the best treatment. UAB had an annual retreat where they looked at cancer data and realized we have to address this as a major problem. They spent the next 2-3 years building relationships with small communities and then in 1999, submitted a $5,000,000.00 National Cancer Institute Grant. That funding went through 17 years and wound up with over 1,200 volunteers. You have to develop good relationship and build from there.

Achieving Health and Well-being for All

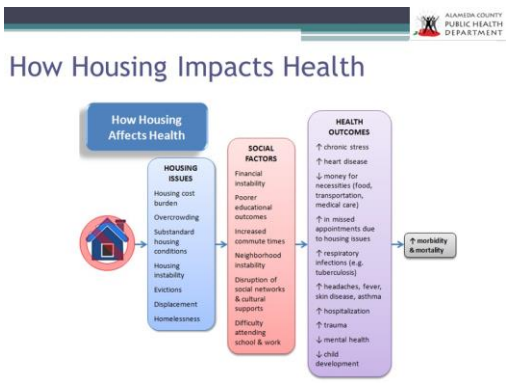
Dr. Denise Koo was the guest and keynote speaker for the seminar. She previously served as the Director in the Division of Scientific Education and Professional Development, Office of Public Health Scientific Services at the Centers for Disease Control.

Dr. Denise Koo completed medical school and residency training. While in medical school, she found herself not wanting to continue her educational quest of becoming a doctor, but to drop out and become a "caterer." As she contemplated her career path, she started an epidemiology class during medical school. While in class she understood that medicine is more than fixing a problem, it is just as much about finding the root cause of the problem; this class saved her from quitting medical school.

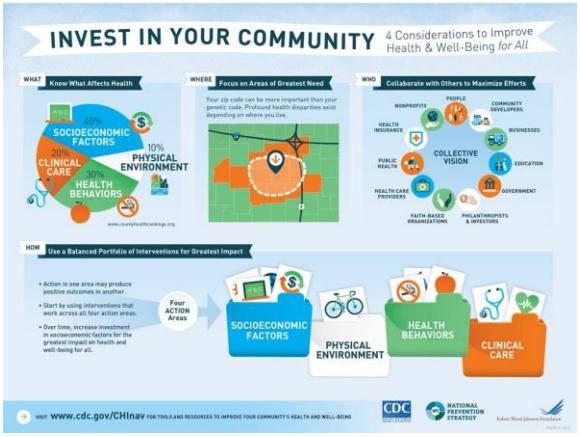
Health is not the same as healthcare and the challenge is when we say healthy people we assume to achieve that is healthcare. A healthy community requires a multi-sector collaboration that are also safe and thriving, with strong healthcare, education, housing, transportation, food, and economic systems.



The United States (U.S.) uses data to look at health outcomes and believes more resources will achieve better outcomes. The U.S. spends the most on health care, yet our life expectancy is lowest. For example housing and health. Housing quality is the extent of exposure to physical hazards (lead, radon, mold); housing security is the adverse effects of homelessness and unstable housing; affordability is paying too much for house (>30% of income) and impact spending on diet, health care; and neighborhood context is walkability, crime, access to transportation, and healthy food.

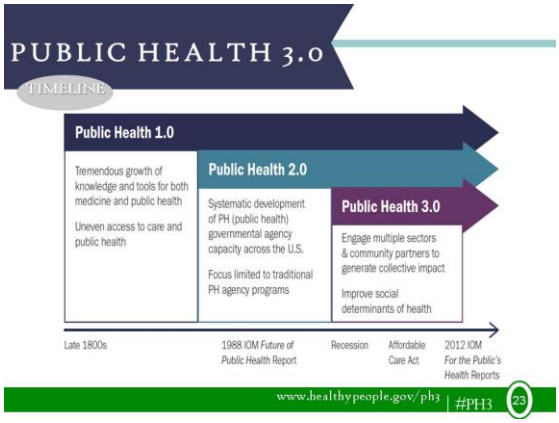


Investment in your community is a way to change the community health outcomes. Community collaborative improvement is a part of the Affordable Care Act (ACA), however it is not realized as a lot of discussion is about access to healthcare. One of the provisions in the ACA is the not-for-profit hospitals (60% in country) are required to conduct a community needs assessments. A community needs assessment can guide us on who to help and what partners they can accomplish their goals with.



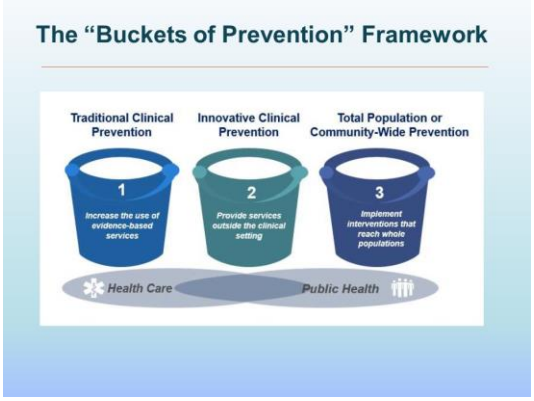
Public Health is what we do together as a society to ensure the conditions in which everyone can be healthy. To achieve this, the CDC created Public Health 3.0 as a major upgrade in public health practice to emphasize cross-sectoral environmental, policy, and systems-level actions that directly affect the social determinants of health and advance health equity. It represents a challenge to business leaders, community leaders, state lawmakers, and federal policymakers to incorporate health into all areas of governance. (CDC, 2017)

The public health system includes all public, private, and voluntary entities that contribute to public health activities within a given area. Entities within a public health system can include hospitals, physicians, managed care organizations, environmental agencies, social service organizations, educational systems, community-based organizations, religious institutions, and many others. All of these organizations play a role in working to improve the public's health. We may use different terms, but they are the same, working across and within systems in a community-integrated health systems (multisector partnerships).



The CDC developed a framework titled The Buckets of Prevention. This describes where prevention and population health fit in with health care in the context of Healthy System Transformation (HST). We hope that it will help public health and healthcare professionals more easily and more quickly determine what they can do to leverage HST changes.

- *Bucket 1* includes traditional clinical preventive services, many of which are now covered benefits without cost-sharing under the Affordable Care Act. They are typically delivered in clinical settings, to individuals who are healthy, as primary or secondary prevention. Examples here include immunizations or colorectal cancer screening tests.
- *Bucket 2* includes innovative services that extend care from the clinic to the community, also delivered to individuals but in community settings. An example here includes the use of a community health worker to assess asthma triggers in the home as a way to augment asthma control in a clinical setting.
- *Bucket 3* includes community-wide prevention to protect people before they get sick. That is, activities that reach whole populations, and are delivered outside of clinical settings. They protect health on a broad scale with any one intervention impacting multiple people and diseases – by improving several risk factors, health equity factors, and health outcomes at the same time. An example is the passage of an indoor smoke free ordinance that would result in smoke-free air for the entire community.



From the Buckets of Prevention Framework, came the Health Impact in 5 Years (HI-5) initiative. HI-5 highlights non-clinical, community-wide approaches that have evidence reporting 1) positive health impacts, 2) results within five years, and 3) cost effectiveness and/or cost savings over the lifetime of the population or earlier. (CDC, 2016)

Booth Memorial Child Development Center in Oakland, CA is a success story of HI-5. Low Income Investment Fund provided funding to renovate the center. Booth Memorial replaced dusty and dirty carpets, put in new child-sized sinks, created more active play space, installation of a garden. The changes resulted in decreased asthma attacks among children and staff, increased attendance, increased income and decreased staff disability claims, growth of healthy food in garden, and stabilized Booth Memorial's finances.

Another success story is the Los Angeles Department of Health Services (LADHS) Housing for Health program. LADHS was spending around $70 million per year on inpatient costs for homeless patients. LASDH decided to facilitate the creation of thousands of housing units with co-located or coordinated clinical and support services. They contacted their partners to help assist in this endeavor. Their partners were housing developers, case managers, health care providers, housing finance agencies and philanthropic organizations. The result of Housing for Health's permanent supportive housing created $32,000 per person/year in cost savings, 77% reduction in emergency room visits, 77% reduction in inpatient admissions, and 85% reduction in inpatient days.

For individuals it is not just about their behaviors, it is about their options at the given moment. Community partnerships are essential in assisting individuals with more options then what they currently have. If you want to go fast, go alone. If you want to go far, go together.

Question and Answer

- All answers were from Dr. Koo unless otherwise noted.

Question 1: **What about chronic mental health issues?**
Answer: That is a real challenge for us and under addressed, very interrelated, and sectors are starting to work well together with education and more training

Question 2: **Please talk about necessarily financial invectives alignments.**
Answer: Most obvious is fee for service to fee for value. When you do more you get paid more. Health care providers are not always ethically driven with different motivations.

Nebraska Medicaid Approach: Panel Discussion

Social Determinants of Violence: Solutions for Public Health was the topic of the third panel discussion. Led by moderator Kenny McMorris, Charles Drew Health Center. The panel included the following individuals: Kathleen A. Mallatt, United HealthCare Community Plan; Ryan Sadler, Nebraska Total Care; Melanie Surber, WellCare of Nebraska, Inc.; Lisa White, Nebraska Medicaid Program. Panelist biosketches are in Appendix II in the program book.

The panel gave opening remarks regarding their organizations and then took questions from the audience.

Nebraska Medicaid Program: The Nebraska Medicaid Program is divided into three medical organizations and under the brand name Heritage Health. Medicaid provides health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. Medicaid provides health care for more than one in every ten Nebraskans.

WellCare of Nebraska: The mission of WellCare is a commitment to quality care. WellCare has about 1/3 of Nebraska's Medicaid population. There is a large turnover for the plan due to majority of clients under the age of 19. The top classifications of clients are foster care children, pregnant moms, and those with disabilities.

Nebraska Total Care: Total Care manages 1/3 of Nebraska's Medicaid population. Total Care was established to deliver healthcare in Nebraska through local, regional and community-based resources. Nebraska Total Care exists to improve the health of its clients through focused, compassionate and coordinated care.

United HealthCare Community Plan: United HealthCare (UHC) manages 1/3 of Nebraska's Medicaid population. UHC has moved away from traditional medical care model of person centered care and moving towards addressing social determinates of care. UHC program is for pregnant mothers, children up to age 19, Adults and families in times of financial hardship, people living with disabilities, people who need help to live independently, and seniors who qualify for both Medicare and Medicaid.

Question and Answer

Question 1:	**What are you expecting the managed care organization (MCO) in managing quality?**
Lisa White:	A committee was initially started with a few dozen people and now we have 72 that are developing process improvement projects are part of the contract that MCO are required to complete.
Melanie Surber:	Working with the state all health plans are required to gather data and report quality.
Ryan Sadler:	What do we do about quality? Taking a step back we are making a welcome call to all these members. Then have them do a health risk screening, next is a health risk assessment including past clinical experience.
Kathleen Mallatt:	We are doing very similar work focusing on a period of time on gaps in care and best practices. We all have different tools we use.
Question 2:	**What are you doing with individuals who are disenfranchised? How are your clients selected and do individuals have the ability to choose their own Primary Care Provider (PCP).**
Kathleen Mallatt:	Yes to PCP. They can choose a health plan and then are assigned in algorithm fashion. Then they could change health plans if they wanted to. We now have some more stability in a case management perspective with the individuals we are serving today.
Question 3:	**We are focusing on the moms/kids, how this would help the elder get the wellness checks even if we are on disabilities and can't get out.**
Kathleen Mallatt:	For United, we are providing the same kind of outreach and programs. Our care management teams are reaching out to those individual's needs. Licensed social worker, mental health providers are all reaching out as well.
Melanie Surber:	WellCare has welcome rooms, physical spaces open to the public and is staffed by a community assistance person that will help advocate for them.
Question 4:	**As a state that did not expand Medicaid, what role do you play for those that can fall through the cracks? Homelessness, undocumented, males, etc.**
Lisa White:	Undocumented, emergency medical services, eligibility (child, single parent). Services would be paid for by the state and work with individuals to get in to community programs.

Question 5:	**What opportunities are available to those in the foster care system?**
Kathleen Mallatt:	Kids are assigned a case manager and we put them in programs we have developed over time. For example we supply duffel bags to NE Family Collaborative for kids since they go home to home and often use trash bags.
Ryan Sadler:	For our children, we have YMCA memberships and weight watchers memberships.

One Size Doesn't Fit All: Breakouts

The conference finished with three group breakout sessions on Case Studies of Lead Contamination in Omaha, Sexually Transmitted Diseases (STD), and Tobacco in Omaha. Participants of the conference were randomly assigned a group. Mr. Thomas Warren moderated the Lead Contamination in Omaha session with Mr. Joel Dougherty as the recorder. For the STD group, it was moderated by Mr. Stephen B. Jackson and recorded by Dr. D. Roselyn Cerutis. The Tobacco in Omaha was moderated by Dr. Martha Nunn and recorded by Ms. Jeanne Burke. Panelist biosketches are in Appendix II in the program book.

Lead Contamination in Omaha

Current Situation

- Significantly high rates of lead in Omaha

Positive Movements

- Sampling from various zip codes and cleanup is free of charge.

Negative Movements

- No health care costs covered.

Solutions

- Have schools track those students from early in life, and provide school mandatory testing.
- Landlords taking action on their rental properties.

Sexually Transmitted Disease (STDs)

Current situation

- Peer pressure is still leading a particular population in our community.
- Parental role and cycle of young people not being educated enough of themselves before they embark upon the activities.
- Youth don't have any true boundaries, because of media, marketing, and music.

Positive Movements

- Faith based solutions are having an adolescent component.
- STD testing has been globalized: in the health centers, community clinics, schools.

Negative Movements

- Legislative Bill in the current Unicameral to affect funding of Title 10 in family planning organizations.
- Academic institution to allow us to have the conversation but won't actively go after funding to assist us with the solutions.

Solutions

- Provide medication and compliance to full regiment of medication.
- Access health literacy and break the cycle cultural expectations, culturally sensitive lens and alleviate these activities.
- Information: make sure we deliver that information in all locations and do it in a systematic way.

Tobacco in Omaha

Current Situation

- No limits to marketing and tobacco sales and who can sell.
- Don't need a license to sell.

Positive Movements

- There are some laws and regulations

Negative Movements

- No regulations on marketing and sales in health disparities areas
- Research data is not being disseminated down to the community level.

Solutions

- Have all health care providers talk to their patients about smoking.
- More school programs covering long term program.
- More option for users to get help.

Conclusion

Expert speakers from the community, organizations, agencies, and academia reviewed many issues in understanding violence and developing public health solutions. Many constructive options emerged. This conference summary is one small step.

Appendix I: PowerPoint Slides

Dr. Sade Kosoko-Lasaki

2017 Progress Report - Nebraska Tobacco Settlement Biomedical Research Development Fund

Sade Kosoko-Lasaki, MD, MSPH, MBA
Health Disparities Seminar
April 29, 2017

Progress Report

- The Creighton University investment of the Nebraska Tobacco Settlement Biomedical Research Development Fund (NTSBRDF) dollars is concentrated in two areas:
  - Research Program and Infrastructure Development
  - Minority Health Research Grants.

Purpose

- The primary purpose and use of the NTSBRDF program at CU is to increase funding from federal health agencies and institutes.

Progress Report

- With the support of the NTSBRDF, Creighton University continues to address some of the world's most complex and perplexing healthcare challenges.
- Researchers play a fundamental role in enhancing the quality of life for individuals and in expanding the research community in Nebraska and the region.

Progress Report

- In 2015-2016, the collective efforts of the research investigators at CU produced significant results:
  - CU received approximately $26.1 million in extramural funding.
  - Investigators were awarded federal grants from the Department of Defense, National Institutes of Health, National Science Foundation, and Centers for Disease Control and Prevention, as well as many other non-federal grants from corporations and foundations.

Minority Health Research Grants

- Creighton's core values *include the inalienable worth of each individual and appreciation of ethnic and cultural diversity coupled with service to others.*
- As such, the NTSBRDF supports CU's commitment to improving the health of racial and ethnic minorities.

Minority Health Research Grants at CU

- Funding from 2009 to 2018 total over $1.3M
- The sum of $178,268 was awarded in **2015-2016** for minority health research.
- Funded since 2009:
  - To: Principal Investigator Sade Kosoko-Lasaki, MD
  - Through: Health Science Multicultural and Community Affairs (HS-MACA)
  - And the Center for Promoting Health and Health Equality (CPHHE)
  - Current Year Funding Yield: $697,339.00

National Funding to CPHHE

- Department of Defense
  - Prostate Cancer Genetics in African Americans
  - Value: $731,278 for 3 years
- Center for Disease Control
  - Center for Promoting Health and Health Equality - Racial and Ethnic Approaches to Community Health (CPHHE-REACH)
  - Value: $1,478,778 for 3 years

Commitment

- Creighton University remains committed to supporting Minority Health and preventing Health Disparities in our community.

Thank you!

Mrs. Doris Lassiter

7

Research Core

Objective: To develop and promote research that targets elimination of health disparities

8

CPHHE PARTNERSHIP

Community Partners

- Nebraska Center for Healthy Families – Mrs. Doris Lassiter – (Chair)
- Charles Drew Community Health Center – Mr. Kenny McMorris (Chair-Elect)
- One World Community Health Center – Mr. Dougherty and Mr. Vasquez
- Urban Indian Health Center – Dr. Donna Polk-Primm
- Douglas County Health Dept. – Mr. Stephen Jackson
- Urban League of Nebraska – Mr. Thomas Warren
- Omaha Police Dept. – Captain Scott Grey
- Dr. Richard Brown
- Mr. John Pierce

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CPHHE PARTNERSHIP
Creighton Academic Partners

- Dr. Roselyn Cerutis
- Ms. Jeanne Burke
- Dr. Rebecca Davis
- Dr. Jacqueline Font-Guzman
- Dr. Beth Furlong
- Dr. Amy Haddad
- Dr. Pamela Runestad
- Dr. Tim Dickel
- Dr. Marty Wilken
- Dr. Martha Nunn
- Mr. Chris Rodgers
- Dr. Jeffrey Smith

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CPHHE SUB-COMMITTEES

- Executive Committee
- Governance
- Violence
- Media
- Research and Development

11

CPHHE COMMUNITY ACADEMIC PARTNERSHIP SUCCESS

- **Long-Term Partnerships**
- **CDC FUNDING – R.E.A.C.H. - RACIAL ETHNIC APPROACHES TO COMMUNITY HEALTH**

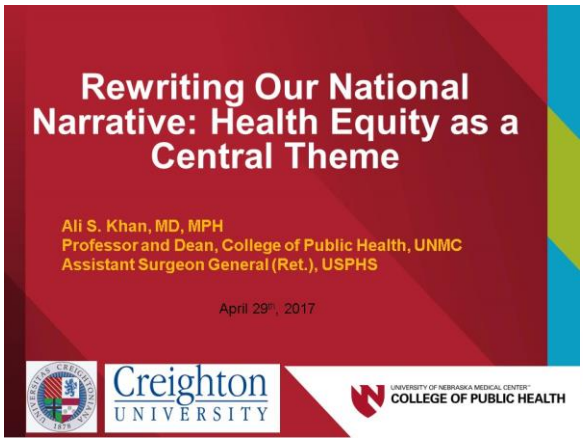
12

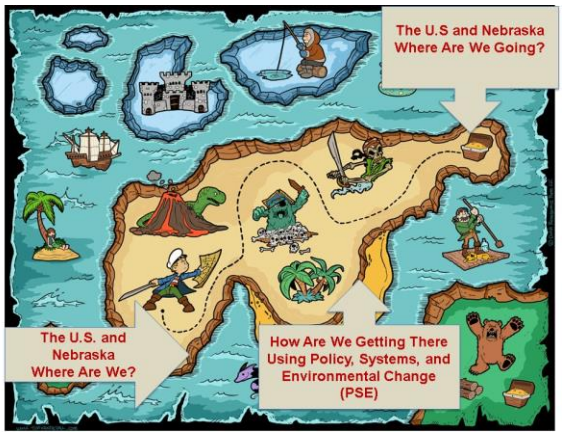
Questions?

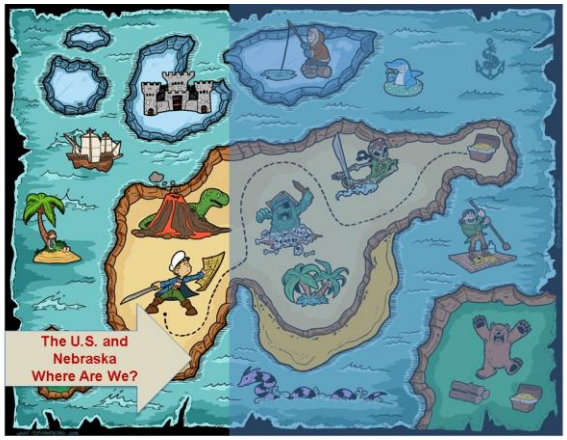
13

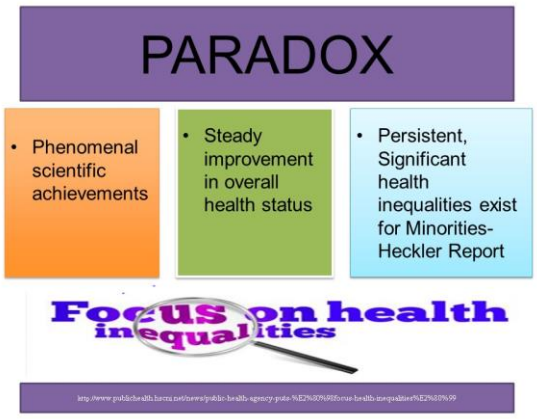
Thank you.

Dr. Ali Khan







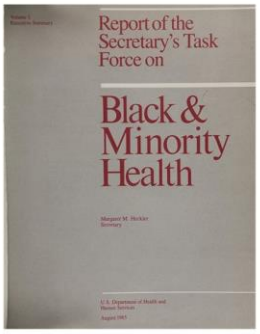


1985 HSS Heckler Report

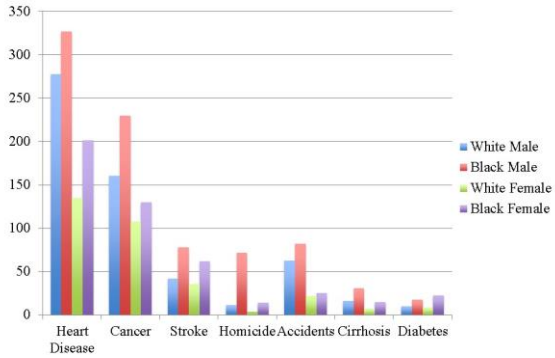
- Secretary Margaret M. Heckler's report on minority health in the U.S.
- The first time the DHHS has consolidated minority health issues into one report
- Legitimization of health disparities as an area of research
- Focus on biomedical factors

"Just as individual well-being is not static, the health needs of minority populations are changing. They are influenced by a diverse set of factors of which disease is but one aspect"

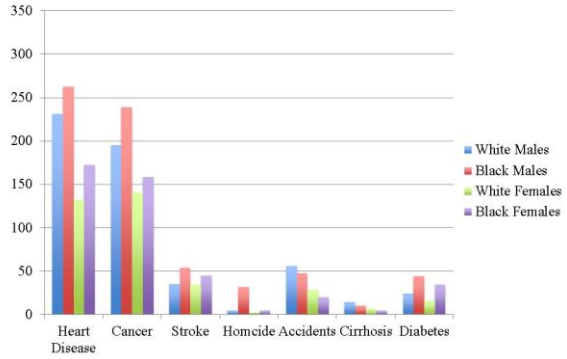
Thomas F. Malone: Chairman, Heckler Report Task Force



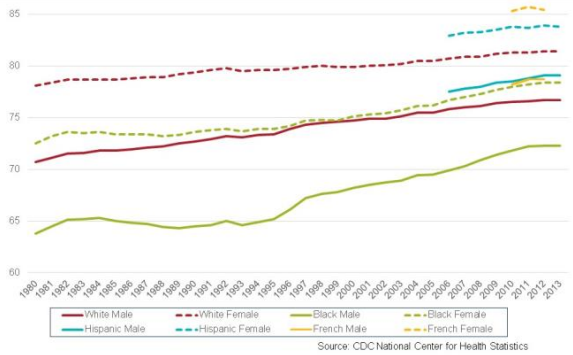
Age-Adjusted Death Rates by Cause, Race, and Sex United States, 1980 (Rate per 100,000 Population)



Age-Adjusted Death Rates by Cause, Race, and Sex United States, 2013 (Rate per 100,000 Population)

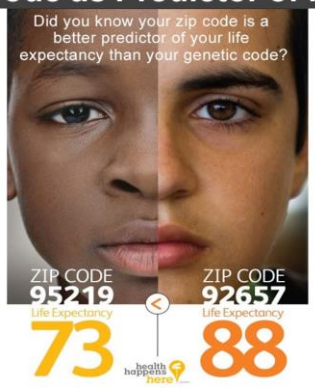


Life Expectancy by Race/Ethnicity and Sex 1980-2013



Source: CDC National Center for Health Statistics

Zip Code as Predictor of health



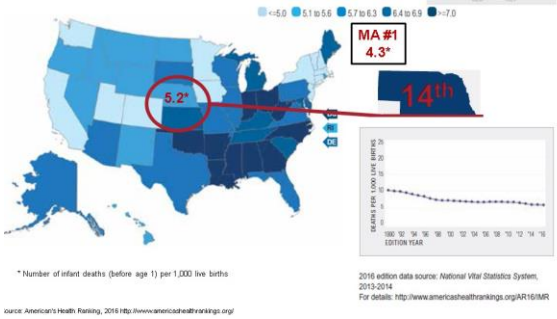
Disparity in Health Status

2016 edition data source: *Behavioral Risk Factor Surveillance System, 2015*
For details: http://www.americashealthrankings.org/AR16/healthstatus_disparity

* Difference in the percentage of adults with vs. without a high school degree who self-reported that their health was very good or excellent

Source: American's Health Ranking, 2016 http://www.americashealthrankings.org/

Infant Mortality



* Number of infant deaths (before age 1) per 1,000 live births

2016 edition data source: *National Vital Statistics System*, 2013-2014
For details: http://www.americashealthrankings.org/AR16/IMR

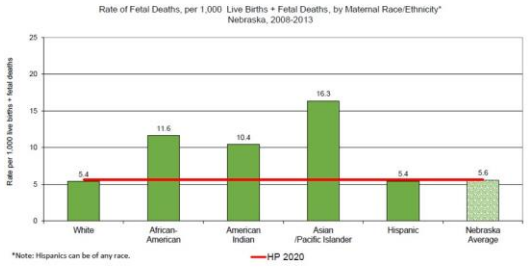
ource: American's Health Ranking, 2016 http://www.americashealthrankings.org/

Infant Mortality, U.S 2016

- Nebraska's infant mortality is 5.2 per one thousand live births compared to 5.9 of the U.S.
- Healthy People 2020 target is 6.0 infant deaths per 1000 live births

https://www.statista.com/statistics/252064/us-infant-mortality-rate-by-ethnicity--2011/
https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives

Infant Mortality, by Race, in Nebraska



*Note: Hispanics can be of any race.

Nebraska Department of Health and Human Services (2015) "Nebraska Title V 2015 Needs Assessment". Retrieved on Jan. 16th, 2016 from dhhs.ne.gov/publichealth/MCHBlockGrant/Documents/**Infants** Outcomes.pdf

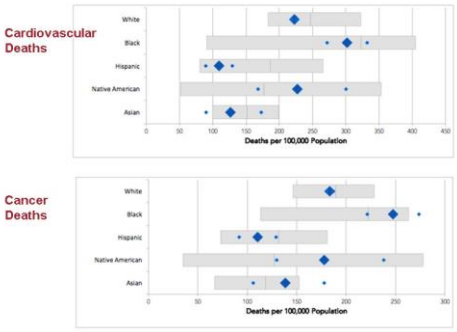
Cancer Survival Rates by Race and Ethnicity in Nebraska (1991-2005)

Race/Ethnicity	2 years +	5 years +	total cases
NH-White	51.2	33.7	75306
All minority groups	38.6	22.8	3096
NH-Black	35.1	18.1	1975
NH-American Indian	39.3	24.1	270
NH-Asian	40.5	27.9	247
Hispanic White	50.2	36.4	574
Other Hispanics	30.0	16.7	30
Missing-race-info	12.0	7.1	633

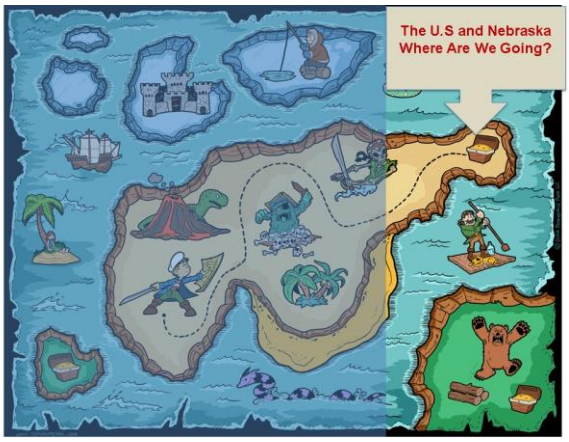
http://dhhs.ne.gov/publichealth/Pages/ced_cancer_data.aspx

The Hispanic Paradox

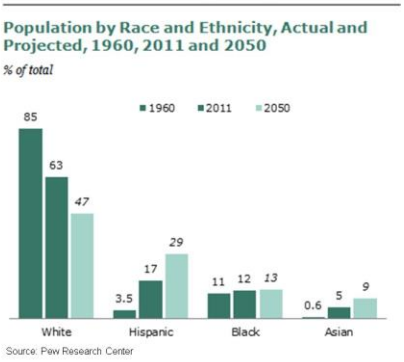
Hispanics have the lowest rates of cardiovascular and cancer deaths in Nebraska.



Source: America's Health Rankings, 2014

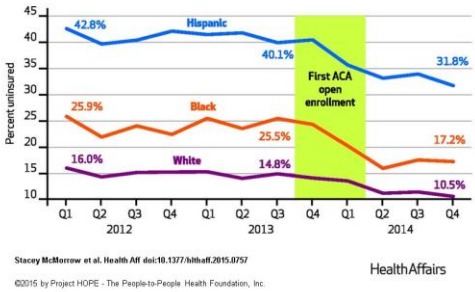


Shift to a "Majority-Minority"



Source: Pew Research Center

Percentages Uninsured For Adults Ages 18–64, By Race And Ethnicity, 2012–14

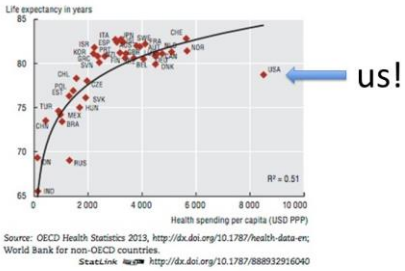


Stacey McMorrow et al. Health Aff doi:10.1377/hlthaff.2015.0757

©2015 by Project HOPE - The People-to-People Health Foundation, Inc.

HealthAffairs

Our Life Expectancy vs. Cost, 2013



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en; World Bank for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888932916040

"It seems like one of the central goals of health care is to keep people not dead longer . . . not the ONLY goal but a big one." *The Incidental Economist* blog

http://theincidentaleconomist.com/wordpress/life-expectancy-and-health-care-spending/

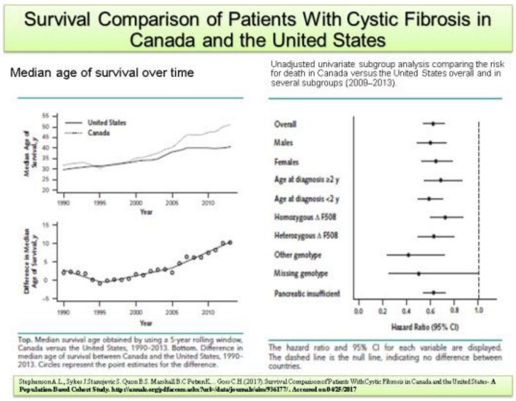
Disparities in Healthcare

- Sociodemographic characteristics of patients can influence **Physicians' perceptions of patients** (Ryn and Burke,2000)
- Perceptions can influence treatment recommendations, independent of clinical factors

Disparities in Healthcare

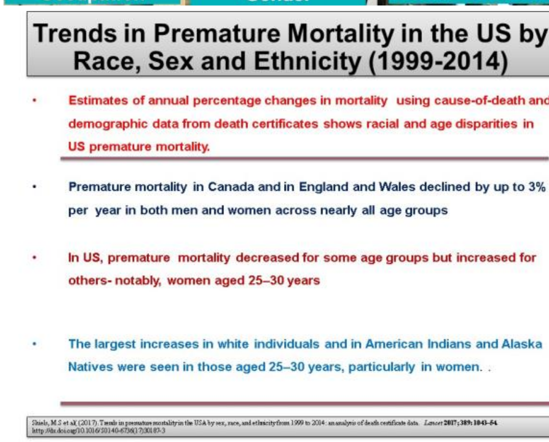
- Evidence point to implicit and explicit bias among doctors against overweight patients
- Physicians view obesity as largely a behavioral problem reinforcing negative societal stereotypes
- Negative perceptions results in decline in health service utilization
- Studies show obese persons are less likely to undergo age-appropriate screenings for breast, cervical, and colorectal cancer.

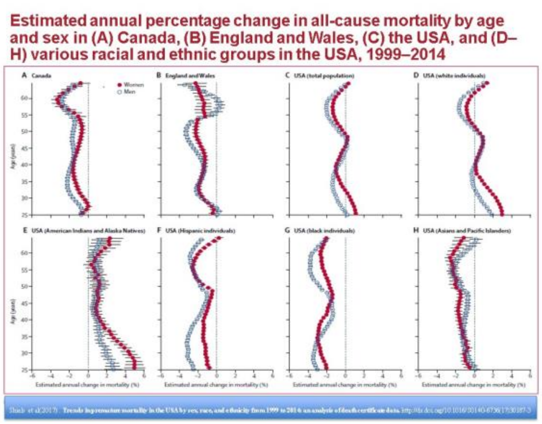
Source:http://search.proquest.com/openview/a2de726f03d0282681dc33a44f16d7ce/1?pq-origsite=gscholar&cbl=38964
Obesity (2009) 17, 941–964. doi:10.1038/oby.2009.636

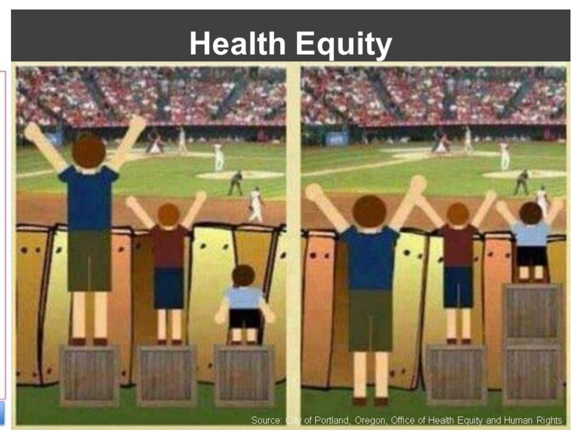

Survival Comparison of Patients With Cystic Fibrosis in Canada and the United States
Median age of survival over time
Unadjusted univariate subgroup analysis comparing the risk for death in Canada versus the United States overall and in several subgroups (2009–2013).
United States
Canada
Overall
Males
Females
Hazard Ratio (95% CI)
Top. Median survival age obtained by using a 5-year rolling window, Canada versus the United States, 1990-2013. Bottom. Difference in median age of survival between Canada and the United States, 1990-2013. Circles represent the point estimates for the difference.
The hazard ratio and 95% CI for each variable are displayed. The dashed line is the null line, indicating no difference between countries.

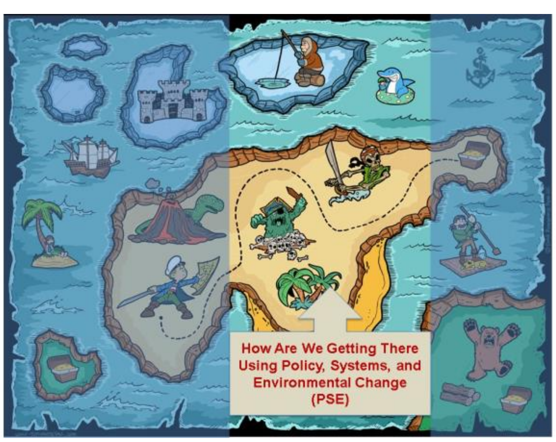

Social Determinants of Health
Race/Ethnicity
Culture
Neighborhood
Education
Social Economic Status
Geographic Location
Occupation
Gender
Sexual Orientation

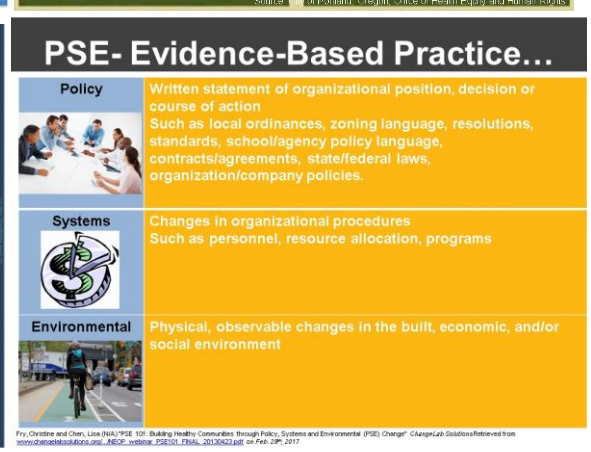

"Mounting evidence indicates that sexual and gender minority populations have less access to health care and higher burdens of certain diseases, such as depression, cancer, and HIV/AIDS. For example, research shows that sexual and gender minorities who live in communities with high levels of anti-SGM prejudice die sooner—12 years on average—than those living in more accepting communities."
-Dr. Eliseo J. Perez- Stable-
Director of the NIMHD


Trends in Premature Mortality in the US by Race, Sex and Ethnicity (1999-2014)
Estimates of annual percentage changes in mortality using cause-of-death and demographic data from death certificates shows racial and age disparities in US premature mortality.
Premature mortality in Canada and in England and Wales declined by up to 3% per year in both men and women across nearly all age groups
In US, premature mortality decreased for some age groups but increased for others- notably, women aged 25–30 years
The largest increases in white individuals and in American Indians and Alaska Natives were seen in those aged 25–30 years, particularly in women.


Estimated annual percentage change in all-cause mortality by age and sex in (A) Canada, (B) England and Wales, (C) the USA, and (D–H) various racial and ethnic groups in the USA, 1999–2014


Health Equity
Source: City of Portland, Oregon, Office of Health Equity and Human Rights


How Are We Getting There Using Policy, Systems, and Environmental Change (PSE)


PSE- Evidence-Based Practice…
Policy
Written statement of organizational position, decision or course of action
Such as local ordinances, zoning language, resolutions, standards, school/agency policy language, contracts/agreements, state/federal laws, organization/company policies.
Systems
Changes in organizational procedures
Such as personnel, resource allocation, programs
Environmental
Physical, observable changes in the built, economic, and/or social environment

PSE: A National Example

PSE Used to Accelerate Chronic Disease Prevention

- CDC funded 50 communities to implement PSE interventions in a 2-year initiative
- Interventions aimed to reduce obesity, tobacco use, and second-hand smoke exposure for a combined 55 million residents

Improving Nutrition:
97% of communities (38) that chose to improve nutrition used media strategies to promote healthy food and beverage choices

Increasing Physical Activity:
97% of communities (38) addressed obesity prevention by using media to encourage physical activity

Reducing Tobacco Use and Secondhand Smoke Exposure
22 communities addressing tobacco prevention use media to advance PSE changes

Bunnell R. et al (2012) Fifty Communities Putting Prevention to Work: Accelerating Chronic Disease Prevention Through Policy, Systems, and Environmental Change. J Community Health (2012) 37:1081-1090

PSE: Research in Nebraska

- The Partners for a Healthy City project (PHC), implemented in Douglas County, Nebraska collaborated with local organizations to…
- Select and implement one or more policies that promoted healthy eating and physical activity
- 346 organizations participated and completed the follow-up assessment
- Results:
- 92% implemented at least one (1) new policy, or expanded an existing policy related to healthy food and drink options and physical activity
- Totaling 952 individual policy changes
- PHC initiative had an impact on more than 84,000 individuals

Feyerherm L., Tibbits M., Wang H., Schram S.,& Bellutti M.,(2014) "Partners for a Healthy City: Implementing Policies and Environmental Changes within Organizations to Promote Health" July 2014, Vol 104, No. 7 | American Journal of Public Health

Stair promotion poster

A Local Example

An organizational agreement to:
- Increase availability of fresh and locally grown produce
- Educate community about gardening and suitability
- Build community through gardening

Policy
Systems
Environment

http://www.omahasprouts.org/about

Work with Omaha area residents and volunteers to grow, educate, and build community through gardening

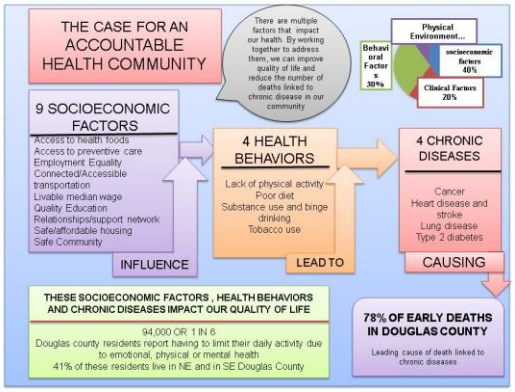
Provide space for education and gardening to take place

Moving to Healthcare 3.0

The Health Care Delivery System – a journey of transformation

Acute Health Care System 1.0	Coordinated Seamless Health Care System 2.0	Community Integrated Health Care System 3.0
✓High quality acute care	▸ High quality acute care	▸ High quality acute care
▸ Accountable care systems	✓Accountable care systems	▸ Accountable care systems
▸ Shared financial risk	✓Shared financial risk	▸ Shared financial risk
▸ Case management and preventive care systems	✓Case management and preventive care systems	▸ Case management and preventive care systems
▸ Population-based quality and cost performance	✓Population-based quality and cost performance	▸ Population-based quality and cost performance
▸ Population-based health outcomes	▸ Population-based health outcomes	✓Population-based health outcomes
▸ Care system integration with community health resources	▸ Care system integration with community health resources	✓Care system integration with community health resources

AHCos



Source: Live Well Omaha

Accountable Health Community (AHCo)

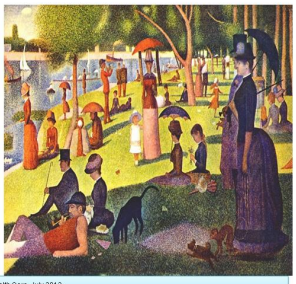
Model how population health can be advanced through collaborative, multi-institutional efforts to improve health and health systems on a community basis.

First one in Akron, Ohio

How do we create healthier communities?

We can…

- involve citizens in local delivery system reform and stewardship of their financial resources
- promote shared responsibility for the health of the community
- focus on the social determinants of health, clinical-community linkages, and whole person care.



Source: Magnan et al, Achieving Accountability for Health and Health Care, July 2012

Acknowledgements

Trang Hoang, MPH

Phillip Amara, MSC

Ms. Deb Esser

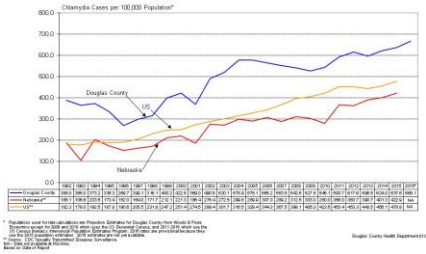

Policy Development
Debra Esser, MD, MMM, FAAFP
CMO and VP Medical Management
Blue Cross Blue Shield of Nebraska
BlueCross BlueShield Nebraska
Thinking About Policy Development
Why do you need a policy?
What problem are you trying to solve?
Do you and others agree?
Has anyone done this for a similar issue?
What are the emotions behind the issue?
BLUE CROSS AND BLUE SHIELD OF NEBRASKA
The Policy You Want
Is it a "BIG P" or a "little p"?
Smoke-free State
-vs- Smoke-free Restaurant
-vs- Smoke-free Parks
Who is your audience?
State legislators, business owners, city council?
Have they heard this before?
Previous attempts?
How did they go?
BLUE CROSS AND BLUE SHIELD OF NEBRASKA
In Making a Policy
Ex: Smoke-free State (public spaces)
Who Wins?
- The Public
The Pros:
- Health
What else will they want? Is this the beginning of more?
- Smoke-free public housing
- Public space perimeters
Who Loses?
- Tobacco
The Cons:
- Loss of jobs (?)
What else can be leveraged to make it a "win-win"?
- Smoke-free, but e-cigarettes make up for lost business
BLUE CROSS AND BLUE SHIELD OF NEBRASKA
Additional Things to Consider
Is there another solution?
Have you thoroughly vetted the environment to know the perils and pitfalls?
Do you have data that is easily digestible to non-subject-matter-experts?
Have you thought about how you will track this policy's effectiveness?
Do you know the funding impacts of your policy?
BLUE CROSS AND BLUE SHIELD OF NEBRASKA

Ms. Brenda Council

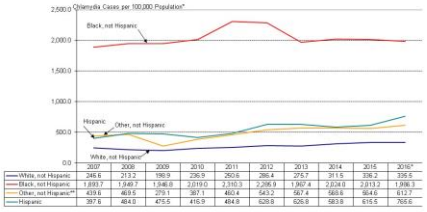
DOUGLAS COUNTY STD RATES

As Reported in the State of Public Health 2017

Chlamydia Rates
Douglas County, Nebraska, and US 1992-2016*

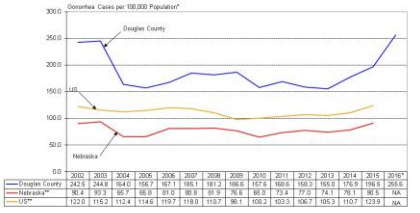


Chlamydia Rates by Race/Ethnicity
Douglas County, NE 2007-2016*



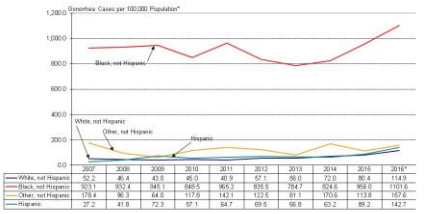
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
White, not Hispanic	246.6	213.2	198.9	236.9	250.6	286.4	275.7	311.5	336.2	336.6
Black, not Hispanic	1,893.7	1,949.7	1,946.8	2,019.0	2,310.3	2,295.9	1,997.4	2,024.0	2,013.2	1,998.3
Other, not Hispanic**	439.6	469.5	479.1	387.1	460.4	543.2	567.4	588.6	664.6	612.7
Hispanic	397.6	484.0	475.5	416.9	484.9	628.8	626.8	683.8	615.5	765.6

Gonorrhea Rates
Douglas County, Nebraska, and US 2002-2016*



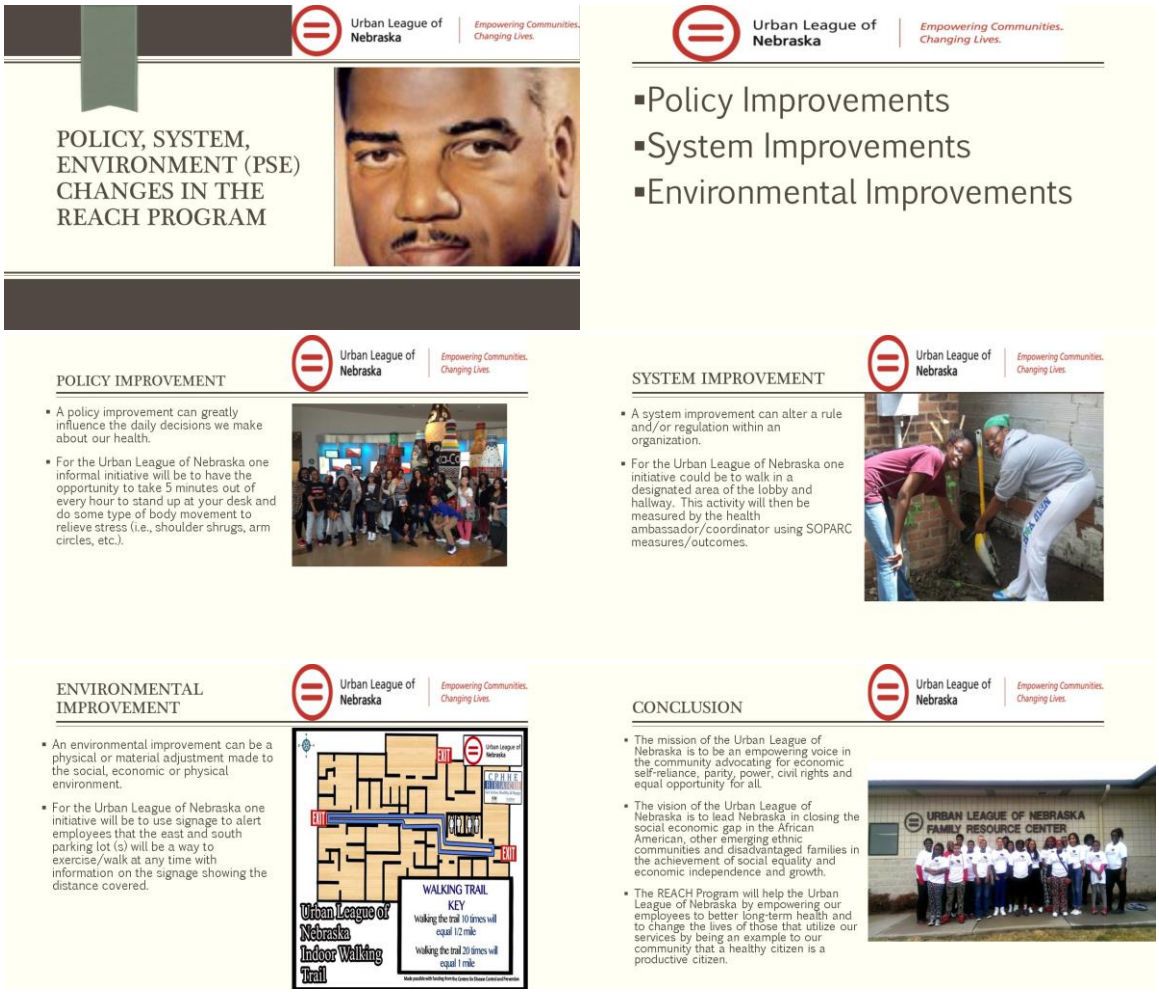
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
Douglas County	242.5	244.8	164.0	156.7	167.1	185.1	181.2	168.6	157.6	168.6	158.3	165.8	176.9	196.6	264.6
Nebraska**	90.4	93.3	66.7	66.8	81.0	86.8	81.9	76.6	66.3	73.4	77.0	74.1	76.1	90.5	NA
US**	122.8	115.2	112.4	114.6	119.7	118.0	110.7	98.1	108.2	103.3	106.7	105.3	110.7	123.9	NA

Gonorrhea Rates by Race/Ethnicity
Douglas County, NE 2007 - 2016*

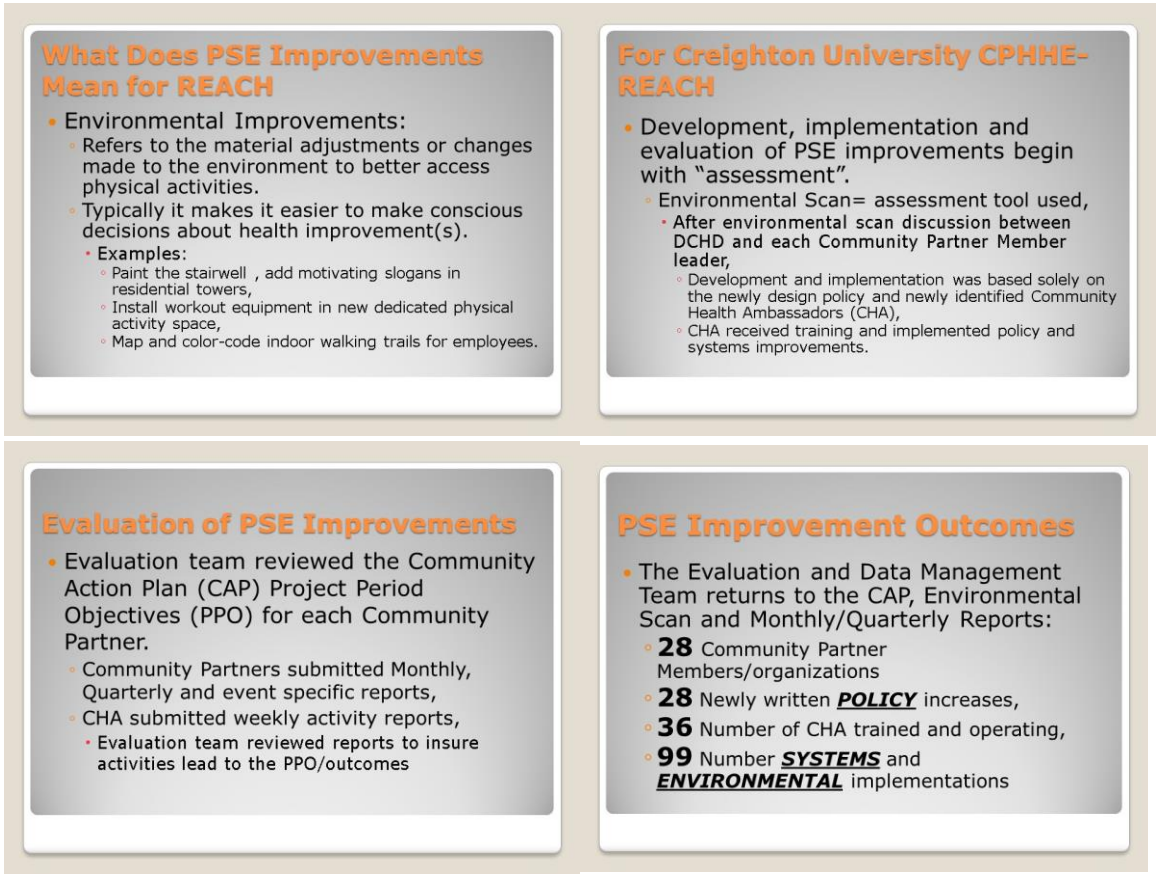


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
White, not Hispanic	52.2	46.4	43.0	46.0	48.9	57.1	56.0	72.0	80.4	114.9
Black, not Hispanic	923.1	932.4	945.1	848.5	965.2	856.5	784.7	824.6	958.0	1101.6
Other, not Hispanic	178.4	96.3	64.8	117.8	142.1	122.5	81.1	170.6	113.8	157.6
Hispanic	27.2	41.8	72.3	57.1	64.7	69.5	66.6	63.2	89.2	142.7

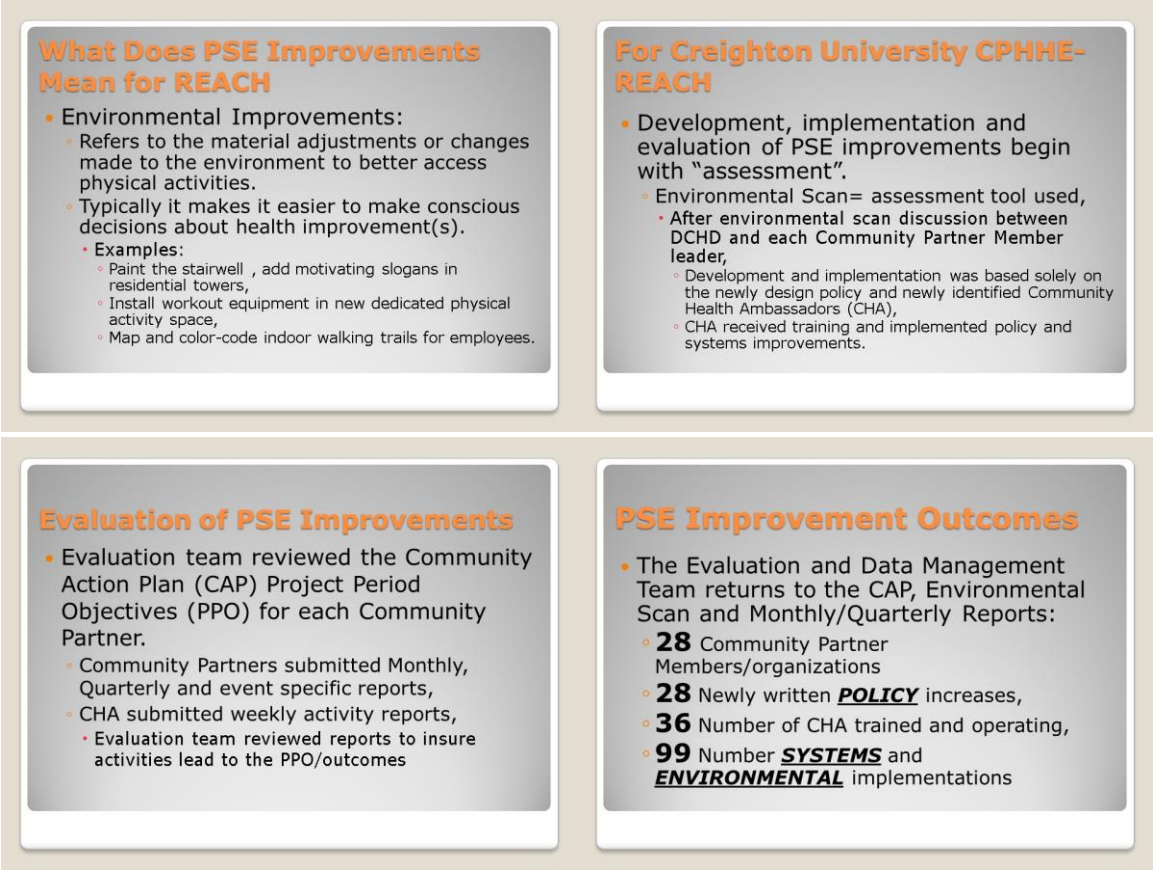
Mr. Jeffrey Williams



Mr. Jeffrey Smith


What Does PSE Improvements Mean for REACH
Environmental Improvements:
Refers to the material adjustments or changes made to the environment to better access physical activities.
Typically it makes it easier to make conscious decisions about health improvement(s).
Examples:
Paint the stairwell , add motivating slogans in residential towers,
Install workout equipment in new dedicated physical activity space,
Map and color-code indoor walking trails for employees.
For Creighton University CPHHE-REACH
Development, implementation and evaluation of PSE improvements begin with "assessment".
Environmental Scan= assessment tool used,
After environmental scan discussion between DCHD and each Community Partner Member leader,
Development and implementation was based solely on the newly design policy and newly identified Community Health Ambassadors (CHA),
CHA received training and implemented policy and systems improvements.
Evaluation of PSE Improvements
Evaluation team reviewed the Community Action Plan (CAP) Project Period Objectives (PPO) for each Community Partner.
Community Partners submitted Monthly, Quarterly and event specific reports,
CHA submitted weekly activity reports,
Evaluation team reviewed reports to insure activities lead to the PPO/outcomes
PSE Improvement Outcomes
The Evaluation and Data Management Team returns to the CAP, Environmental Scan and Monthly/Quarterly Reports:
28 Community Partner Members/organizations
28 Newly written POLICY increases,
36 Number of CHA trained and operating,
99 Number SYSTEMS and ENVIRONMENTAL implementations

Mr. John Stone


What Does PSE Improvements Mean for REACH
Environmental Improvements:
Refers to the material adjustments or changes made to the environment to better access physical activities.
Typically it makes it easier to make conscious decisions about health improvement(s).
Examples:
Paint the stairwell , add motivating slogans in residential towers,
Install workout equipment in new dedicated physical activity space,
Map and color-code indoor walking trails for employees.
For Creighton University CPHHE-REACH
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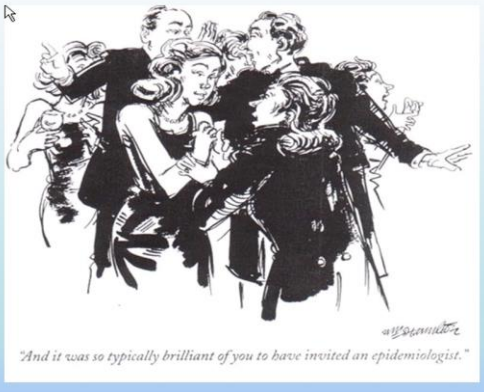
Dr. Denise Koo

Achieving Health and Well-Being for All

Denise Koo, MD, MPH
Addressing Health Disparities Seminar
Creighton University
April 29, 2017



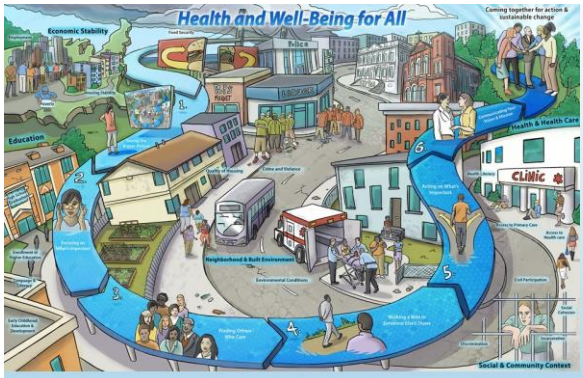
Overview

- What influences health
  - Determinants of Health
  - Terminology
  - Frameworks for addressing health
- What we can DO to improve the health of our communities
  - Selected CDC initiatives
  - Selected success stories/examples
- Environmental scan of selected social determinants initiatives
  - Data/metrics
  - Federal government (non-health) initiatives
  - Toolkits

Disclaimer: these slides do not represent the opinions or perspectives of the CDC or the federal government

Key Points

- Health > healthcare
- Healthy community requires multi-sector collaboration
- The healthiest communities are also safe and thriving, with strong healthcare, educational, housing, transportation, food, economic systems



Meeting in a Box: www.cdcfoundation.org/health-in-a-box

Discussion of Map

- What do you see in this visual?
- What other factors not visible in the picture also affect health?
- Which of these determinants (whether visualized or not) is most important in your community? Why?

Terminology

- How would you define population health? (How would the healthcare system define the term?)
- How is population health different from public health?
- What, then, is community health?

Population Health, Public Health, Community Health

- **Population health = the health outcomes of a group of individuals, including the distribution of such outcomes within the group (Kindig)**
- **Public health = what we as a society do to assure the conditions in which people can be healthy (IOM)**
- **Public Health = governmental public health versus public health**
- **The Public's Health**
- **Community health* = community health and well-being, but also an approach that:**
  - Involves multiple disciplines and sectors
  - Engages and works with community in culturally sensitive way
  - Uses public health science and evidence-based strategies

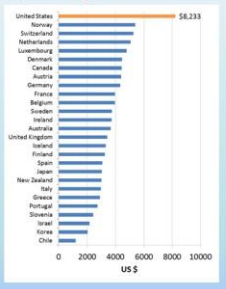
*Adapted from Goodman RA, Bunnell R, Posner SF. What is "community health? Examining the meaning of an evolving field in public health. Preventive Medicine 2014; 67 (S1): S58-S61

Dartmouth Atlas of Health Care Some Key Conclusions

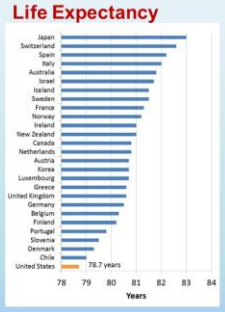
- **"Higher volume of care does not produce better outcomes for patients"**
- **Additional services provided to Medicare beneficiaries in higher-spending regions all fall into the category of "supply-sensitive care": discretionary care that is provided more frequently when a population has a greater per capita supply of medical resources.**
  - Where there are more hospital beds per capita, patients are more likely to be admitted to the hospital - and Medicare will spend more on hospital care
  - Where there are more intensive care unit beds, more patients will be cared for in the ICU - and Medicare will spend more on ICU care
  - The more CT scanners are available, the more CT scans patients will receive
- **There is *higher* mortality in high-resourced, high-utilization areas than in low-resourced, low-utilization areas**

Health Care Alone Is Not Enough

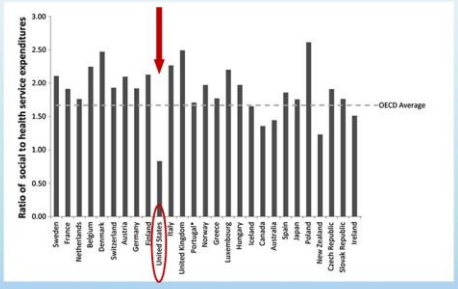
Spending on Health Care



Life Expectancy



Ratio of Social to Health Services: Spending by Country



Source: *BMJ Quality & Safety*: Health and social services expenditures: associations with health outcomes, EH Bradley, BR Elkins, J Herrin, B Elbel, March 2011

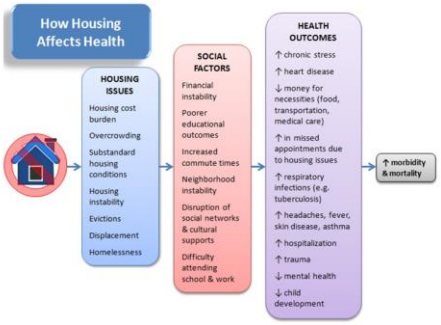
Housing and Health

- **Housing Quality**
  - Extent of exposure to physical hazards (lead, radon, mold, etc.)
- **Housing Security**
  - Adverse effects of homelessness and unstable housing
- **Affordability**
  - Paying too much for housing (>30% of income) can impact spending on diet, health care, etc.
- **Neighborhood Context**
  - Walkability, crime, access to transportation and healthy food, etc.

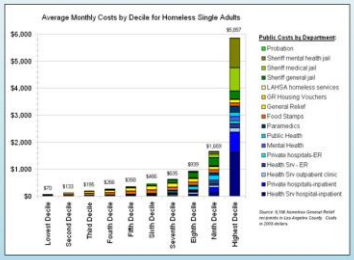
Adapted from a slide from U.S. Department of Housing and Urban Development

ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT

How Housing Impacts Health

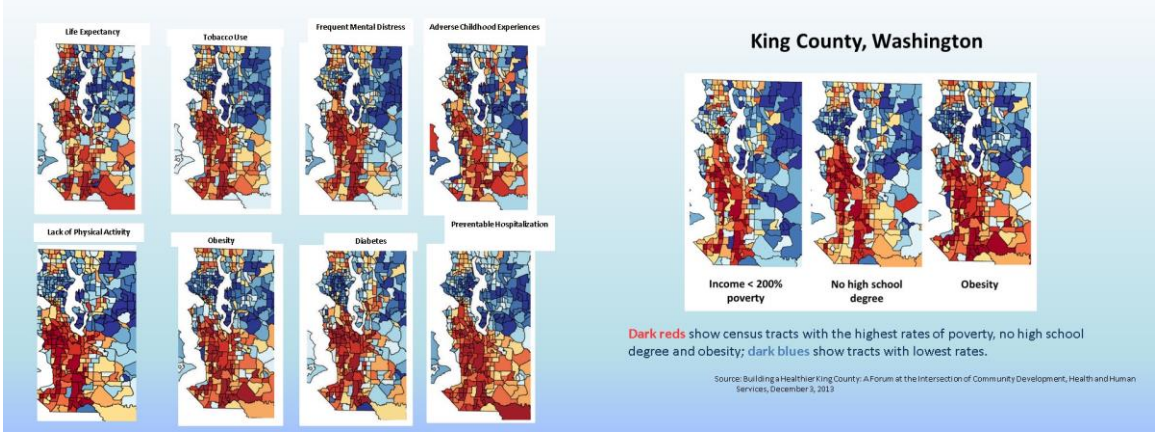


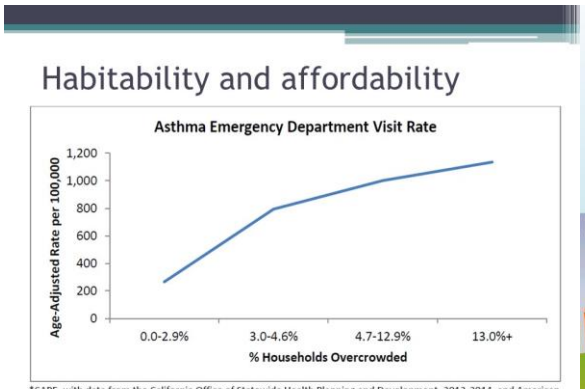
Needs of complex patients

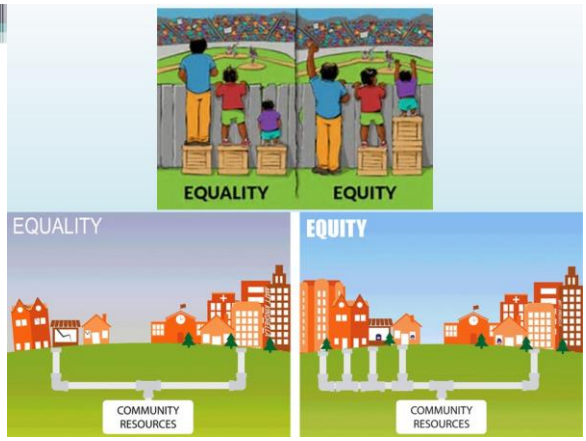


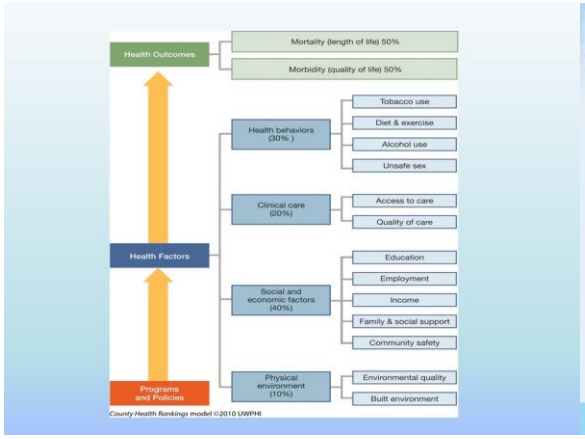
10% of the Los Angeles homeless population accounts for 55% of public costs

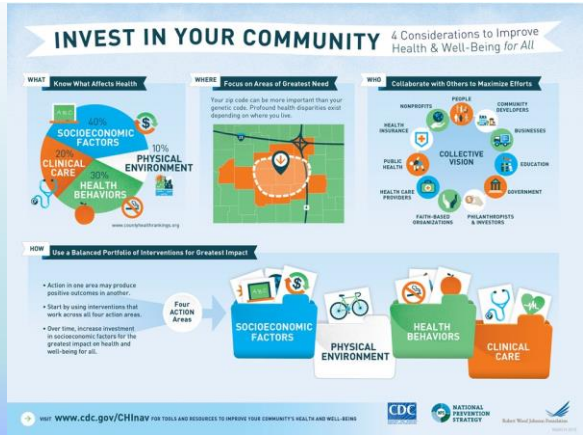
Health services alone will not lead to big health improvements









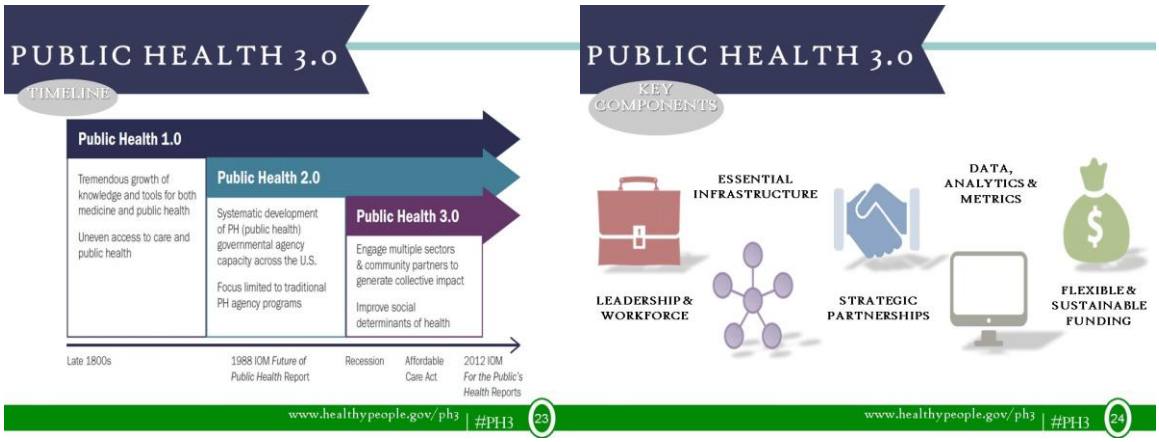


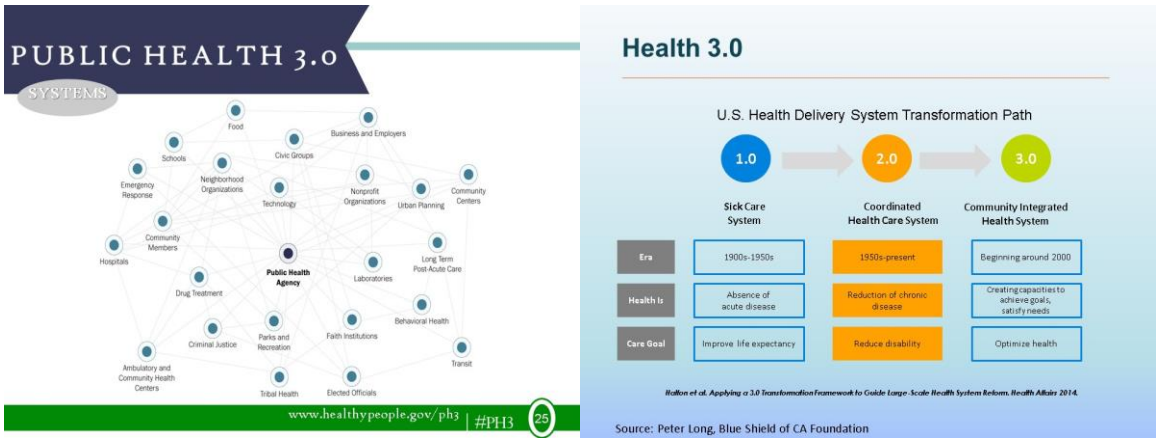
PUBLIC HEALTH

What we do together as a society to ensure the conditions in which everyone can be healthy.

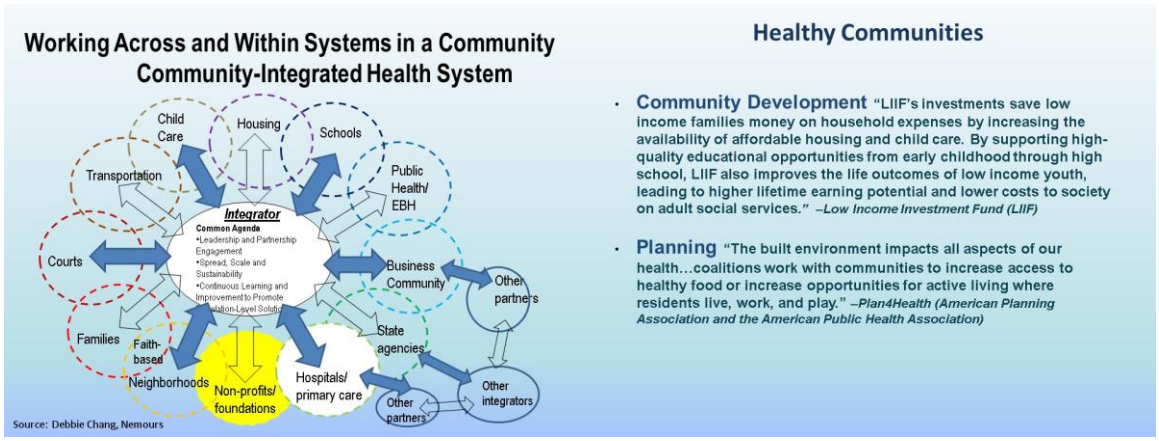
PUBLIC HEALTH 3.0

Social Determinants of Health
are the conditions in which people are born, live, work and age.


PUBLIC HEALTH 3.0
TIMELINE
Public Health 1.0
Tremendous growth of knowledge and tools for both medicine and public health
Uneven access to care and public health
Public Health 2.0
Systematic development of PH (public health) governmental agency capacity across the U.S.
Focus limited to traditional PH agency programs
Public Health 3.0
Engage multiple sectors & community partners to generate collective impact
Improve social determinants of health
Late 1800s
1988 IOM Future of Public Health Report
Recession
Affordable Care Act
2012 IOM For the Public's Health Reports
www.healthypeople.gov/ph3 | #PH3 23
PUBLIC HEALTH 3.0
KEY COMPONENTS
ESSENTIAL INFRASTRUCTURE
DATA, ANALYTICS & METRICS
LEADERSHIP & WORKFORCE
STRATEGIC PARTNERSHIPS
FLEXIBLE & SUSTAINABLE FUNDING
www.healthypeople.gov/ph3 | #PH3 24


PUBLIC HEALTH 3.0
SYSTEMS
Food
Business and Employers
Schools
Civic Groups
Emergency Response
Neighborhood Organizations
Nonprofit Organizations
Urban Planning
Community Centers
Technology
Community Members
Hospitals
Public Health Agency
Long Term Post-Acute Care
Laboratories
Drug Treatment
Behavioral Health
Criminal Justice
Parks and Recreation
Faith Institutions
Transit
Ambulatory and Community Health Centers
Tribal Health
Elected Officials
www.healthypeople.gov/ph3 | #PH3 25
Health 3.0
U.S. Health Delivery System Transformation Path
1.0
2.0
3.0
Sick Care System
Coordinated Health Care System
Community Integrated Health System
Era
1900s-1950s
1950s-present
Beginning around 2000
Health Is
Absence of acute disease
Reduction of chronic disease
Creating capacities to achieve goals, satisfy needs
Care Goal
Improve life expectancy
Reduce disability
Optimize health
Halton et al. Applying a 3.0 Transformation Framework to Guide Large-Scale Health System Reform. Health Affairs 2014.
Source: Peter Long, Blue Shield of CA Foundation


3.0
Principles & Design Strategies
Community Empowerment and Engagement
Community Integration Functions
Information and Measurement
Financing Approaches
Source: Peter Long, Blue Shield of CA Foundation
Bringing 3.0 design elements together in communities
California Accountable Communities for Health Initiative (CACHI)
Imperial County Public Health Department, Imperial County
Merced County Department of Public Health, Merced County
Be There San Diego/University of California, San Diego, San Diego County
Dignity Health/St. Joseph's Medical Center, San Joaquin County
Santa Clara County Public Health Department, Santa Clara County
Sonoma County Department of Health Services, Sonoma County
Source: Peter Long, Blue Shield of CA Foundation


Working Across and Within Systems in a Community
Community-Integrated Health System
Child Care
Housing
Schools
Transportation
Public Health/ EBH
Integrator
Common Agenda
•Leadership and Partnership Engagement
•Spread, Scale and Sustainability
•Continuous Learning and Improvement to Promote Population-Level Solutions
Courts
Business Community
Other partners
Families
Faith-based
State agencies
Neighborhoods
Non-profits/ foundations
Hospitals/ primary care
Other partners
Other integrators
Source: Debbie Chang, Nemours
Healthy Communities
Community Development "LIIF's investments save low income families money on household expenses by increasing the availability of affordable housing and child care. By supporting high-quality educational opportunities from early childhood through high school, LIIF also improves the life outcomes of low income youth, leading to higher lifetime earning potential and lower costs to society on adult social services." –Low Income Investment Fund (LIIF)
Planning "The built environment impacts all aspects of our health…coalitions work with communities to increase access to healthy food or increase opportunities for active living where residents live, work, and play." –Plan4Health (American Planning Association and the American Public Health Association)

Four Behaviors: 40% of all deaths

- Lack of physical activity
- Poor nutrition
- Tobacco use
- Excessive alcohol

Source: National Center for Chronic Disease Prevention and Health Promotion, CDC

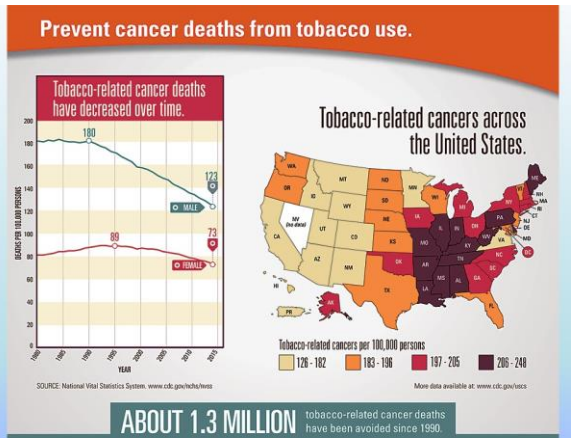
Douglas County, NE

- Nebraska #12 among states in America's Health Rankings
- #52 of 78 NE counties (County Health Rankings 2016)
- Compared to "peer" counties (County Health Status Indicators) in 2015
  - Top quartile (good): motor vehicle deaths, uninsured, teen births, male and female life expectancy, limited access to healthy food, access to parks
  - Bottom quartile: chronic lower respiratory deaths (54/100,000), cancer (incidence), adult binge drinking (19.4%)

Cancer and Tobacco Use in the U.S.

- Tobacco use causes 12 types of cancer
- 40% of cancers diagnosed in the U.S. are linked to tobacco use
- 3 in 10 of all cancer deaths are caused by cigarette smoking
- 343,000 people die each year from cancers related to tobacco
- Actions
  - Comprehensive cancer control programs focusing on cancer prevention, education, screening, access to care, support for cancer survivors, and good health for all.
  - Make tobacco cessation treatments more available to people who want to quit.
  - Create tobacco-free environments

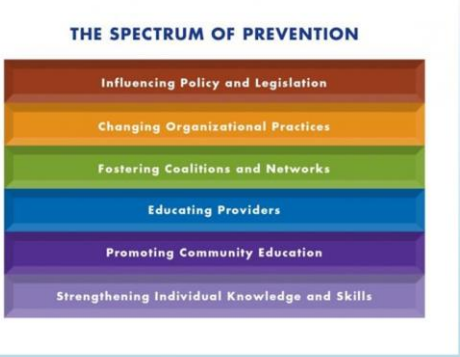
Source: CDC Vital Signs, November 2016



Excessive Alcohol Consumption in the United States

- 88,000 deaths/year attributed to alcohol, 1 in 10 deaths among working-age adults
- Economic cost $223.5 billion—lost workplace productivity, healthcare costs, crime
- Binge drinking main problem, accounting for >1/2 of deaths and 3/4 of costs
- Alcohol pricing strategies
  - Increased alcohol prices & taxes decreases excess consumption, improves health outcomes
  - Health impacts include: motor vehicle crashes, STDs, mortality, violence

Source: CDC



Source: Prevention Institute

The "Buckets of Prevention" Framework

Buckets 1 and 2

Traditional clinical | Innovative clinical

- 6 high-burden health conditions, 18 associated interventions shown to improve health and/or control costs in 1-5 years
- Improving access, availability and use of high-quality healthcare services
- Learning from health system partners how to implement and then, how to scale such

www.cdc.gov/sixeighteen

Bucket 3
Community-wide prevention

- How do we improve population health in our states and communities?
- What is the best evidence *and* lowers cost?
- What can we do that will begin to show results soon?

www.cdc.gov/hi5

Success Stories

- **Booth Memorial Child Development Center, Oakland, CA**
  - Low Income Investment Fund provided funding to renovate the center.
    - Actions: Replaced dusty, dirty carpets, put in new child-sized sinks, created more active play space, installation of a garden
    - Results:
      - Decreased asthma attacks among children and staff
      - Increased attendance
      - Increased income and decreased staff disability claims
      - Growth of healthy food in garden
      - Stabilized Child Development Center finances

Housing Saves Health Care Dollars

- **Los Angeles Department of Health Services (LADHS) Housing for Health program**
  - **Problem:** Without permanent supportive housing, the LADHS was spending around $70 million per year on inpatient costs for homeless patients.
  - **Action**: facilitated the creation of thousands of housing units with co-located or coordinated clinical and support services
  - **Partners:** housing developers, case managers, health care providers, housing finance agencies and philanthropic organizations.
  - **Result:** Housing for Health's permanent supportive housing created
    - $32,000 per person/year in cost savings
    - 77% reduction in emergency room visits
    - 77% reduction in inpatient admissions
    - 85% reduction in inpatient days

Scholarship Program Improves Local Graduation Rates

- **Pittsburgh, Pennsylvania**
  - **Problem**: economic stagnation, retention of population
  - **Action**: Investment in the Pittsburgh Promise scholarship program, including scholarships for alumni of Pittsburgh public schools to attend Pennsylvania colleges
  - **Partners:** University of Pittsburgh Medical Center, Pittsburgh Public Schools, the Pittsburgh Foundation, and other funders.
  - **Results:**
    - Increase in local public high school graduation rate from 63% to 72%
    - Increase in the number of graduates enrolling in post-secondary education from 58% to 68%
    - Retention of young residents, leading to the city's first population growth in 50 years

Collaborative Job Creation

- **Cleveland, Ohio—Vision 2010**
- **Action: Vision 2010 construction project focused on the use of a diverse and local labor force, local and sustainable suppliers, and women- and minority-owned contractors to build community wealth**
- **Partners: City of Cleveland, local businesses, local trade unions (the Cleveland Building Construction Trades Council) and University Hospitals**
- **Results:**
  - **Generation of 5,200 construction jobs, $500 million in wages and 1,200 permanent jobs**
  - **Investment in capacity building of local women- and minority-owned businesses to fulfill large-scale contracts**

Major Cross-cutting Health Metrics Efforts

- Healthy People 2020 Leading Health Indicators
- National Prevention Strategy
- America's Health Rankings
- County Health Rankings
- Community Health Status Indicators
- Institute of Medicine Core Metrics/Vital Signs
- Robert Wood Johnson Foundation Culture of Health

AARP Livability Index for Quality of Life in Communities

- Environment (clean air & water)
- Transportation (safe, convenient)
- Housing (affordability/access)
- Neighborhood (access to life, work & play)
- Opportunity (income inequality, high school graduation rate, jobs/worker)
- Health (prevention, access, quality—includes healthy behaviors, preventable hospitalizations)
- Engagement (voting rates, social engagement)

Healthy Communities Index Primary Domains

- Environmental Hazards
- Health Systems and Public Safety
- Neighborhood Characteristics
- Transportation
- Natural Areas
- Housing
- Employment Opportunities
- Educational Opportunities
- Social cohesion
- Economic Health

U.S. Department of Housing and Urban Development

Selected Non-Health Federal Initiatives

- Corporation for National and Community Service: http://www.nationalservice.gov/programs/social-innovation-fund
- Department of Agriculture: https://www.hudexchange.info/programs/promise-zones/
- Department of Housing and Urban Development:
  - Healthy Housing Program
  - Healthy Communities Transformation Initiative (Example of Healthy Communities Assessment Tool available now for Providence, RI: http://hcat.providenceri.com/)
- Department of Transportation: https://www.transportation.gov/transportation-health-tool
- Federal Reserve:
  - San Francisco federal reserve bank, in particular http://www.frbsf.org/community-development/initiatives/healthy-communities/
  - Dallas federal reserve bank, as well http://www.dallasfed.org/cd/healthy/index.cfm

Toolkits Supporting Collaboration

- Community Toolbox
- Action Center (County Health Rankings)
- Community Commons
- Build Healthy Places Network
- The Practical Playbook
- Community Health Improvement Navigator

If you want to go fast, go alone.
If you want to go far, go together.
--African proverb

If you first make the wrong choice, choose again.
--heard on NPR a few weeks ago

Ultimate Frisbee
A fast-moving team sport combining soccer, football, and basketball and rewarding sportsmanship

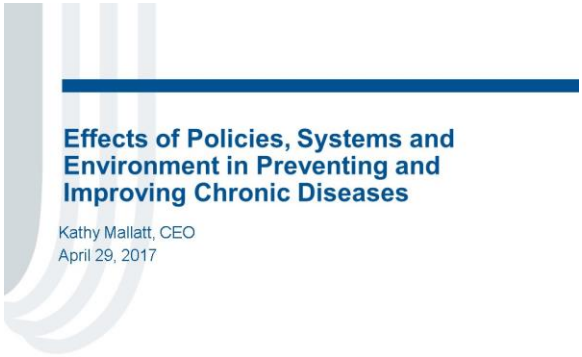
Thank you for your attention

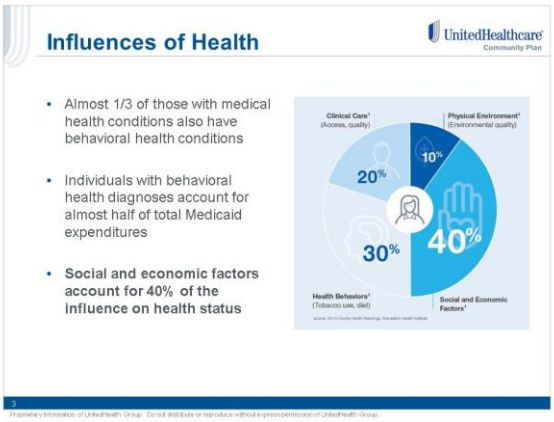
Koo et al. Environmental Scan of Recent Initiatives Incorporating Social Determinants in Public Health
(Reference—or just google my name and National Academy of Medicine or Preventing Chronic Disease)

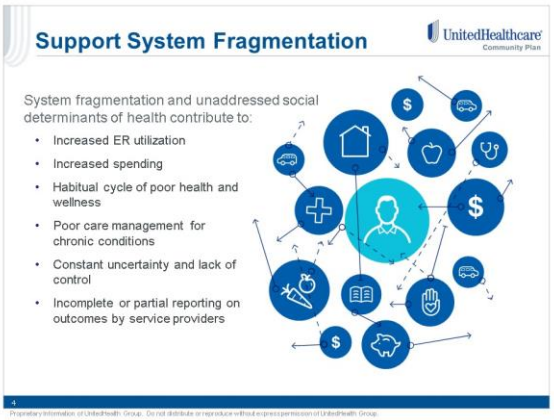
National Academy of Medicine:
- https://nam.edu/an-environmental-scan-of-recent-initiatives-incorporating-social-determinants-in-public-health/

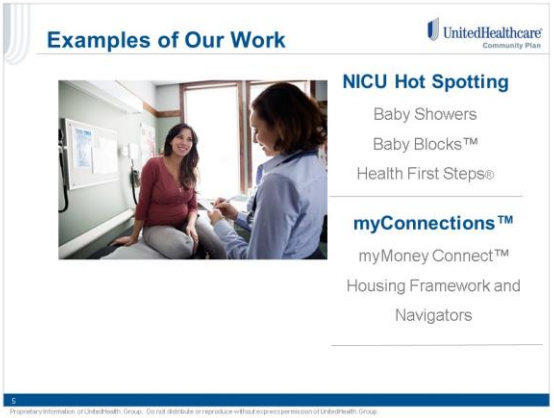
Preventing Chronic Disease:
- http://www.cdc.gov/pcd/issues/2016/16_0248.htm

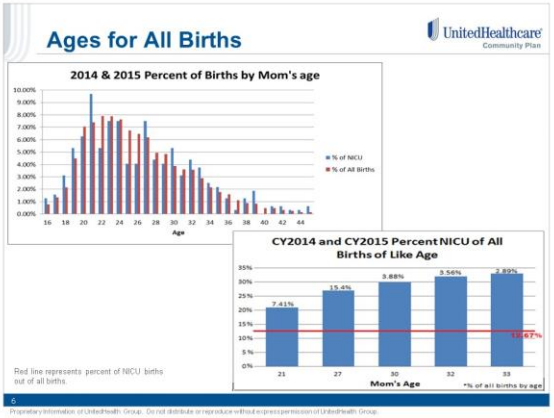
Ms. Kathleen Mallatt









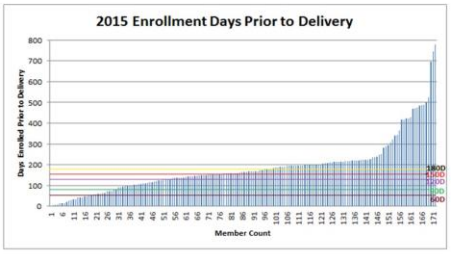


Enrollment Prior to NICU Delivery

UnitedHealthcare Community Plan

Overall Average Days of Enrollment Prior to 2015 NICU Birth: 179.9 days

- 12.6%, 60 days or less (average age 25)
- 17.2%, 90 days or less (average age 26)
- 27%, 120 days or less (average age 26)



7

Supporting Good Prenatal Care

UnitedHealthcare Community Plan

Baby Blocks™	Build a healthy future for new mom and baby plus earn great rewards. This program keeps mom-to-be and baby healthy during pregnancy and the baby's first 15 months of life. Gives reminders and rewards gift cards for clothing and more.
Healthy First Steps®	Our Healthy First steps program makes sure that both mom and baby get good medical attention on nutrition, fitness, getting supplies such as breast pumps and more.
Baby Showers	We provide education and awareness on prenatal/postpartum care to pregnant moms. A community partner presents health education on pregnancy to the moms. Special rewards are available for participation.
text4Baby	We provide health and wellness information related to pregnancy, childbirth and childcare.
Breast Pumps	We assist members with access to breastfeeding services. We will pay the cost of a portable electric breast pump. If members have questions about pumps or need help finding an in-network medical equipment company, they call Member Services.

8

myConnections™ Overview

UnitedHealthcare Community Plan

myConnections™ provides individuals better access to health and social services proven to boost health and wellness outcomes

We help individuals and families…

- Improve whole-person health and well-being
- Become self-sufficient
- Integrate services across the health care continuum

Our vision to help communities…

- Revitalize neighborhoods
- Reduce jobless rates
- Provide access to food and lower-cost banking options
- Drive cost efficiencies by alleviating "revolving door" of frequent admissions

9

myMoney Connect™

UnitedHealthcare Community Plan

myMoney Connect™ encourages whole-person well-being and financial independence for Medicaid members.

Wellness Rewards	Reward dollars are earned when members complete preventive health visits and simple wellness tasks. Funds are automatically loaded onto a prepaid debit MasterCard®.
General Spending	Members can easily load personal funds onto the debit card to pay bills or buy things they really need, like groceries, gas, or pharmacy items.
Budgeting	Allows personal funds to be set aside for later and enables monthly budget management. Funds can be managed from anywhere with the app or website.

10

Housing Framework

UnitedHealthcare Community Plan

Why a Housing Framework?

Medicaid members – both those with and without disabilities, often struggle with finding and keeping safe, affordable and sometimes supportive housing to ensure they can return or continue to live as independently as possible in the community. Homelessness, housing insecurity and the ability to return or stay in the community impact health of the individual and the community. Housing is the foundation of being able to live a healthy life.

Objectives

Design housing solutions collaborating with local experts for homeless, at risk, precariously housed or rent burdened Members.

Ensure housing meets HCBS standards, is safe, affordable, accessible, and supportive so members can live as independently as possible in the community.

11

Questions

UnitedHealthcare Community & State

Kathy Mallatt, CEO
UnitedHealthcare Community Plan of Nebraska
kmallatt@uhc.com

12

Mr. Ryan Sadler

HERITAGE HEALTH nebraska total care

Nebraska Total Care

5/13/2017

CENTENE Corporation

WHAT WE DO

29 states
with government sponsored healthcare programs

Medicaid (22 states) | Exchanges (15 States) | Medicare (12 States) | Correctional (8 States)

11.5 million members

238,000 Physicians & 2,300 Hospitals
in our provider networks

WHO WE ARE

St. Louis
based company founded in Milwaukee in 1904

28,000 employees

Transforming the health of the community, one person at a time

5/13/2017

Overview of Nebraska Total Care

- Nebraska Total Care is a Managed Care Organization (MCO) that provides health insurance to Nebraska residents enrolled in Nebraska's Heritage Health Medicaid program.
- Local presence is backed by a nationally recognized MCO: Centene Corporation
- Expertise in serving low-income populations
- Providing benefit coverage in all 93 counties
- Over 160 employees located in Omaha and Lincoln
- Membership approximately 77,000

5/13/2017

Our Philosophy

LOCAL APPROACH & JOB CREATION
Centene's core philosophy is that quality healthcare is best delivered locally. Our local approach enables us to provide accessible, high quality and culturally sensitive healthcare services to our members. Our care coordination model utilizes integrated programs that can only be delivered effectively by a local staff, resulting in meaningful job creation within the communities we serve.

CARE COORDINATION
Our proprietary care management programs promote a medical home for each member and enable Centene to partner with its trusted providers to ensure members receive the right care, in the right place, at the right time.

HEALTHCARE COMPLIANCE
State and Healthcare Effectiveness Data and Information Set (HEDIS) reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management team.

CULTURAL SENSITIVITY
We successfully coordinate care for our diverse membership by recognizing the significance of the many different cultures our members represent and by forming partnerships in communities that bridge social, ethnic and economic gaps.

4

Medical Management

Concurrent Review:

- Determines if patient meets medical necessity for hospitalization for all products offered
- Tracks patients while in hospital and projects length of stay
- Helps with Discharge Planning for patient
- Assists Finance with cost projections
- If monitoring is needed after discharge, member is referred to Disease Management or Outpatient Case Management

5/13/2017

Medical Management

Case Management:

- OB Case Management
  - Work with high risk pregnant women to support healthy pregnancy and delivery.
  - Nationally recognized StartSmart®, MemberConnections®, and ConnectionsPlus® programs.
- Outpatient (OP) Case Management
  - Manage wide variety of non-OB member issues (asthma, diabetes, HIV, catastrophic).
  - Focus on minimizing unplanned re-admissions and non-emergent ER utilization.
  - Evaluate risk scores for members with certain conditions for Case Management.
- Both programs consist of teams of RNs, behavioral health clinicians, social workers, and Program Coordinators.
- Foster Care Program Liaison
- EPSDT Coordinator

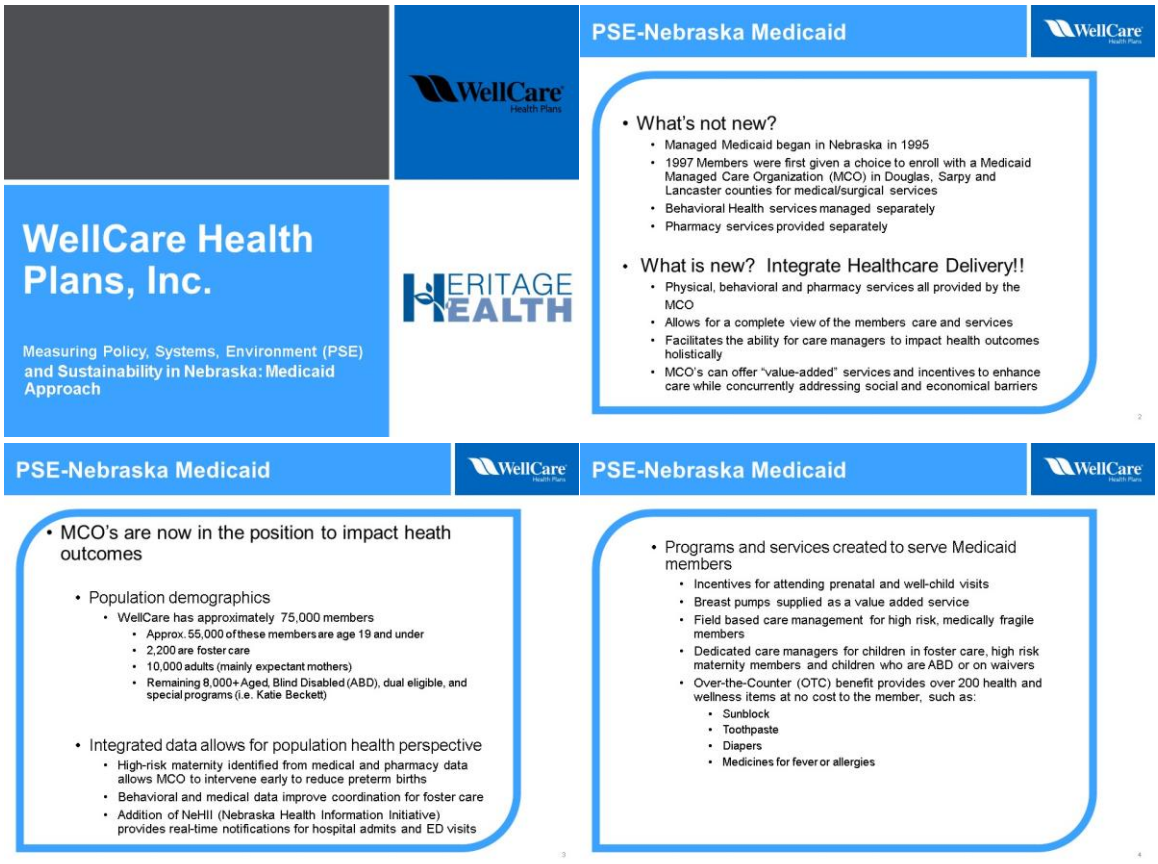
5/13/2017

HERITAGE HEALTH nebraska total care

Questions???

5/13/2017

Ms. Melanie Surber



Ms. Morgan Murphey

SMUDGED GLASSES

HEALTHCARE IN THE CONTEXT OF IMPLICIT BIAS

MORGAN MURPHREY

IN MEMORY: FRANK T. PEAK, Ph.D, MPA

Dr. Peak sought to make an impact in his community through **health advocacy** and **education.**

In keeping with Dr. Peak's life work, the purpose of this presentation is to empower you to further these aims.

GOALS FOR TODAY

- What is **implicit bias**?
- How does implicit bias affect **healthcare?**
  - What does **implicit bias** mean for **healthcare providers and recipients?**
- How can healthcare providers and professionals **combat** implicit bias?

*Most importantly: **increase awareness** of implicit bias*

WHAT IS IMPLICIT BIAS?

Associations **outside conscious awareness** that lead to a **negative evaluation** of a person on the basis of **irrelevant characteristics**, such as race or gender.[1]

IMPLICIT BIAS: A SNAPSHOT

Implicit vs. explicit bias

Explicit bias : intentional, conscious and controllable
Implicit bias : unintentional, unconscious and uncontrollable

First described in **1995** by Anthony Greenwald and Mahzarin Banaji.[2]

A "hot topic" in recent years.

COMMON IMPLICIT BIASES

BIGGEST ISSUE WITH IMPLICIT BIAS:

Implicit biases are **unconsciously held** and often in **disagreement with conscious** values.

...implicit bias may unconsciously affect the way you behave in a way that you would not consciously desire.

HOW DOES IMPLICIT BIAS AFFECT HEALTH CARE AND HEALTH DISPARITIES?

1. Implicit bias is prevalent in the healthcare setting.

   The presence of pro-White bias was significant among physicians of all racial groups except African Americans.[3]

2. There is a relationship between implicit bias and patient care.

   Implicit bias was significantly related to patient provider interactions, treatment decisions, treatment adherence, and patient health outcomes.[4]

HOW DOES IMPLICIT BIAS AFFECT HEALTH CARE AND HEALTH DISPARITIES?

3. This relationship is leading disparities in healthcare.

   Diagnostic Workup:

   Female patients were less likely than males to receive 4 of 5 types of physical exam.[5]

   Treatment Plans:

   As physicians' pro-white implicit bias increased, so did their likelihood of treating white patients and not treating black patients with thrombolysis.[6]

   Midlife women were asked fewest questions and prescribed less medication appropriate for congestive heart disease versus other populations.[7]

WHAT DOES THIS ALL MEAN?

- An unconscious source of bias that may be affecting the way you interact with others
  - Termed "**implicit bias.**"
- Logically, personal biases should not influence healthcare decision-making
  - Often overlooked problem is **implicit bias.**
- **Like smudges on reading glasses,** individuals are not acutely aware of their implicit biases, yet they may affect their view of the world and the outcome of their patients.

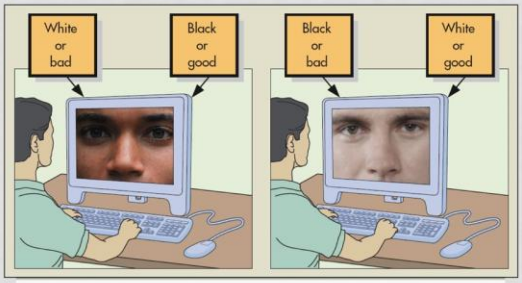
HOW CAN WE COMBAT THIS?

- **Step 1**: Increase awareness of **implicit bias.**

  Recognizing implicit bias may, at the very least, increase concern about discrimination and personal awareness of bias.[7]

- **Step 2**: Recognize personal implicit biases with the use of **Implicit Association Tests.**

- **Step 3**: Facilitate and participate in **interventions** aimed at mitigating implicit bias.



IMPLICIT ASSOCIATION TESTS

SIMPLE, ONLINE TESTS TO IDENTIFY IMPLICIT BIAS

IMPLICIT ASSOCIATION TESTS

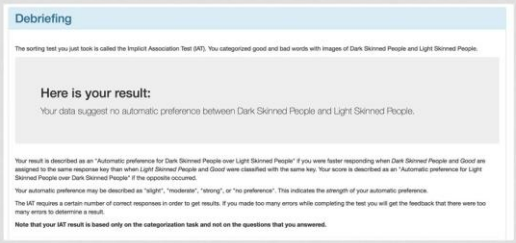
- Developed by social psychologists
- Measure attitudes **not explicitly measured** through self-reporting
- **Five** main parts
- Quickly sort words into categories on **opposite sides** of a computer screen

IMPLICIT ASSOCIATION TESTS

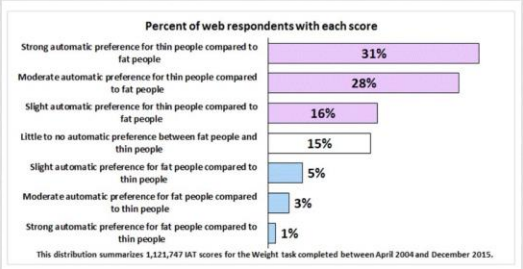
IMPLICIT ASSOCIATION TESTS

Available online at: https://implicit.harvard.edu/implicit/takeatest.html

IMMEDIATE RESULTS



NATIONAL COMPARISONS



INTERVENTIONS

What does an intervention entail?

- **Two afternoon** training sessions
- Participants are **educated on implicit bias**
- Participants are **provided daily strategies** to diminish its effects

Examples of Trainings:

- Stereotype replacement
- Counter-stereotypic imaging
- Individuation
- Perspective taking
- Increasing opportunities for contact

IN REVIEW…

Implicit bias – unconsciously held biases

- Often in **disagreement** with **conscious** values

These **implicit biases** result in disparities

The relationship between implicit bias and healthcare disparities provides a **potential avenue for improvement** by healthcare professionals and institutions.

WHAT IT ALL BOILS DOWN TO:

Implicit biases

-unconsciously held

-often in disagreement with conscious values

With the help of **tools such as IATs**, healthcare professionals, trainees, and institutions may be better equipped to:

-mitigate implicit bias

-serve as **advocates for change and improvement** in the healthcare system

REFERENCES

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2. Greenwald, A.G., & Banaji, M.R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. Psychological Review, 102, 4-27.
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4. Hall, W. J., et al. (2015). "Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review." Am J Public Health **105**(12): e60-76.
5. McKinlay JB, et al. Sources of Variation in physician adherence with clinical guidelines; results from a factorial experiment. J Gen Intern Med. 2007; 22:289-96.
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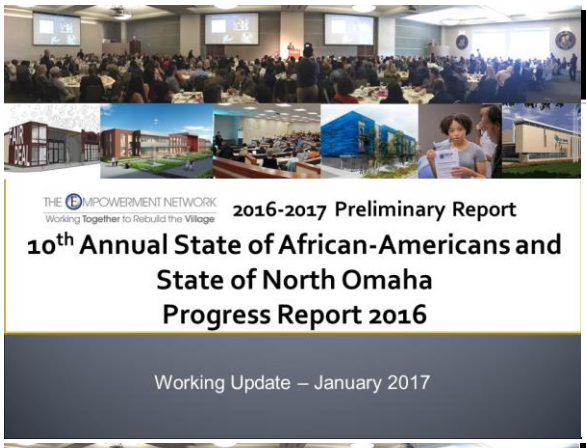
Mr. Willie Barney



THE EMPOWERMENT NETWORK
Working Together to Rebuild the Village

2016-2017 Preliminary Report

10th Annual State of African-Americans and State of North Omaha Progress Report 2016

Working Update – January 2017

7 Step Empowerment Plan and Transformation 2025 Plan

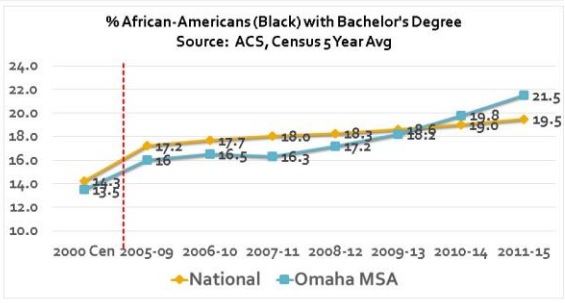
1. Employment & Entrepreneurship
2. Education and Youth Development
3. Housing and Neighborhood Development
4. Faith and Hope
5. Violence Prevention and Intervention
6. Financially Sound and Healthy Families
7. Arts, Culture, Media and Communications

American Community Survey U.S. Census Update Key Trends for African-Americans

Working Update – December 2016

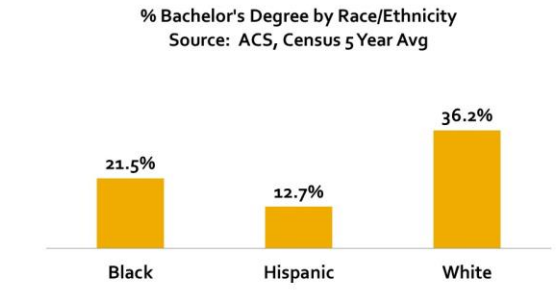
ACS Update Compiled and Prepared by:
David Drozd – Research Coordinator – UNO
Willie Barney – President & Facilitator - Empowerment Network

% of African-Americans with Bachelors Degree or Higher: Omaha MSA



Source: American Community Survey, U.S Census Bureau 2000, 5 Year Reports 2005-2009 to 2011-2015
Compiled and Prepared by: David Drozd – Research Coordinator – UNO and Willie Barney – Empowerment Network

% with Bachelors Degree or Higher: By RACE – Omaha MSA



Source: American Community Survey, U.S Census Bureau 5 Year Report 2011-2015
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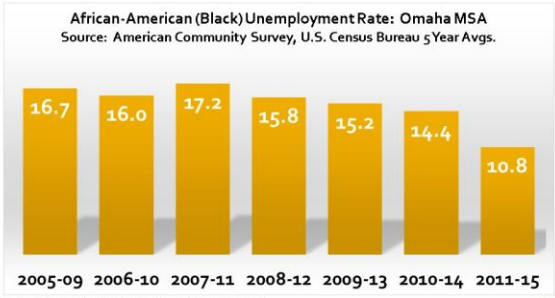
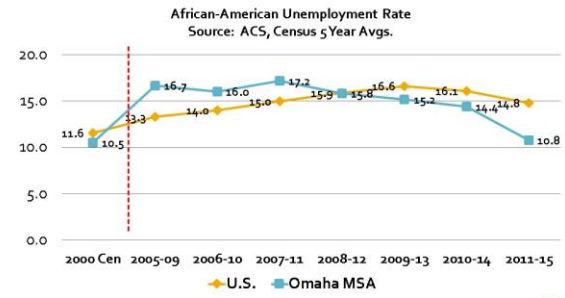
Unemployment Rate Trend African-American – Omaha MSA



2016-2017 State of African Americans and State of North Omaha Report
Source: American Community Survey, U.S. Census Bureau 5 Year Reports 2005-2009 to 2011-2015
Compiled and Prepared by: David Drozd – Research Coordinator – UNO and Willie Barney – Empowerment Network

Unemployment Rate Trend African-American: US vs. Omaha



Source: American Community Survey, U.S. Census Bureau 2000, 5 Year Reports 2005-2009 to 2011-2015
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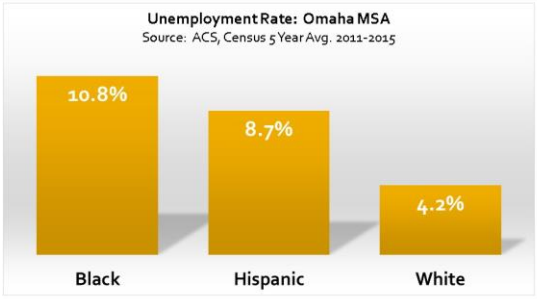
Unemployment by Race: Omaha MSA



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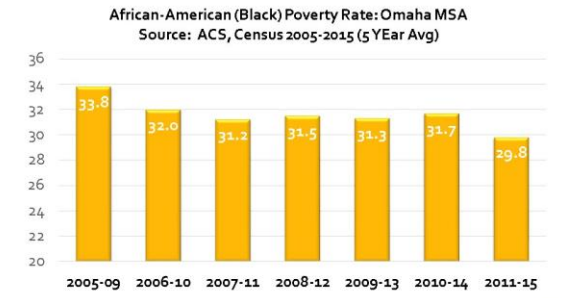
African-American Poverty Rate Omaha MSA



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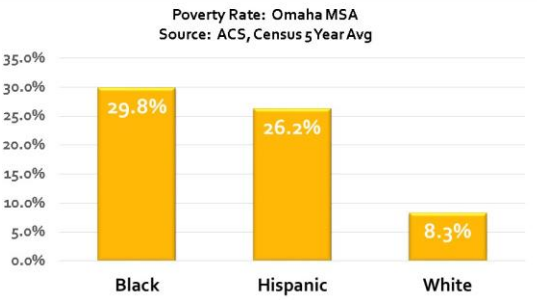
Poverty by Race/Ethnicity Omaha MSA



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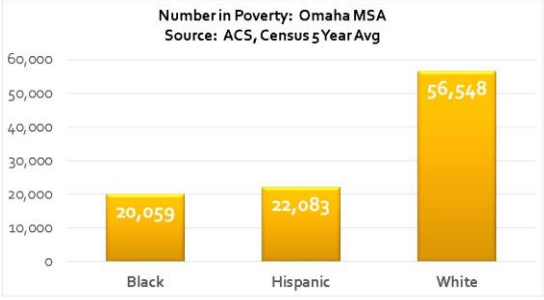

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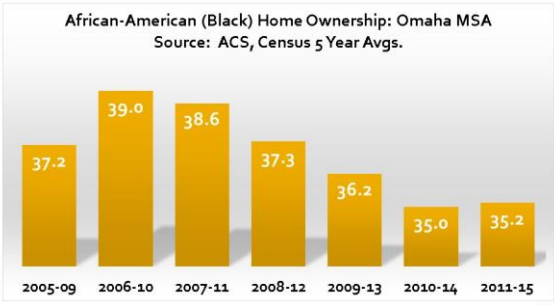
Family Poverty Rates

Family Poverty Rates by Family Type by Race/Ethnicity in the Omaha Metro: 2011-2015
Source: Table S1702, 2011-2015 American Community Survey, U.S. Census Bureau
Compiled by: David Drozd, UNO Center for Public Affairs Research on 12-8-2016

	Poverty Rates (%)			Percent of Families	
Race/Ethnicity	All families	Married couples	Female headed family, no husband	That are married couples	That are female headed, no husband
Black	26.2	9.1	42.0	42.4	48.8
Hispanic	24.1	15.2	48.1	61.9	24.1
Non-Hispanic White	5.4	2.3	20.4	79.6	14.5

Source: American Community Survey, U.S. Census Bureau 5 Year Reports 2011-2015
Compiled and Prepared by: David Drozd – Research Coordinator – UNO and Willie Barney – Empowerment Network

Home Ownership: African-American Omaha MSA



Source: American Community Survey, U.S. Census Bureau 5 Year Reports 2005-2009 to 2011-2015
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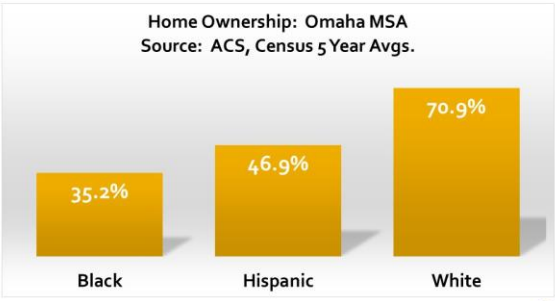
Home Ownership by Race/Ethnicity Omaha MSA



Source: American Community Survey, U.S. Census Bureau 5 Year Report 2011-2015
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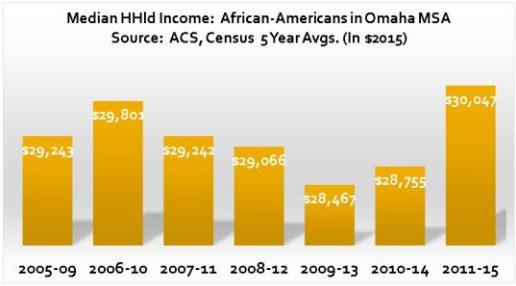
Household Income: African-Americans Omaha MSA



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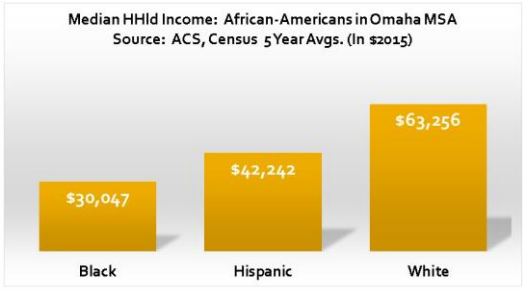
Household Income – By Race/Ethnicity Omaha MSA



Source: American Community Survey, U.S. Census Bureau 2011-2015
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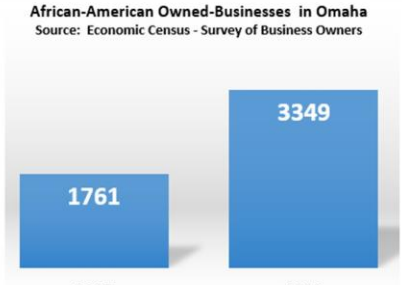
Business Ownership

Omaha MSA: Growth, but only 200 have Employees



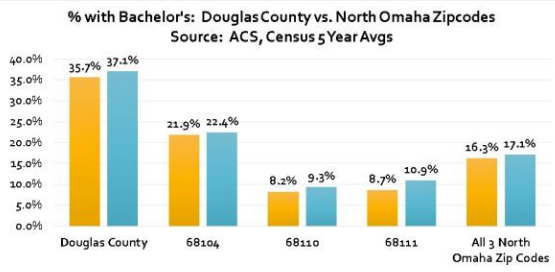
Source: U.S. Census Bureau Economic Census
Compiled and Prepared by: Empowerment Network

ACS - U.S. Census Update North Omaha: Key Trends

Working Update – December 2016

ACS Update Compiled and Prepared by:
David Drozd – Research Coordinator – UNO
Willie Barney – President & Facilitator - Empowerment Network

Education Trend: Bachelor's Degrees Douglas County vs. North Omaha



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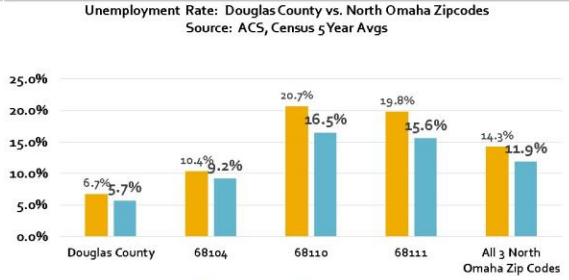
Unemployment Rate Trend Douglas County vs. North Omaha



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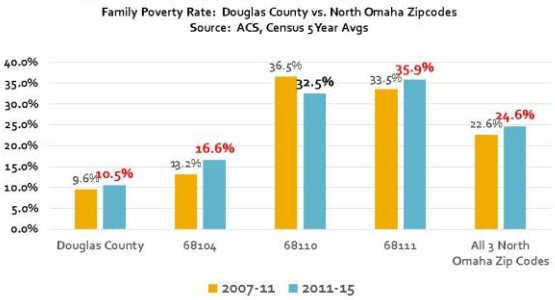
Family Poverty Rate Trend: Douglas County vs. North Omaha



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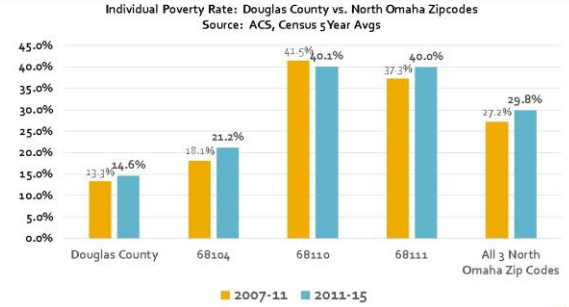
Individual Poverty Rate Trend: Douglas County vs. North Omaha



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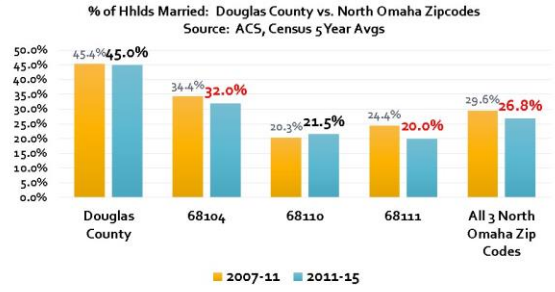
Marriage Rate as % of HHlds Douglas County vs. North Omaha



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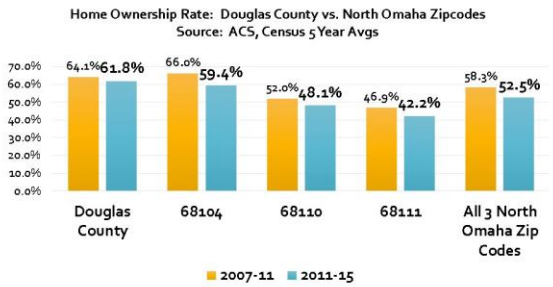
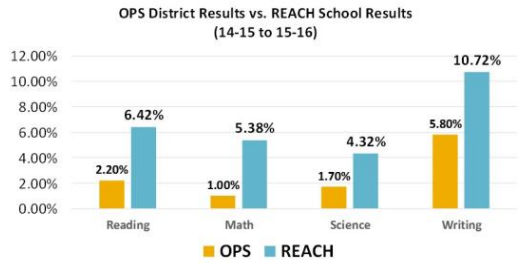
Compiled and Prepared by: David Drozd – Research Coordinator – UNO and Willie Barney – Empowerment Network

Home Ownership Trend Douglas County vs. North Omaha



Source: American Community Survey, U.S. Census Bureau 5 Year Reports 2007-2011 to 2011-2015
Compiled and Prepared by: David Drozd – Research Coordinator – UNO and Willie Barney – Empowerment Network

Elementary REACH Schools: Average Increase in Proficiency Percentage



Pastors and Faith Leaders…

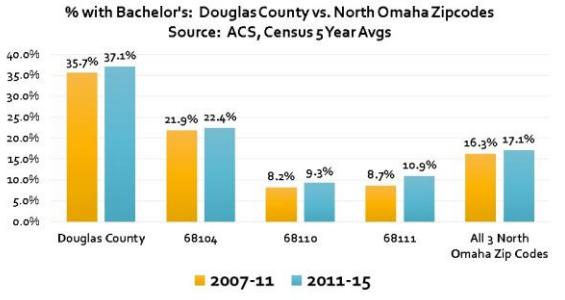
- Specific Initiatives
  - Prayer – Individual and Corporate
  - Build Relationships
  - Mobilize Members
  - PrayerWalks
  - Adopt-A-School
  - Adopt-A-Block and Village Stakeholders
  - Adopt-A-Unit
    - DCYC
    - DC Jail
    - Prison
  - Church-based Economics

Demographics & Population Trends North Omaha

Category	2000 Census	2007-11 ACS	2011-15 ACS		2000 to 2015 Growth Rate
Total Population	70,708	66,723	65,903		-6.8%
Black (non-Hispanic)	32,793	29,883	28,693		-12.5%
White (non-Hispanic)	32,463	26,155	25,469		-21.5%
Hispanic	2,219	5,175	5,663		155.2%
Foreign Born	1,789	4,306	5,424		203.2%
					2000 to 2015 Change
Percent of Population	100.0%	100.0%	100.0%		0.0%
Black (non-Hispanic)	46.4%	44.8%	43.5%		-2.8%
White (non-Hispanic)	45.9%	39.2%	38.6%		-7.3%
Hispanic	3.1%	7.8%	8.6%		5.5%
Foreign Born	2.5%	6.5%	8.2%		5.7%

Source: American Community Survey, U.S. Census Bureau 2000 and 5 Year Reports 2005-2009 to 2011-2015
Compiled and Prepared by: David Drozd – Research Coordinator – UNO and Willie Barney – Empowerment Network

Education Trend: Bachelor's Degrees Douglas County vs. North Omaha



Source: American Community Survey, U.S. Census Bureau 5 Year Reports 2007-2011 to 2011-2015
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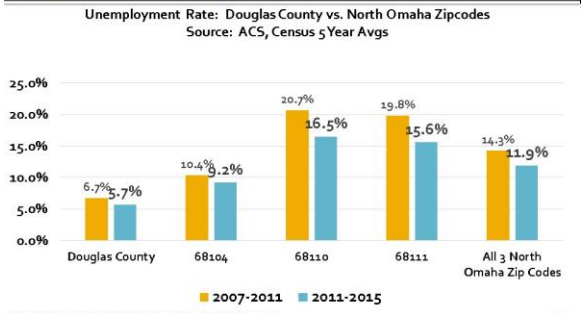
Unemployment Rate Trend
Douglas County vs. North Omaha



2016-2017 State of African-Americans and State of North Omaha Report
Source: American Community Survey, U.S. Census Bureau 5 Year Reports 2007-2011 to 2011-2015
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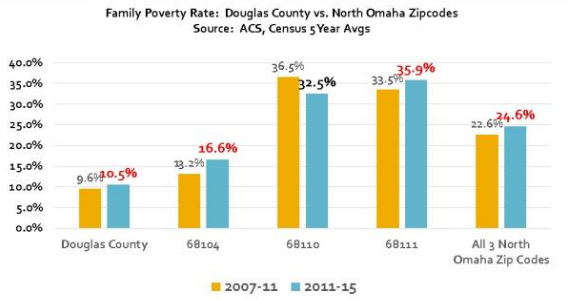
Family Poverty Rate Trend:
Douglas County vs. North Omaha



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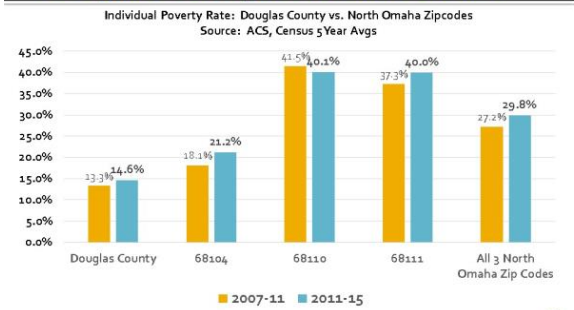
Individual Poverty Rate Trend:
Douglas County vs. North Omaha



Source: American Community Survey, U.S. Census Bureau 5 Year Reports 2007-2011 to 2011-2015
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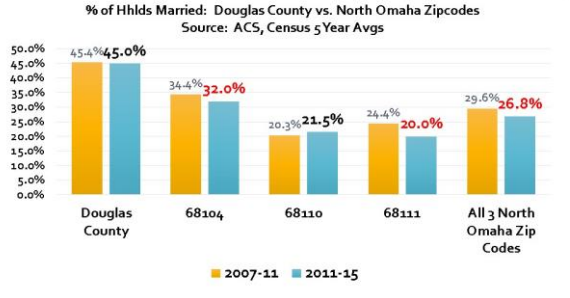
Marriage Rate as % of HHlds
Douglas County vs. North Omaha



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Home Ownership Trend
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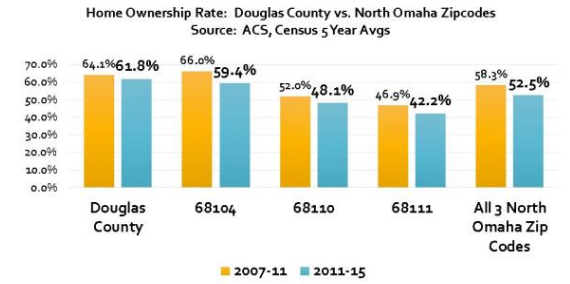

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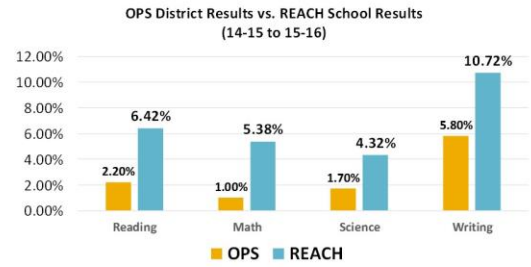
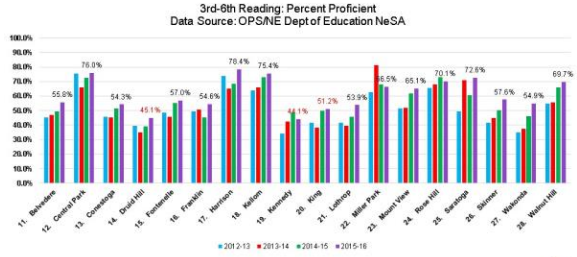
Elementary REACH Schools:
Average Increase in Proficiency Percentage

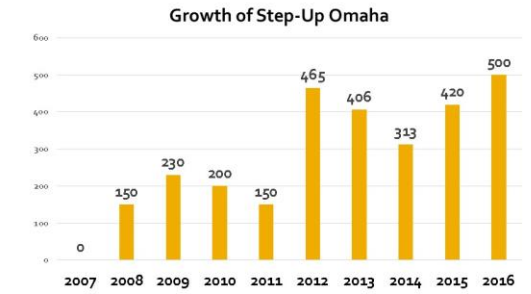


School Improvement: Reading
North Omaha Elem. Schools

- 83% of Schools Returned their Highest Proficiency Level
- 83% of Schools Improved their Results Over their 14-15 Proficiency Level

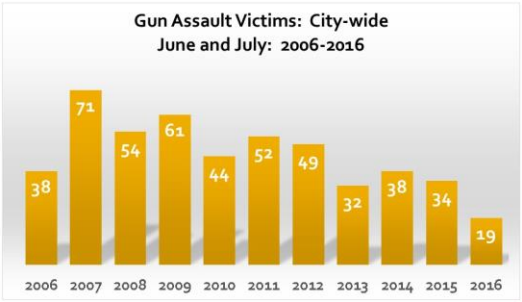


Step-Up Omaha!
Youth Employment Program



Source: Empowerment Network and City of Omaha

Gun Assault Victims: City-wide Summer (June-July): 2006 to 2016



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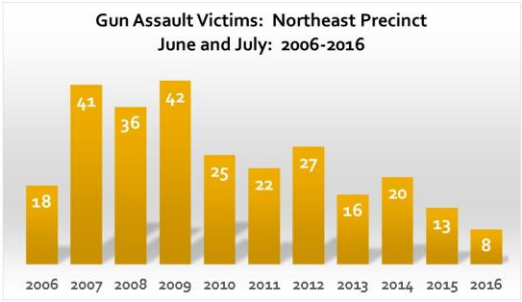

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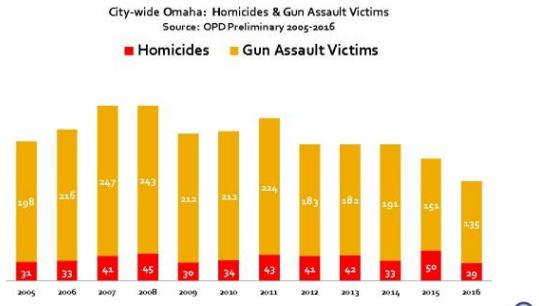
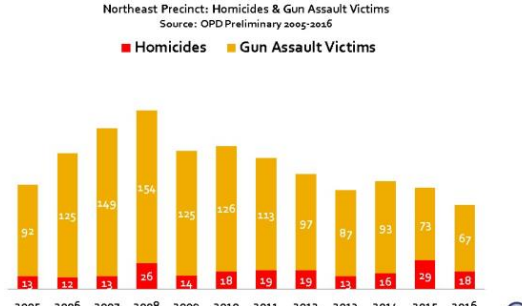
City-wide Gun Assault Victims & Homicides Trend 2005 to 2016: Jan-Dec.

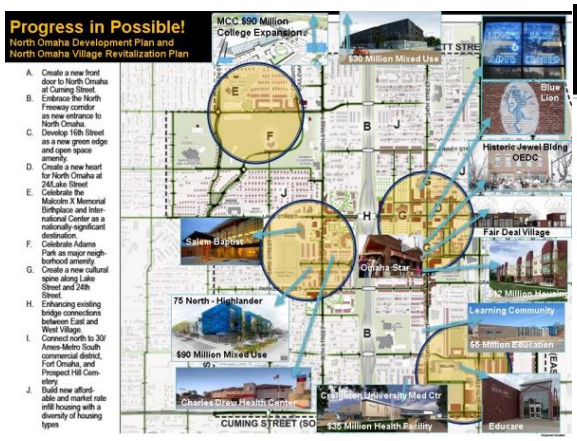


Northeast Gun Assault Victims & Homicides Trend 2005 to 2016: Jan-Dec.



Progress in Possible!

North Omaha Development Plan and North Omaha Village Revitalization Plan



Can change happen? YES!

Progress from 2007 to 2016

1. **H.S. Grad Rates Up** +20%; **% with Bachelor Degrees** is up
2. **Reading and Math Scores Up** +20% to +28%
3. **Gun Violence Rates Down** - 40% City-wide (-55% in Northeast Omaha)
4. **Unemployment Rate is trending down for AA and N.O.**
5. **Poverty Rate is trending down for AA, up for N.O.**
6. **More business training, new businesses and expansion; more needed**
7. **Summer Jobs/Youth Emp. increased** from 30 to over 500+ annually
8. **Housing and Revitalization:** Major developments; more needed
9. **Arts, Culture & Business District:** Increased Attendance/Rebuilding

North Omaha: Remaining Gaps

1. Declining Home Ownership Rate
2. Wage Rate Gap ($5 gap per hour for people of color vs. white workers)
3. Lack of Jobs in the Area (need more job centers in North Omaha)
4. Lack of Businesses in the Area (Of Size)
5. Marriage Rate Decline and Increase in Single Parent Hhlds
6. Loss of Population and Concentrated Poverty
7. Concentrated Gun Violence
8. Dilapidated Housing/Housing Stock/More Affordable & Mixed Income Needed
9. Physical and Mental Health Concerns
10. Improvements in Education; but significant gaps remain (Math, MS, HS)

2016-2017 Preliminary Report
State of African-Americans and State of North Omaha

Progress Update for African-Americans, North Omaha and City-wide

Working Update – September 2016

Pastors as Village Leaders

- Serving
  - Members
  - Community (Community Pastors)
  - Residents in Need/Crisis
- Leadership & Engagement
  - Pastors and Faith Leaders
  - Omaha 360
  - Saturday Village Meeting
  - Village Stakeholders
  - PrayerWalks in Your Area
  - Host Positive Events

Village Connection

- Connecting Members & Residents to Resources
  - Employment – Urban League/HWS/Step-Up
  - Entrepreneurship – OSBN, NEF, Reach, Revive!
  - Education – School, After School, Summer, Camps
  - Safety – OPD, YouTurn and others
  - Housing – FHAS, Holy Name, Habitat, other
  - Financial Stability – FHAS
  - Drug/Alcohol Counseling
  - Other

What do you need?

- Prayer – Specific Time, wherever you are…Our City
  - 10:02 and Possible Prayerline
- Pastors and Faith Leaders: Inside and Out…
- Directory – Who is which one? What they are sponsoring? How to get connected?
- Services – Connection Points/Where to go?
- Resource list of Partners – Willing to step in to minister to family. Assists with funerals.
- Training on working with families in crisis.
- Training on dealing with trauma.
- Tour the Jail
- Relationship Education/Marriage is Cool

Education & Youth Development

Working Update – December 2016

Reading and Math Proficiency Trend

North Omaha Cradle to Career

N.O. Cradle to Career Strategies

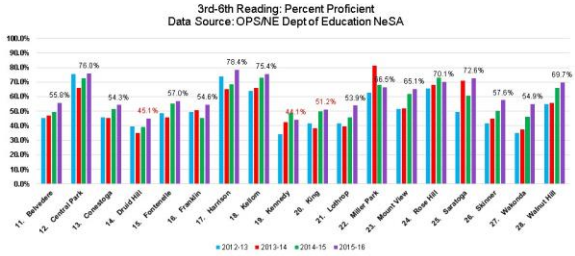
1. Equity & Resources
2. Empowered Families and Community
3. Early Childhood Investments
4. Excellent Schools
   - Strong Principals
   - Effective Teachers
   - Challenging Curriculum
5. Support for Families/Integrated Learning Supports
6. Effective Use of Time/More Time on Task
7. Student Engagement
8. Student Leadership/Opportunities

North Omaha Cradle to Career Community Partners

- Empowerment Network
- OPS
- Learning Community
- AAAC
- Collective for Youth – A/S
- MMP Omaha - Mentoring
- Urban League
- 100 Black Men - Mentoring
- Charles Drew Health Center
- United Way
- College Possible
- D2 Engagement Center
- Bellevue University
- MCC
- Creighton University
- UNO
- Family Housing Advisory Services
- Building Healthy Futures
- Plus, 40 Other Partners

School Improvement: Reading North Omaha Elem. Schools

- 83% of Schools Returned their Highest Proficiency Level
- 83% of Schools Improved their Results Over their 14-15 Proficiency Level



School Improvement: Math North Omaha Elem. Schools

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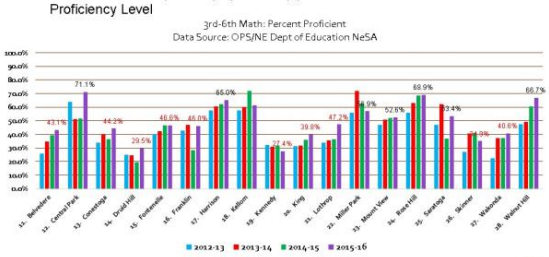
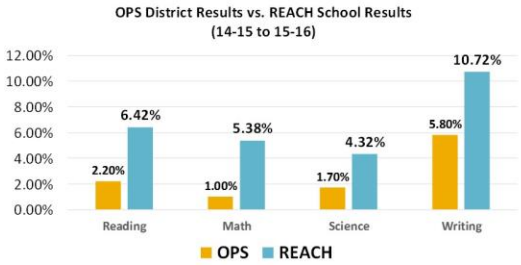


REACH Resources – Employing Supports

- REACH Supervisors
- Literacy Facilitators
- Math Coaches
- Social Workers
- School Support Liaisons
- Academic Data Representative Meetings
- Minnesota Humanities Center
- REACH Leadership Meetings
- Technology – Laptops
- District Departments
- Consultants

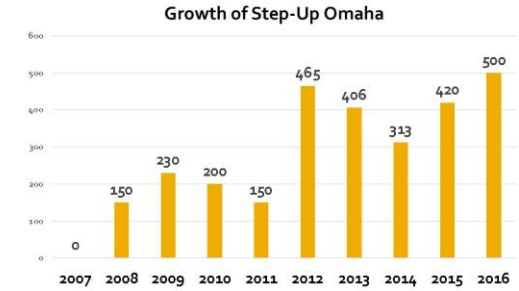
Elementary REACH Schools: Average Increase in Proficiency Percentage



Youth Employment

- Step-Up Omaha! Summer
- Step-Up Omaha! Extended Pilot
- Hope Center
- OPS
- Urban League - WIOA

Step-Up Omaha! Youth Employment Program



Source: Empowerment Network and City of Omaha

Employment: (Adults)

- U.L. Bootcamp
- HWS/Res Care
- Cross Training
- MCC
- Maximus/Employment First
- Other

Entrepreneurship & Contracting

Working Update – December 2016

Entrepreneurship

- Omaha Small Business Network (OSBN)
- Nebraska Enterprise Fund (NEF)
- REACH (Greater Omaha Chamber)
- OEDC – Fair Deal Village MarketPlace
- Revive! Business Network
- Other

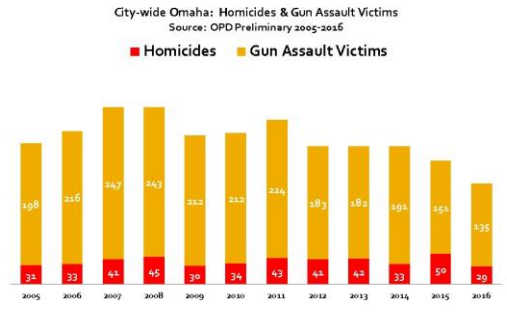
OEDC's Fair Deal Village Marketplace

- 10 New Businesses
- 32 New Jobs

Safety & Justice

Working Update – September 2016

City-wide Gun Assault Victims & Homicides Trend 2005 to 2016: Jan-Dec.



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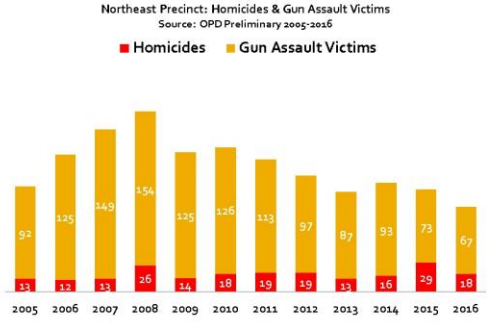

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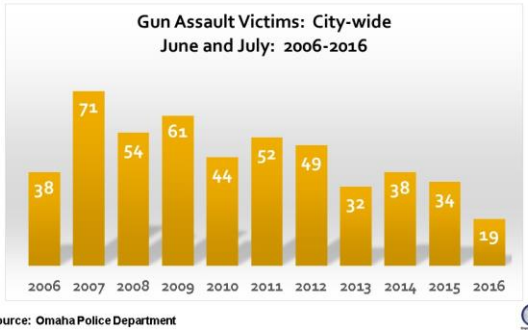

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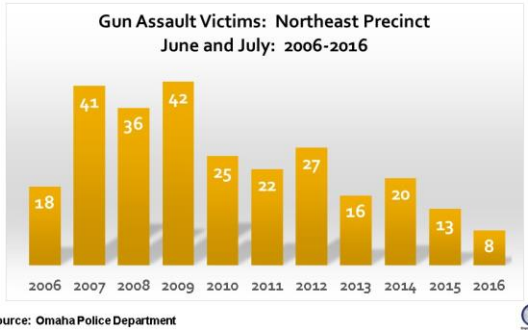

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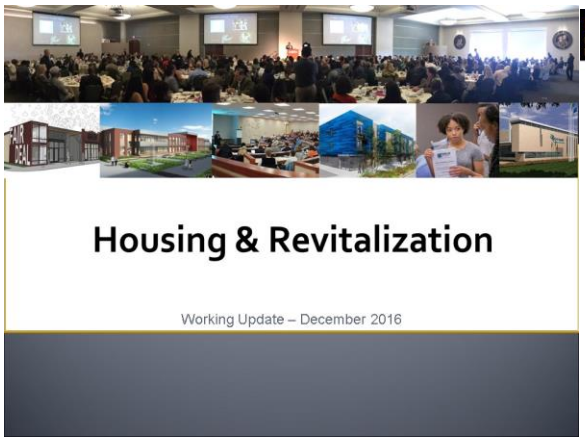
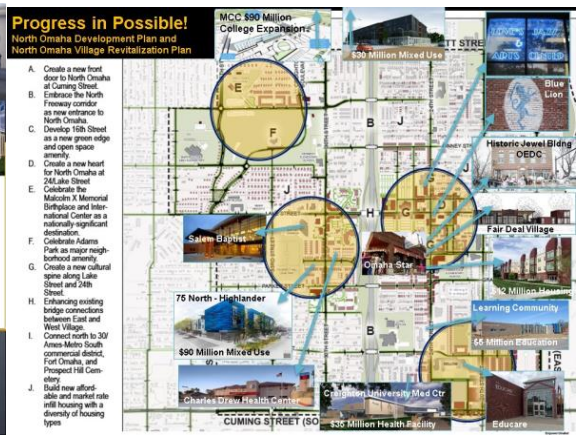


Housing & Revitalization

Working Update – December 2016



Health and Healthy Families

- Healthy Relationships, Marriages & Parenting
- Access to Insurance and Health Care (Physical, Dental and Mental)
- Address mental and behavioral health (inc. trauma)
- Access to Healthy Foods
- Reducing Disparities (Obesity – priority)

Economic Benefits to the City of Omaha!

Return on Investment:

- Create New Jobs
  - Construction Jobs
  - Permanent Jobs
- Build New Businesses and Increase Tax Revenues
- Prepare Omaha Workforce for Current and Future Jobs
  - Close the Skills Gap
- Increase Economic Impact (Growth/Consumer Spending)
- Increase Tourism
- Improve Services to Residents (Roads, Parks, etc)
- Reduce Social Costs
- Reduce Tax Payer Burden

Omaha Small Business Network North Omaha Impact for 2016

Number of new businesses	2
Sales Generated by new businesses	$50k
New employees added	18
Number of expanded businesses	8
Sales Generated by expanded businesses	$1.5MIL
Employees added	20
Number of new loans	11
Dollar Amount of Loans	$300,000
TOTAL IMPACT w/ New & Existing TENANTS	$4 Million

Nebraska Enterprise Fund North Omaha

- 37 Unique Businesses Funded
- 87 Total Loans disbursed
- $1,511,803 Value of Loans Disbursed
- 153 jobs impacted

REACH: Contracts

50	# Contracts
$5,103,243	$ Contracts
$102,065	Avg $ Contract
$61,318	Avg $ Contract *

REACH: Loans and Financing

88	Total # of loans
$1,388,153	Total value of loans
$15,774	Avg value of loans
$1,000	Smallest loan
$102,000	Largest loan
0	Total # of defaults
73	# Invoice Financing
$438,869	$ Invoice Financing

REACH: Bonds

- 9 # bonds facilitated
- $1,450,657 $ bonds facilitated
- $161,184 Avg. bond value
- $12,000 Smallest bond
- $548,505 Largest bond
- 4 # first time bonding

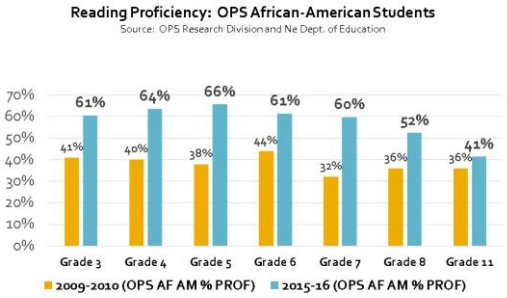
Education & Youth Development

Working Update – December 2016

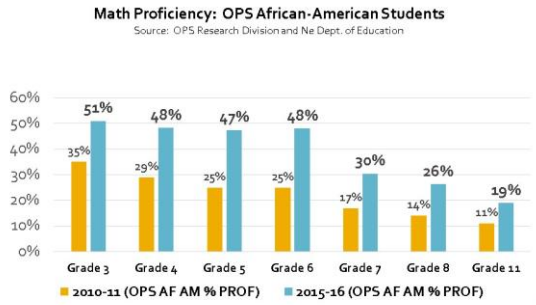
Reading and Math Proficiency Trend

African-American Students in Omaha Public Schools

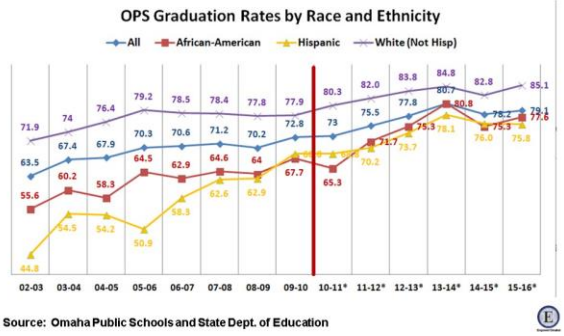
Education Trend: Reading Proficiency African-American



Education Trend: Math Proficiency African-American



OPS Graduation Rates



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North Omaha Cradle to Career
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- AAAC
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- Urban League
- 100 Black Men - Mentoring
- Charles Drew Health Center
- United Way
- College Possible
- D2 Engagement Center
- Bellevue University
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Mark Evans
Omaha Public Schools District

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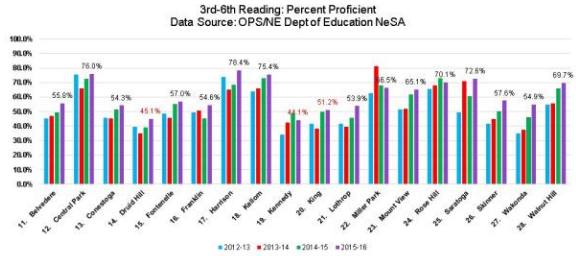

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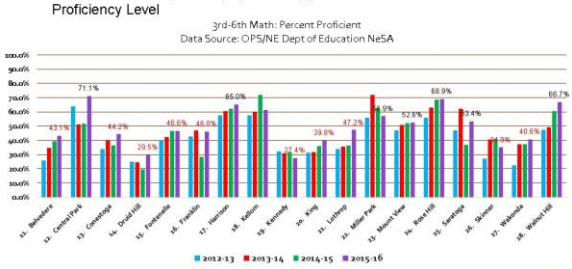


REACH Schools
Resources Employed Accordingly Creating Hope

Executive Directors
School Support and Supervision

Elementary
Dr. Dwayne Chism
Mrs. Melissa Comine
Ms. Lisa A. Utterback

Secondary
Mrs. Pam Cohn

REACH Program

- **R**esources **E**mployed **A**ccordingly **C**reating **H**ope
- Low achieving schools have the highest need for support in OPS
- Built on the shared belief that "all students can and will learn"
- Composed of differentiated and strategically aligned supports

Elementary Reach School	
Belvedere (N)	Conestoga (N)
Druid Hill (N)	Franklin (N)
Highland	Jackson
Kennedy (N)	King (N)
Lothrop (N)	Minne Lusa (N)
Skinner (N)	Wakonda (N)

Note. N = Cradle to Career Identified as North Omaha School

REACH Program

- **R**esources **E**mployed **A**ccordingly **C**reating **H**ope
- Low achieving schools have the highest need for support in OPS
- Built on the shared belief that "all students can and will learn"
- Composed of differentiated and strategically aligned supports

Secondary Reach Schools	
Benson High (N)	Bryan High
South High	
Monroe Middle School (N)	Norris Middle School

Note. N = Cradle to Career Identified as North Omaha School

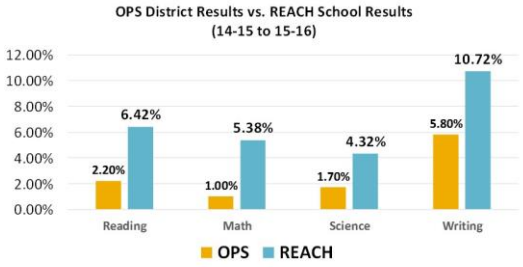
REACH Resources – Employing Supports

- REACH Supervisors
- Literacy Facilitators
- Math Coaches
- Social Workers
- School Support Liaisons
- Academic Data Representative Meetings
- Minnesota Humanities Center
- REACH Leadership Meetings
- Technology – Laptops
- District Departments
- Consultants

North Omaha Cradle to Career
FACE & Integrated Learning Supports

- **Family Supports**
  - Basic Needs and Health Needs – Physical, Mental, Dental, Vision
  - Housing and Employment
  - Early Childhood Education
  - Parent/Family Educational Opportunities – GED/HS/College
- **Student Supports**
  - Mentoring
  - Tutoring
  - After School
  - College Placement
  - ACT/College Prep
  - Vocational Training
  - Career Exploration and Work Experience

Elementary REACH Schools:
Average Increase in Proficiency Percentage



Education – Career & Job Training

- OPS Career Academies
- OPS Career Center
- MCC
- Cross Training
- Other

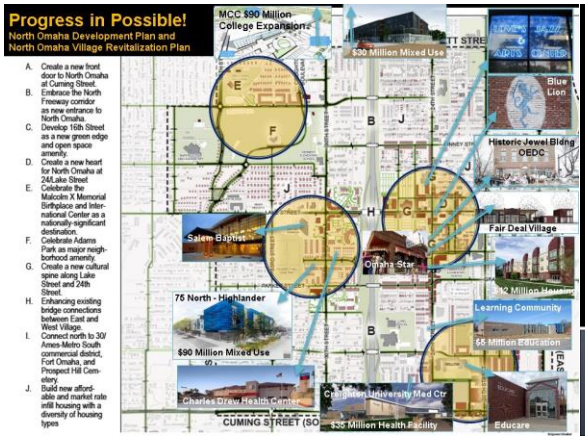
North Omaha Schools
Graduation Rate

Randy Schmailzl

Metropolitan Community College

Housing & Revitalization

Working Update – December 2016



Othello Meadows

75 North – Highlander

Housing Development

- 75 North — 101 in development
- White Lotus — 260 in development
- Holy Name Housing — 30 completed in 2016
- Habitat for Humanity — 20 new completed in 2016
- City of Omaha — 44 (supported by City – HN 27, GESU 6, City 6, Habitat 4)
- GESU — 6 completed in 2016
- Private Developers

Housing: Rehab and Demo

- **Demolition**
  - City — 76
- **Rehab**
  - City
  - Habitat — 21
  - Other

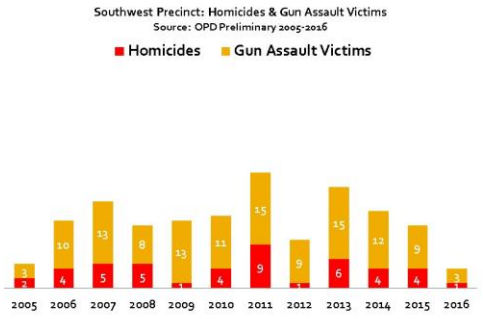
Safety & Justice

Working Update – September 2016

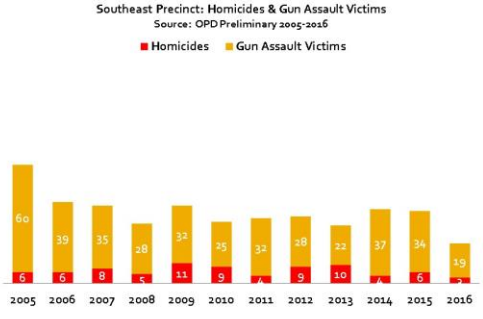
Chief Todd Schmaderer

Omaha Police Department

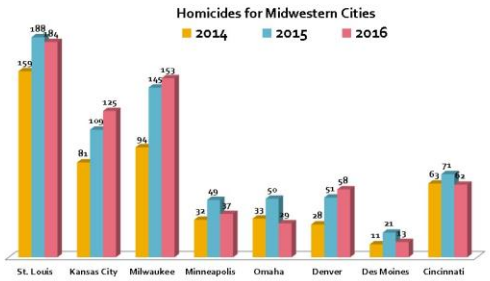
Southwest Gun Assault Victims & Homicides Trend 2005 to 2016: Jan-Dec.



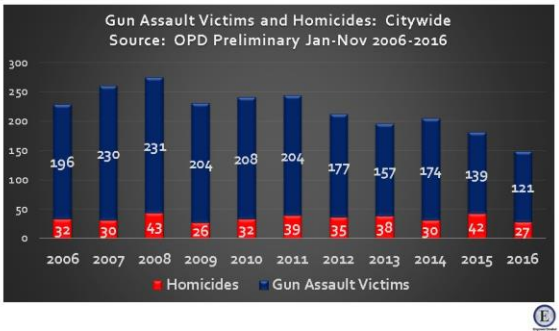
Southwest Gun Assault Victims & Homicides Trend 2005 to 2016: Jan-Dec.



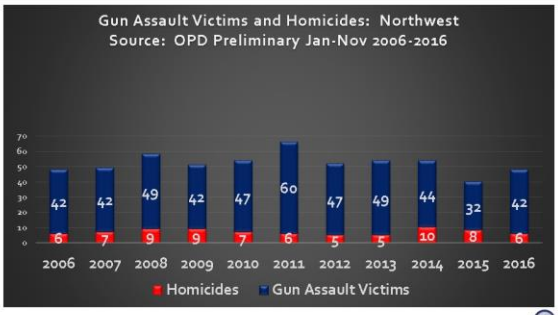
Midwestern Cities



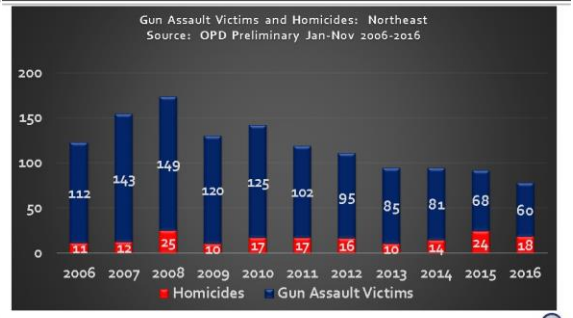
City-wide Gun Assault Victims & Homicides Trend 2006 to 2016: Jan-Nov.



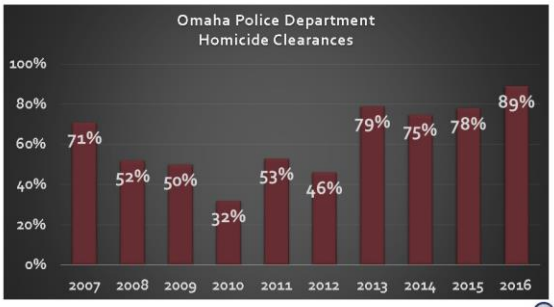
Northwest: Gun Assault Victims & Homicides Trend 2006 to 2016: Jan-Nov.



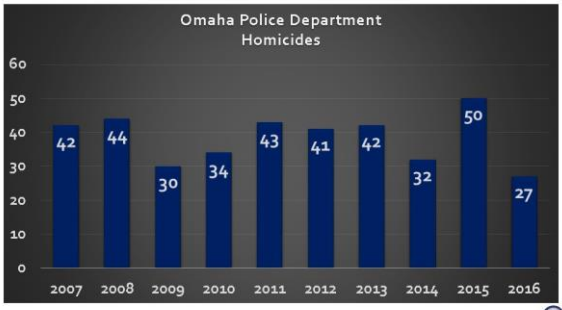
Northeast Gun Assault Victims & Homicides Trend 2006 to 2016: Jan-Nov.



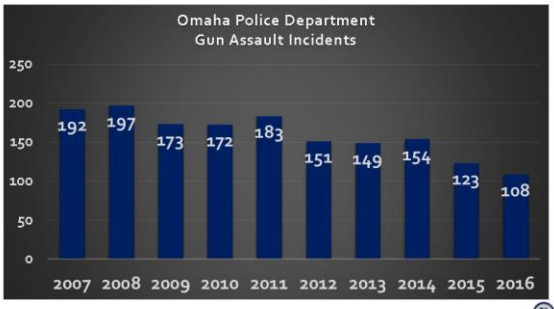
Homicide Clearances: Jan 2007 to Dec 2 2016 Source: Omaha Police Department



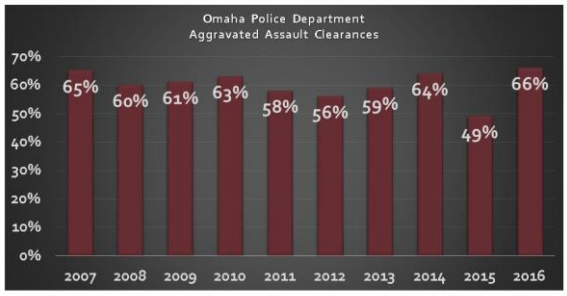
City-wide Homicide Trend: Jan 2007-Dec 2 2016 Omaha Police Department



City-wide Gun Assault Incidents: Jan 2007-Dec 2 2016 Source: Omaha Police Department



City-wide Assault Clearances: Jan 2007 to Oct. 31 2016 Source: Omaha Police Department



National Average Aggravated Assault Clearance Rate = 56.3%

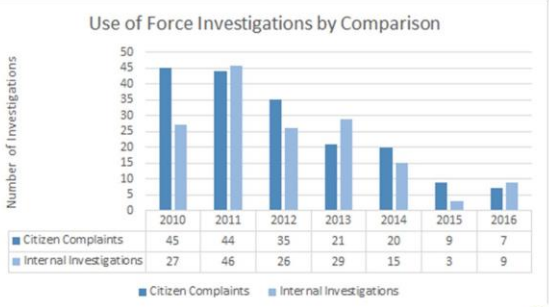
Population Based Aggravated Assault Clearance Rate = 47.5%

Omaha Community Recommendations

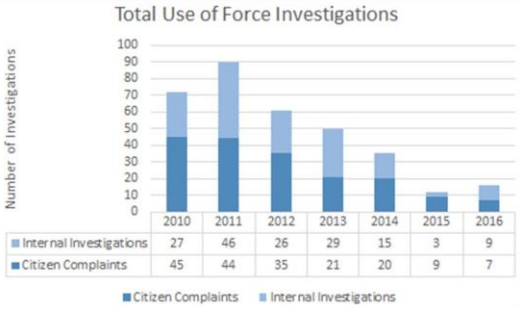
Omaha 360 Justice Summit: Community and Police Relations

1. Create more venues where police and community can interact
2. Diversify Police Force and Criminal Justice System (should reflect the community)
3. Implement police training on Culture/Racial Bias
4. Institute police training to address mental health issues/situations
5. Expand training for youth and community on how to best engage with police
6. Implement Body Cameras
7. Continue to improve & make complaint process more transparent
8. Monitor and address racial profiling/use of force
9. Hold officers accountable/Accountability
10. More and better bias screening in the hiring process
11. Create a consistent forum to address justice issues/complaints
12. Address disproportionate arrests, sentencing & incarceration
13. Independent review/process for officer involved shootings

Use of Force Investigations Omaha Police Department



Use of Force Investigations Omaha Police Department



OPD Diversity: 11/21/2016

Current OPD Sworn Demographics

	OPD	City of Omaha*
Race		
White/Caucasian	80%	68%
African American	8%	13.70%
Hispanic	10%	13.10%
Asian	2%	2.50%
Other	1%	3.80%
Gender		
Male	83.00%	49.20%
Female	17%	50.80%

OPD Diversity:

OPD Recruit Class Demographics (2014-2016)

	2014 Recruit Class	2015 Recruit Class	2016 Recruit Class	City of Omaha*
Race				
White/Caucasian	63%	64%	60%	68%
African American	15%	16%	19%	13.70%
Hispanic	15%	16%	18%	13.10%
Asian	5%	2%	2%	2.50%
Other	2%	2%	2%	3.80%
Gender				
Male	82%	82%	84%	49.20%
Female	18%	18%	16%	50.80%

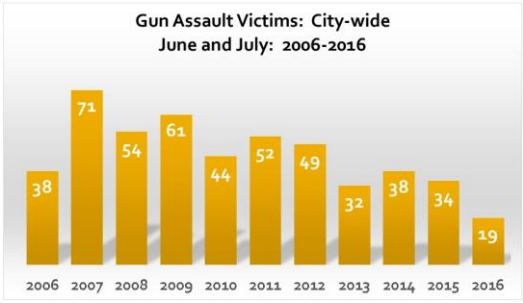
*The US Census Bureau includes additional race/ethnicity categories such as "two or more races" that are not tracked by the City of Omaha Human Resources Department. In addition, The US Census Bureau calculates "race" and "ethnicity" separately (i.e., Hispanic or Not Hispanic or Latino) while the City of Omaha does not separate "Hispanic" from other race categories.

Body Cameras

OPD Training

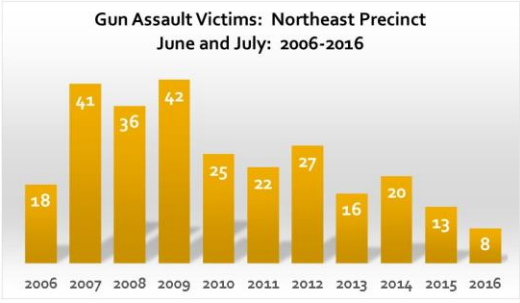
- Cultural Bias
- Mental Health

Gun Assault Victims: City-wide Summer (June-July): 2006 to 2016



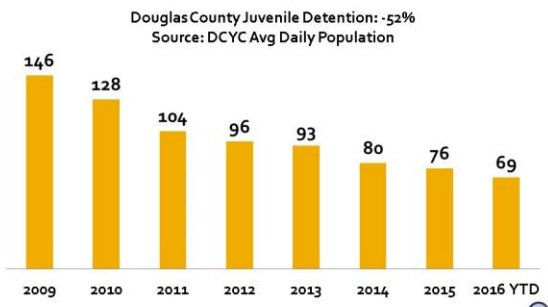
Source: Omaha Police Department

Gun Assault Victims: Northeast Precinct Summer (June-July): 2006 to 2016



Source: Omaha Police Department

Reductions in Juvenile Detention



Health & Healthy Families

Working Update – December 2016

Health and Healthy Families

- Healthy Relationships, Marriages & Parenting
- Access to Insurance and Health Care (Physical, Dental and Mental)
- Address mental and behavioral health (inc. trauma)
- Access to Healthy Foods
- Reducing Disparities (Obesity – priority)

Accelerating the Pace of Change and Closing the Remaining Gaps

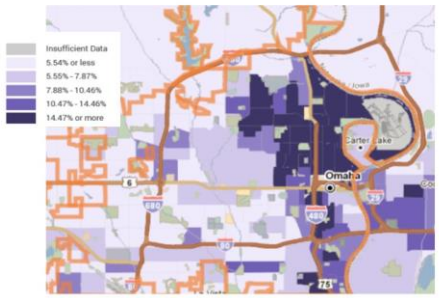
Working Update – December 2016

Unfinished Business: The Achilles Heel?

"If Omaha could fix north Omaha, if you guys could solve that problem, Omaha could be almost mythical." – Kiplinger Financial Report

Unemployment Rate

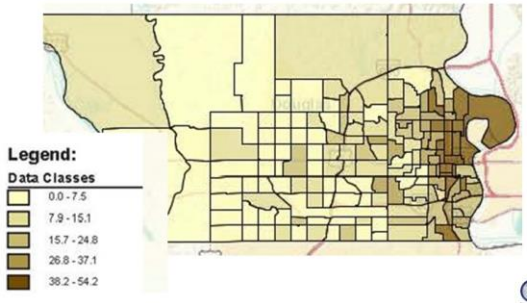
Concentrated Unemployment



Data Source: Census.gov American Community Survey – 2015 Release – 5 Year Avg

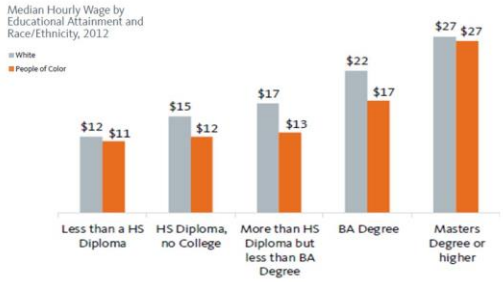
Poverty Rate

Concentrated Poverty



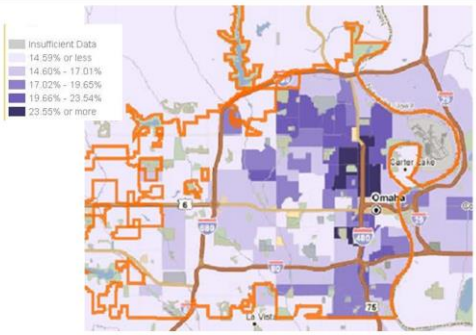
Wage Gap

Omaha Region

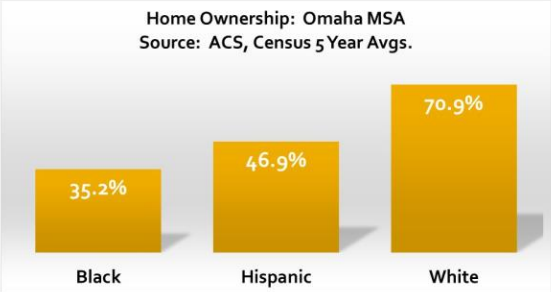


Source: PolicyLink Equity Profile - 2014

Areas of Poor Health

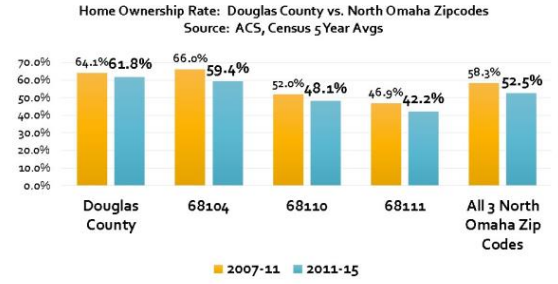


Home Ownership by Race/Ethnicity Omaha MSA



Source: American Community Survey, U.S. Census Bureau 5 Year Report 2011-2015
Compiled and Prepared by: David Drozd – Research Coordinator – UNO and Willie Barney – Empowerment Network

Home Ownership Trend Douglas County vs. North Omaha



Source: American Community Survey, U.S. Census Bureau 5 Year Reports 2007-2011 to 2011-2015
Compiled and Prepared by: David Drozd – Research Coordinator – UNO and Willie Barney – Empowerment Network

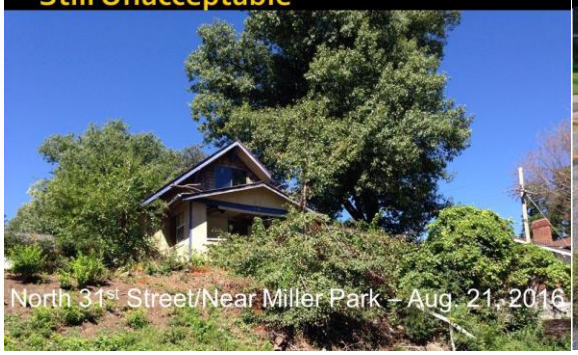
Some Neighborhood Conditions... Still Unacceptable

32nd & Parker in Prospect Village (June 2016)

Some Neighborhood Conditions... Still Unacceptable

Across the Street from Hope Center (2016)

Some Neighborhood Conditions... Still Unacceptable

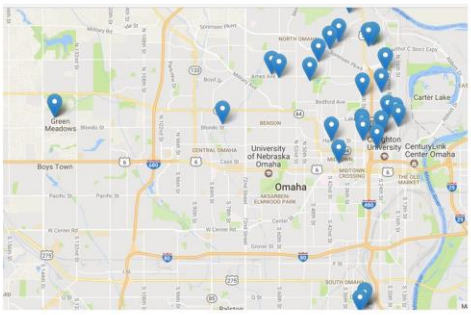


North 31st Street/Near Miller Park – Aug. 21, 2016

Some Neighborhood Conditions... Still Unacceptable

Fontenelle Basketball Court– Aug. 22, 2016

2016 Homicides: Lower, but still too high and concentrated



Can change happen? YES!

Progress from 2007 to 2016

1. **H.S. Grad Rates Up** +20%, **% with Bachelor Degrees** is up
2. **Reading and Math Scores Up** +20% to +28%
3. **Gun Violence Rates Down** - 40% City-wide (-55% in Northeast Omaha)
4. **Unemployment Rate is trending down for AA and N.O.**
5. **Poverty Rate is trending down for AA, up for N.O.**
6. **More business training, new businesses and expansion; more needed**
7. **Summer Jobs/Youth Emp. increased** from 30 to over 500+ annually
8. **Housing and Revitalization:** Major developments; more needed
9. **Arts, Culture & Business District:** Increased Attendance/Rebuilding

North Omaha: Remaining Gaps

1. Declining Home Ownership Rate
2. Wage Rate Gap ($5 gap per hour for people of color vs. white workers)
3. Lack of Jobs in the Area (need more job centers in North Omaha)
4. Lack of Businesses in the Area (Of Size)
5. Marriage Rate Decline and Increase in Single Parent Hhlds
6. Loss of Population and Concentrated Poverty
7. Concentrated Gun Violence
8. Dilapidated Housing/Housing Stock/More Affordable & Mixed Income Needed
9. Physical and Mental Health Concerns
10. Improvements in Education; but significant gaps remain (Math, MS, HS)

What does the disinvestment cost North Omaha, South Omaha, City of Omaha, Douglas County & Nebraska?

- **Social**
  - Image & Perception
  - Crime & Violence
  - Loss of Life; Injuries
  - Post Traumatic Stress
  - Life-long Impact on Children
- **Economic**
  - Loss of Employers/Businesses that choose to locate elsewhere
  - Loss of Workers/Workforce Productivity
  - Loss of Earnings/Economic Growth
  - Loss of Tax Revenue
  - Unpaid Child Support/Social Service Costs
- **These Issues Rob People and Omaha of LIVES and POTENTIAL**

Moving Forward Omaha can Lead the Nation…

- It has been well-documented. Omaha faces tremendous challenges and gaps when it comes to racial and geographic disparities regarding employment, education, housing, poverty, gun violence, health and other quality of life factors.
- Hundreds of organizations and thousands of individuals are working together to address these gaps.
- The results of these efforts show measurable progress is possible.
- With more engagement, alignment and strategic investments, the city is poised to accelerate the progress and close long-standing gaps. Omaha has the potential of becoming an example for the rest of the country. National leaders and hopeful citizens from cities across the nation are paying close attention.
- We can work together to implement a 10 Year Plan to **LEAD** the Nation and **CLOSE** Long Standing **ECONOMIC** Gaps in **OMAHA. IT'S TIME TO FINISH THE JOB!**
- Most of the strategies and initiatives outlined within can be accomplished by reallocating existing funds and revenue generated by market growth.

North Omaha 2025 Community Plan

A 10 Year Comprehensive Strategy

Working Update – December 2016

Transformation 2025
One. Great. Omaha.

Planning and Proposal

1. A Common Agenda: AA and North Omaha
2. Leadership and Structure
3. Pathway to 2025 Goals
4. City of Omaha Proposal
5. OPS/Board/Superintendent Search/Charters
6. Federal/State Changes
7. Election: City Council/Mayor
8. Priority Updates: Revitalization, Employment, Entrepreneurship, Health, Safety & Justice

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5. Marriage Rate Decline and Increase in Single Person Hhlds
6. Loss of Population and Concentrated Poverty
7. Gun Violence is still concentrated
8. Dilapidated Housing/Housing Stock/More Affordable & Mixed Income Needed
9. Physical and Mental Health Concerns
10. Improvements in Education; but significant gaps remain (Math, MS, HS)

North Omaha is an untapped asset!

- **People**
  - Gifts
  - Talents
  - Skills
  - Creativity
- **Land**
- **Buildings**
- **History**
- **Promise and Potential**

Now is the Time to Accelerate Progress and Close Long-Standing Gaps

Accelerate the Pace of Progress…

Key Principles

- Bi-partisan
- Personal Responsibility and Mobilization
- Leadership Engagement and Accountability
- Comprehensive Collaboration and Alignment
- Social & Economic Return on Investment

When North Omaha and South Omaha win, the entire City, County, State and Region will Win!

Economic Benefits to the City of Omaha!

Return on Investment:

- Create New Jobs
  - Construction Jobs
  - Permanent Jobs
- Build New Businesses and Increase Tax Revenues
- Prepare Omaha Workforce for Current and Future Jobs
  - Close the Skills Gap
- Increase Economic Impact (Growth/Consumer Spending)
- Increase Tourism
- Improve Services to Residents (Roads, Parks, etc)
- Reduce Social Costs
- Reduce Tax Payer Burden

North Omaha Community Agenda

1. **Corridor Revitalization:** Create Economic Engines (Arts, Culture and Business Districts based on greatest needs and creating economic engines/increasing tourism)
   - North 24th/24th and Lake, North 30th and Ames
   - Entrepreneurship Fund/Assistance: More Businesses, Services and Shopping Options
   - Contractor Development Fund/Tech. Assistance/Training: More Contractors
2. **Jobs and Job Training:** Close the Skills Gap (Address unemployment & underemployment)
3. **Education and Youth Development:** Cradle to Career
4. **Housing & Neighborhoods/Revitalization:** Improve Neighborhoods
   - Allocate additional city funds for housing; to be used for demolition, rehab or new mixed-income housing projects; Neighborhood Projects w/ most significant issues
   - Streets, Roads and Transportation: Improve Streets and Multi-modal Transportation
     - Invest in North Omaha and South Omaha road/streets
5. **Public Safety/Violence Prevention and Intervention:** Reduce Violence
6. **Health and Healthy Families**

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Specific Recommendations

2018 City of Omaha Investment: $18,000,000

Jobs and Job Training (Close the Skills Gap)	
Heartland Workforce Solutions/Urban League	$1,000,000
Step-Up Omaha! Summer and Year Round	$1,000,000
Land Acquisition & Prep for Job Creation	$2,000,000
Entrepreneurship Fund/Assistance	
Small Business Technical Assistance/Training- OSBN	$2,000,000
Contractor Development Fund/Tech. Assistance/Training	
OSBN/MPSDC/Reach	$2,000,000
Education (Omaha Male Achievement Initiative)	$500,000
Housing & Neighborhoods/Revitalization	
Allocate additional city funds for housing	$5,000,000
Local non-profits and developers would apply to City for Funding, similar to CDBG Process; to be used for demolition, rehab or new mixed-income housing projects	
Neighborhood Ldrship/Allocate for NONA/SONA	$500,000 (Neighborhood Projects w/ most significant issues)
Roads and Multi-modal Transportation	
Invest in North Omaha roads	Ames, Lake, and other neighborhood streets
Invest in South Omaha roads	10th, 16th, 24th and other
Public Safety/Violence Prevention and Intervention	
Invest in community-based programs	$1,000,000 (prevention, intervention and reentry programs)
Invest in faith-based outreach/village coordination	$500,000
Organizations would apply to City for Funding – similar to Office of Violence Prevention Process or match grants approved by OVP process	
Healthy Families (Environmental Improvements/Lead Paint)	$500,000
Arts, Culture and Business Districts (based on greatest needs and creating economic engines/increasing tourism)	
Invest in North 24th/24th and Lake/Malcolm X	$2,000,000
Use same process as Turnback Tax or specifically allocations to venues in the location	
Invest in South 24th Street & other Hist. Districts	$1,000,000

Specific Recommendations:NO/SO

2018 City of Omaha Investment: $18,000,000 to $25,000,000

	North Omaha	North & South Omaha
Jobs and Job Training (Close the Skills Gap)		
Heartland Workforce Solutions/Urban League	$1,000,000	$2,000,000
Step-Up Omaha! Summer and Year Round	$1,000,000	$1,000,000
Land Acquisition & Prep for Job Creation	$2,000,000	$3,000,000
Entrepreneurship Fund/Assistance		
Small Business Technical Assistance/Training- OSBN	$2,000,000	$3,000,000
Contractor Development Fund/Tech. Assistance/Training		
OSBN/MPSDC/Reach	$2,000,000	$3,000,000
Education (Omaha Male Achievement Initiative)	$500,000	$1,000,000
Housing & Neighborhoods/Revitalization		
Allocate additional city funds for housing	$5,000,000	$7,500,000
Local non-profits and developers would apply to City for Funding, similar to CDBG Process; to be used for demolition, rehab or new mixed-income housing projects		
Neighborhood Ldrship/Allocate for NONA/SONA	$500,000 (Neighborhood Projects w/ most significant issues)	
Roads and Multi-modal Transportation		
Invest in North Omaha roads	Ames, Lake, and other neighborhood streets	
Invest in South Omaha roads	10th, 16th, 24th and other	
Public Safety/Violence Prevention and Intervention		
Invest in community-based programs	$1,000,000 (prevention, intervention and reentry programs)	
Invest in faith-based outreach/village coordination	$500,000	$750,000
Organizations would apply to City for Funding – similar to Office of Violence Prevention Process or match grants approved by OVP process		
Healthy Families (Environmental Improvements/Lead Paint)	$500,000	$750,000
Arts, Culture, Entertainment and Business Districts (based on greatest needs and creating economic engines/increasing tourism)		
Invest in North 24th/24th and Lake/Malcolm X	$2,000,000	$3,000,000
Use same process as Turnback Tax or specifically allocations to venues in the location		

2025 Transformation Goals

Each Person Must Do Their Part

Personal Responsibility & Mobilization

- **Participation/Commit to Pledge/Challenge** +5,000
- **Parental Engagement** 90%
  - School
  - Home
- **Neighborhood Engagement**
  - Neighborhood Association Members +2,500
- **Community Engagement**
  - Mentoring +2,500
- **Civic Engagement**
  - Volunteering +2,500
  - Voting 70%

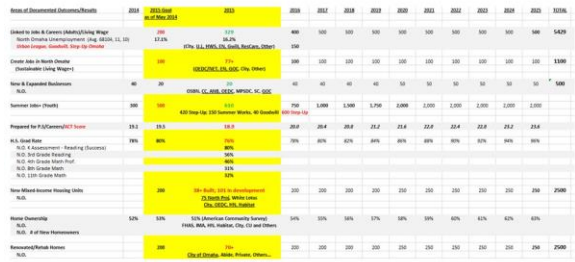
2025 Transformation GOALS

10 Year Vision to Rebuild the Core and Transform the City!

Leadership and Collaboration/Alignment

- 5,000 Employed; Sustainable Living Wage
- 90% Graduation Rate
- 5,000 New and Improved Housing Units
- 90% Safer and Healthier Community
- 2,500 Families Lifted Out of Poverty
- 250,000 Visitors & Tourists

Annual Goals & Benchmarks Part 1



Annual Goals & Benchmarks Part 2

How to pay for it?

- **Public**
  - City
  - County
  - State
  - Federal
- **Business**
- **Philanthropic**
- **United Way**
- **Community**

Strategies

1. **Increase employment** – summer employment, targeted subsidized/transitional programs, career advancement, business incentives
2. **Increase entrepreneurship & contracting** – grow, recruitment, training, investment, development
3. **Improve educational outcomes** – early childhood, excellent schools in every neighborhood, college/career pathways and placement
4. **Increase home ownership** – mixed-income; mixed-use developments
5. **Enhance neighborhood revitalization** – engagement, demo, rehab, roads
6. **Increase public safety**- prevention, intervention, enforcement, reentry, support services, justice reform
7. **Improve access to health care**, healthy foods and exercise
8. **Create financial empowerment** – training, IDA/EITC, minimum wage
9. **Create healthy families** – reduce teen pregnancy, increase marriage rate, increase engagement of fathers
10. **Create Arts and Culture Economic Engine** – North Omaha Village Zone; 24th and Lake, Malcolm X, South 24th and other core business districts

Economic Benefits to the City of Omaha!

The Vision: One. Great. Omaha.
***ONE GREAT city**, thriving & **prosperous**, in **every zip code & neighborhood**.*

Principles: Bi-partisan, Shared Decision-Making, Personal Responsibility, Leadership Accountability and Comprehensive Collaboration.

Return on Investment:

- **Create New Jobs: Construction Jobs and Permanent Jobs**
- **Increase Tax Revenues**
- **Prepare Omaha Workforce for Current &Future Jobs Close the Skills Gap**
- **Increase Economic Impact (Growth/Consumer Spending)**
- **Increase Tourism**
- **Improve Services to Residents (Roads, Parks, etc)**
- **Reduce Social Costs**
- **Reduce Tax Payer Burden**

2014 Proposal: Return on Investment

Transformation 2025 focused on Prevention & Economic Growth

- **Transformation 2025 Initiative**
  - Employment
  - Entrepreneurship
  - Education
  - Housing & Revitalization
  - Public Safety
  - Prison Alternatives/Reform
  - Healthy Families
  - Poverty Elimination & Financial Empowerment
- **Annual Budget: $230 Million**
  - **Mixture of Public and Private Investments**
  - **Mostly reallocation of existing funds, plus new revenue generated by growth**
- **Return on Investment:**
  - Jobs – Construction and Permanent
  - Economic Impact (Growth/Spending)
  - Taxes Paid
  - Child Support Paid
  - Social/Back End Expenses Reduced

1968: A.V. Sorenson

- Most people in leadership positions "are not pursuing a vision of what the total society needs."
- "I think Omaha is ready for a true coalition, business, labor, the professions, universities, people of all walks of life…" to address employment, housing, educational and training needs of its people."
- He felt that meeting those needs would require significant commitment in local taxes.

1969: A.V. Sorenson

- Sorenson proposes "challenge to the conscience of the community."
- Proposes a two-mil property tax increase to meet the needs of disadvantaged citizens.
- The funds would be used for a battle against dilapidated housing and unemployment in Omaha.
- "I don't really believe we the people of Omaha have made the commitment that must be made if we are to live in peace and harmony. And commitment means cash commitment."

Specific Recommendations
2018 City of Omaha Budget Request: $14,000,000

- Jobs and Job Training
  - Heartland Workforce Solutions/Urban League $1,000,000
  - Step-Up Omaha! Summer and Year Round $1,000,000
  - Land Acquisition & Prep for Job Creation $2,000,000
- Entrepreneurship Fund/Assistance
  - Small Business Technical Assistance/Training- OSBN $1,000,000
- Contractor Development Fund/Tech. Assistance/Training
  - OSBN/MPSDC/Reach $2,000,000
- Education (Omaha Male Achievement Initiative) $500,000
- Housing & Neighborhoods/Revitalization
  - Allocate additional city funds for housing $3,000,000
    Local non-profits and developers would apply to City for Funding, similar to CDBG Process; to be used for demolition, rehab or new mixed-income housing projects
  - Neighborhood Ldrship/Allocate for NONA/SONA $500,000 (Neighborhood Projects w/ most significant issues)
- Roads
  - Invest in North Omaha roads Ames, Lake, and other neighborhood streets
  - Invest in South Omaha roads 10th, 16th, 24th and other
- Public Safety/Violence Prevention and Intervention
  - Invest in community-based programs $1,000,000 (prevention, intervention and reentry programs)
  - Invest in faith-based outreach/village coordination $500,000
    Organizations would apply to City for Funding – similar to Office of Violence Prevention Process or match grants approved by OVP process
- Healthy Families (Environmental Improvements/Lead Paint) $500,000
- Arts, Culture and Business Districts (based on greatest needs and creating economic engines/increasing tourism)
  - Invest in North 24th/24th and Lake $1,000,000
    Use same process as Turnback Tax or specifically allocations to venues in the location
  - Invest in South 24th Street & other Hist. Districts $1,000,000

Specific Recommendations
2017 City of Omaha Budget Request: $6,250,000

- Jobs and Job Training
  - Heartland Workforce Solutions/Urban League $500,000 (Paid job training to help close skills & unemployment gap)
  - Land Acquisition & Prep for Job Creation in N.O. $2,000,000 (Redevelopment Bonds)
- Entrepreneurship Fund/Assistance
  - Small Business Technical Assistance/Training- OSBN $250,000
- Contractor Development Fund/Tech. Assistance/Training
  - OSBN/MPSDC/Reach $250,000
- Education (Omaha Male Achievement Initiative) $250,000
- Housing & Neighborhoods/Revitalization
  - Allocate additional city funds for housing $500,000
    Local non-profits and developers would apply to City for Funding, similar to CDBG Process; to be used for demolition, rehab or new mixed-income housing projects
  - Neighborhood Ldrship/Allocate for NONA/SONA $500,000 (Neighborhood Projects w/ most significant issues)
- Roads
  - Invest in North Omaha roads Ames, Lake, and other neighborhood streets
  - Invest in South Omaha roads 10th, 16th, 24th and other
- Public Safety/Violence Prevention and Intervention
  - Invest in community-based programs $250,000 (prevention, intervention and reentry programs)
  - Invest in faith-based outreach/village coordination $500,000
    Organizations would apply to City for Funding – similar to Office of Violence Prevention Process or match grants approved by OVP process
- Healthy Families (Environmental Improvements/Lead Paint) $250,000
- Arts, Culture and Business Districts (based on greatest needs and creating economic engines/increasing tourism)
  - Invest in North 24th/24th and Lake $500,000
    Use same process as Turnback Tax or specifically allocations to venues in the location
  - Invest in South 24th Street & other Hist. Districts $250,000

Nebraska Enterprise Fund

- Sales Acceleration Training – 22 attendees
- 11 completing the 5 session intense course.
- Start Up to Success Seminar – 45 attendees
- Credit Score Workshop – 15 attendees (in collaboration with SCORE)
- Accounting and Finance Workshop – 15 attendees (in collaboration with SCORE)
- Bridging Boundaries Workshop – 77 attendees (in collaboration with SCORE)
- Congressional Roundtable with Congressman Ashford with 15 diverse businesses representing all parts of Omaha including N. Omaha, and S. Omaha

REACH: Training

- **5,837.22**
  - **Total hours of REACH & MCC Contractor Academy training**
- **3,451.22**
  - **Hours of REACH group & 1-on-1 education has been provided to-date**
- **1751.5**
  - **Hours of REACH classroom instruction**
- **51**
  - **Number of REACH group trainings**

Appendix II: Speaker Guide

Denise Koo, MD, MPH

Community Health and Health Systems Consultant
Former Advisor to the Associate Director for Policy Center for Disease Control and Prevention

Denise Koo, MD, MPH recently retired from her position as Advisor to the Associate Director for Policy at the Center for Disease Control and Prevention.(CDC) In that role, she was the chief architect of the CDC Community Health Improvement Navigator (www.cdc.gov/chinav), a unifying frame work and tools for stakeholders interested in improving the health of their communities, and led the development of an innovative tool for accelerating learning about social determinants of health, the Health and Well-Being for All Meeting-in-a-box (www.cdcfoundation.org/health-in-a-box).

Dr. Koo holds a bachelor's degree in biochemical sciences from Harvard University, a master's of public health degree in epidemiology from University of California, Berkley, and a medical degree from University of California, San Francisco. She completed a residency in internal medicine at the Brigham and Women's Hospital in Boston.

Dr. Koo held several leadership positions during 25 years at the CDC, including as Chief of the National Notifiable Diseases Surveillance System, Director of the Division of Public Health Surveillance and Informatics, and Director of the Division of Scientific Education and Professional development. As part of a 6-month assignment in 2015 with Dr. Karen DeSalvo, Acting Assistant Secretary for Health, US Department of Health and Human Services, Dr. Koo H help launch the current Public Health 3.0 initiative. She is also Adjunct Professor of Epidemiology and of Global Health at Rollins School of Public Health, Emory University, and Consulting Professor of family and Community Medicine, Duke University School of Medicine.

Willie D. Barney

Willie Barney is the Founder, President, and Facilitator of the Empowerment Network, a collaborative of residents, leaders, and organizations working to facilitate positive change in Omaha, Nebraska and other cities across the country. Launched in September 2006, the Network works collectively to improve the economic condition and quality of life for African Americans, North Omaha residents, and citizens of the Greater Omaha area. The movement has evolved into a nationally recognized approach for community engagement, collaboration, capacity-building and leadership development. The comprehensive, community-based development collaborative has launched major initiatives with measurable outcomes with a focus on transforming Omaha into a GREAT city, in every zip code and neighborhood!

For over 25 years, Mr. Barney has worked in strategic planning, marketing, communications, community building and facilitation. In addition to the Empowerment Network, he is president of SMB Enterprises, LLC, a company that provides positive events, media and entertainment in the greater Omaha area. SMB is the parent company of Revive! Omaha Magazine and the North Omaha Community Guide. Mr. Barney is also president of WDB Resultants, LLC, a consulting firm that specializes in strategic planning and marketing, communications, research, community organizing and facilitation. His experience includes work with large corporations, small businesses, non-profits, and faith-based organizations.

Mr. Barney has been an active volunteer in each community where he has lived. He graduated with a double major in Economics and Business Administration from St. Ambrose University, Davenport, Iowa. A strong supporter of life-long learning, Mr. Barney has continued his education through advanced-leadership training including the Summer Leadership Institute for Community Development at Harvard University and Executive Leadership and Management Training at the Northwestern University Media Center in Chicago.

He and his wife, Yolanda, have been married for 18 years. They are both actively involved in their church as associate pastors and ministers where they lead financial empowerment and economic development initiatives. She is the Vice-President of SMB Enterprises and WDB Resultants and Co-Publisher of Revive! Omaha Magazine. They have two children, Nehemiah (15) and Priscilla (10). Their focus, passion, and purpose is working together with others to see the community and each person reach their full potential. For more information, please go to empoweromaha.com.

Richard L. Brown, PhD, FACHE

Richard L. Brown is the Executive Director of CPHHE-REACH, a coalition to reduce health disparities. Dr. Brown has a bachelor's degree in Sociology from Missouri University-St. Louis, a Master degree in Health Services Administration from St. Louis University, and an earned doctorate in Adult and Continuing Education from Florida State University. He is a fellow in the American College of Healthcare Executives and a member of the National Association of Health Services Executives.

Dr. Brown is the past Chief Executive Officer of Charles Drew Health Center, a Federally-qualified health center providing primary health care services. Tremendous growth in services and quality patient care in medical, dental, and behavioral health occurred under his leadership.

Dr. Brown has been influential in the receipt of funding from a variety of organizations including philanthropic, county, state, and federal sources for Nebraska community health centers. He is a champion for the underserved and the fight against the Omaha STD epidemic since 2008. Dr. Brown has testified before the Nebraska legislature on a number of health-related bills. He served as a board member on 12 governing boards at the local and national level as an advocate for health care and healthy living. Dr. Brown provided leadership in the establishment of school-based health centers in the Omaha Public School System and primary-care services in the Omaha public housing towers.

A career spanning over 35 years of administrative experience has been in a variety of health services organizations, both private and non-profit, that serve vulnerable populations. Dr. Brown is skilled at interacting effectively with a wide variety of stakeholders including advocacy organizations, state and local government, philanthropic organizations, as well as health care providers. He is strong in managing program budgets, ensuring financial accountability, quality improvement, staff and physician satisfaction, as well as maintaining operational and performance standards. Dr. Brown is a seasoned administrator with proven leadership, organizational and interpersonal skills.

Additionally, Dr. Brown has 11 years of experience as a professor in teaching courses in health care administration at four universities. He is a co-author of the number one best-selling book titled "Mission Unstoppable, Extraordinary Stories of Failure's Blessings."

Eric Burgin

Eric Burgin, formally from Kansas City, MO, is the youngest of fourteen (14) children. He relocated to Omaha, NE in 1985. A single parent dealing with the judicial system over custody battles, Mr. Burgin became heavily involved as a community activist to support fellow community members dealing with their legal issues. He has since been a member of the Omaha, NE Precinct Community Pact for the Police Department for fifteen (15) years.

Mr. Burgin is the President of three (3) neighborhood association (North Omaha Neighborhood Association, Mama's Park, and Omaha Housing Authority: Crown Tower) residing in North Omaha. He has also served as an active board member for the North Omaha Neighborhood Alliance (NONA). Currently a Community Health Advocate for Creighton University in his second year, Mr. Burgin is also a CPHHE-REACH Health Ambassador. He serves nationally as an activist and committee member for Neighborhood USA. Mr. Burgin promotes knowledge as a powerful tool as he continues to work with and for the community. His greatest accomplishment is being a proud father of fifteen (15) children.

Jeanne Burke, MLIS, MEd

Ms. Burke is the Education Coordinator for the Creighton Health Sciences Library/Learning Resources Center since the fall of 1997. She teaches and develops classes, instructional materials, provides research assistance, and instructional programs that support Creighton's health sciences related academic, education, professional development, clinical practice activities, and service programs. Her responsibilities include serving as the Library's Liaison for the School of Nursing and the Center for Health Policy & Ethics. She is current serving as an Academic Partner for the Creighton Center for Promoting Health and Health Equality.

Her credentials include a Master's Degree in Library & Information Sciences from the University of Missouri-Columbia, (UMC) and a Master's Degree in Education from UMC with additional post-graduate courses in higher and adult education. Before coming to Creighton University, Ms. Burke was Head of the Nebraska Legislative Research Library and oversaw the Government Documents Department at the UMC School of Law Library. She has also worked in the Programming, Education, and Research Departments for KETC-TV, the local PBS affiliate in St. Louis, Mo.

She has been serving on the Steering Committee Immunization Task Force of Metro Omaha since 2014. Ms. Burke is a longtime member and officer of local, regional, and national librarian organizations. Ms. Burke collaborates with various national, international, and campus groups to promote access to health care information for economically challenged and underserved areas. In addition, she is a member of APHA (American Public Health Association), CGEA (Central Group on Educational Affairs, AAMC) and other organizations that promote the teaching, universal access to medical information, evidence based practice, interprofessional education, and patient safety related health care resources.

Rev. Portia Cavitt

Pastor Cavitt serves on CUMC Patient & Family Advisory Council, CHI-Immanuel North Omaha Community Council, as well as the coordinator of the Great Plains UMC/BMCR. She is also a board member for Project Extra Mile, My Sister's Keeper, North Omaha Area Health Clinic (NOAH), Great Plains Black History Museum (GPBHM) and the Executive Officer for Boy Scout Troop/Pack #362. Rev. Cavitt is a foster Mother, a youth mentor and supervises juveniles for community service. In addition, she is member of United Way of the Midlands Community Investment Review Team (CIRT), Vice President of the North Omaha Community Care Council and the Interdenominational Ministerial Alliance. As a Power to End Stroke Ambassador with the American Heart Association, Rev. Cavitt helps and promotes the North Omaha Power Walk, as well as volunteers at Wakonda Elementary, Mt. View Elementary, and Nathan Hale Magnet Middle School. She also runs Clair's Summer Leadership Academy for 4-16-year-old children.

Rev. Cavitt is a member of Alpha Kappa Alpha Sorority, Inc., the NAACP, National Coalition of 100 Black Women Greater Omaha Chapter (NC100BW), and the National Council of Negro Women (NCNW). She was also featured in the 1990 and 1992 issues of Ebony Magazine as one of the "50 Leaders of the Future." In 2013, Rev. Cavitt was the first recipient of the Douglas County Health Department's Golden Beet Award for her commitment to community health. She has received the Susanna Wesley Award of Excellence, the IMA Drum Major for Action Award, the Urban League African-American Leadership Award, and Creighton University's 2017 Drum Major Award.

Rev. Cavitt is a Creighton University CPHHE-REACH Health Ambassador.

D. Roselyn Cerutis, PhD

Dr. Roselyn Cerutis joined Creighton University Dental School in 1998. She is currently an Associate Professor in Oral Biology with a secondary appointment in Pharmacology. She has been a member of the American Association for Dental Education since 2007, the American Society for Pharmacology and Experimental Therapeutics since 2001, and the American Society for Neuroscience since 1992. She studies the biology of the lipid lysophosphatidic acid (LPA) in the context of periodontal disease and Type 2 diabetes with her clinical collaborators.

Dr. Cerutis teaches biochemistry, physiology, pharmacology, and neuroscience, and follows related fields (nutrition, diabetes). Her interests are inflammation and inflammatory mediators in periodontal wound healing / periodontal disease. Another interest is the role of the protective small lipid mediators (the resolvins and maresins) in lung inflammation in agricultural workers, and their potential to be used as agents to treat these pathologies, an area in which she has been collaborating with researchers at the University of Nebraska Medical Center.

Brenda Council. JD

Brenda Council joined the Women's Fund in January 2014 as the Adolescent Health Project Manager. She has an extensive record of public service, including election to the Omaha Public Schools Board of Education, the Omaha City Council and the Nebraska Legislature. Prior to joining the Women's Fund, Ms. Council served for over six (6) years as the facilitator of the Omaha Superfund Community Advisory Group (CAG), which provided input to the Environmental Protection Agency (EPA) on the lead remediation action for the largest residential Superfund site in the nation.

As Adolescent Health Project Manager, Ms. Council leads the Women's Fund's project which seeks to create sustainable, community-wide changes through a research-based, results-focused, comprehensive approach that will increase the sexual knowledge of youth, and thereby decrease the number of youth engaging in risky sexual behavior and ultimately result in the decline in Sexually Transmitted Infections (STIs) and teen pregnancy rates.

Joel Dougherty

Mr. Joel Dougherty has been employed by OneWorld since 2005. From 2010-2013, he oversaw the construction of 64,000 feet of clinical space within two new buildings at One World's main clinic location. Mr. Dougherty co-led the health center's move from paper records to the Next Gen electronic health record and implemented the Dentrix electronic dental record system. He was the project manager for the establishment of One World's first satellite clinic location in a rural community, a satellite clinic in West Omaha in 2013, and three school clinics in 2010. Mr. Dougherty led implementation of renovation of the pharmacy, medical clinic, and a new state-of-the-art data center, the construction of a new 40,000 square-foot health clinic, and the logistics of moving the health center into the new location in 2005.

As Chief Operating Officer, he successfully leads all operations staff at the health center that includes schedulers, front desk, financial counselors, medical records, patient support, facilities and security, disaster preparedness and management, risk management, HIPAA, patient complaints, human resources, WIC program, Learning Community Center, and Medicaid Outreach and Enrollment. He was responsible for implementing new ultrasound and radiology services. In addition, Mr. Dougherty oversees all aspects of the Information Technology department, including the practice management system, electronic health record, electronic dental record software, a data center, and desktop support.

Debra Esser, MD

Debra Esser is a family physician who practiced in the Omaha metropolitan area for 15 years before beginning a career in medical administration. She has worked for several insurance companies and health systems to develop medical management and quality programs. Dr. Esser is a past president of Metro Omaha Medical Society and remains active on the board. She is currently Chief Medical Officer and Vice President Medical Management for Blue Cross Blue Shield (BSBS) of Nebraska. Dr. Esser has responsibility for utilization, medical policies and quality at BCBS. In the past, she worked with the medical society to develop policy for a smoke-free Omaha.

Evelyn Gould, MFA, MBA

Evelyn Gould, born in Lucedale, Mississippi, moved to Omaha, Nebraska when she was still in grade school. She attended Horace Mann (King Science) and Lothrop Omaha Technical High School, both in the heart of North Omaha. She received her undergraduate degree from the University of Nebraska at Omaha and a Master's in Fine Arts (MFA) and a Master's in Business Administration (MBA) from Bellevue University. Mrs. Gould currently works at the University of Nebraska at Omaha in the Human Resources Department.

Mrs. Gould is an active member of Zion Baptist Church where she serves in several capacities. She is the wife of Minister Robert Gould, volunteers as the Sunday School Teacher, and serves on the Deaconess Board. In addition, Mrs. Gould is a member of the Pastor and Baptist Ministers Wives Association, Chair Woman of the Women's Ministry, and is also a CPHHE-REACH Health Ambassador for Zion Baptist Church. An absolute exercise enthusiast, her favorite classes are Zumba and Bikram Yoga (Hot Yoga) that she participates in nearly every morning.

While Mrs. Gould wears many hats, one of her most proud to wear is being a loving wife, mother of five (5) sons, two (2) daughters, and twenty-seven (27) grandchildren.

Stephen B. Jackson, MPH

Mr. Jackson currently serves as the Supervisor for Health Promotion for the Douglas County Health Department. In his role as Supervisor, he oversees the daily functions related to community health education for the local health department. The current community health initiatives within the health promotion section include education programs targeting maternal child health, chronic diseases, refugee health, health disparities, and infant mortality. In addition, Mr. Jackson is responsible for building cooperation amongst public health stakeholders, local health and human service agencies, local nonprofit organizations, public health associations and the Nebraska Department of Health and Human Services as it relates to producing optimal health outcomes for the residents of Douglas County.

Mr. Jackson has obtained extensive experience in medicine, healthcare, and the non-profit business arenas and has several regional community affiliations. He received a bachelor of science (B.S.) degree in Chemistry from Jackson State University and a master's degree in public health (M.P.H.), as well as some medical training from the University of Iowa.

Mr. Jackson is also known for his community service. He is a former President of the Omaha Branch of the National Association for the Advancement of Colored People (NAACP) and currently chairs its Health Committee. Mr. Jackson actively serves on numerous boards including Nebraska Advance Practice Registered Nursing (APRN) Board (Public Member), Creighton's Center for Promoting Health and Health Equality (Research Committee Chair), and Susan G. Komen Great Plains (President).

Mr. Jackson is happily married to Dr. Donna Stewart. They have one son (Myles) and one daughter (Arie).

Ali S. Khan, MD, MPH

Ali S. Khan, MD, MPH is a former Assistant Surgeon General and current Dean of the College of Public Health at the University of Nebraska Medical Center (UNMC). Dr. Khan's professional career has focused on health security, global health, and emerging infectious diseases. He completed a 23-year career as a senior director at the Centers for Disease Control and Prevention (CDC), which he joined as a disease detective. As Dean of the UNMC College of Public Health, his focus is on health system and community based health transformations. Dean Khan's vision is for the College to play an integral role in making Nebraska the healthiest and most equitable state in the Union as a national and global model for wellness.

Dr. Khan received his medical degree from the State University of New York Downstate Medical Center in Brooklyn and has a Master of Public Health from Emory University's Rollins School of Public Health. He has authored numerous papers and publications and consulted extensively for multiple U.S. organizations, ministries of health, and the World Health Organization. Dr. Khan is the author of *The Next Pandemic: On the Front Lines against Humankind's Gravest Dangers.*

Sade Kosoko-Lasaki, MD, MSPH, MBA

Dr. Sade Kosoko-Lasaki leads the office of Health Sciences Multicultural and Community Affairs, with programs like the Health Careers Opportunity Program, Cultural Awareness seminars and Health Disparities Initiatives with a focus on Community- based Participatory Research. Dr. Kosoko-Lasaki also oversees the recruitment of disadvantaged students to the health sciences, and mentors these students to retain them. Dr. Kosoko-Lasaki has lectured nationally and internationally on cultural proficiency and health disparity issues, focusing on the promotion of "pipeline programs" that prepare and support disadvantaged students from grade 4 through health professional schools so they can become successful health care providers.

As an ophthalmologist with a public health degree, Dr. Kosoko-Lasaki is passionate about training and educating individuals in developing countries on blindness prevention, specifically Vitamin-A deficiency; the leading cause of preventable blindness in children and a major public health problem throughout the world and glaucoma. Since 1986, Dr. Kosoko-Lasaki has researched the prevalence of glaucoma in Blacks in St. Lucia, West Indies. With a focus on detecting and treating glaucoma—the most common cause of blindness in African Americans and Hispanics—she has initiated health fairs and screenings through Washington, D.C. metropolitan area, Nebraska, Iowa, Kansas, and the Dominican Republic. Dr. Kosoko-Lasaki created a program for blindness prevention entitled, "Preventing Glaucoma Blindness in Nebraska: A Creighton University Initiative," targeting individuals at risk for glaucoma blindness in surrounding areas.

Doris Lassiter, BS

Mrs. Doris Lassiter is President and CEO of Doris Lassiter Consulting, LLC and project principal associated with the Nebraska Center for Healthy Families, an organization designed to enhance the health and well-being of families through leadership in public and community health practices, collaborations and partnerships.

Mrs. Lassiter was appointed to serve as Assistant National Director and liaison to the Federal Dept. of Health and Human Services for the 7.2 million member National Baptist Convention, the largest African American, a faith-based organization in the country. She co-led a pilot project in collaboration with the Federal Office of Minority Health, Morehouse School of Medicine, and the University of Alabama to address heart disease among African Americans in the Stroke Belt of the South.

Mrs. Lassiter is a visionary who successfully leads national, state and local public policy efforts associated with chronic disease, health disparities and social issues. Other policies have centered on state and federal initiatives such as Teen Pregnancy, Infant Mortality Reduction Initiatives, Fatherhood Initiatives, Marriage and Relationship Education Initiatives. She serves as Director of Health Ministry for the New Era Baptist State Convention of Nebraska, Inc., the largest African-American organization in the state of Nebraska.

Kathleen A. Mallatt

Kathy Mallatt is the CEO in Nebraska for Community and State and has been with UnitedHealthcare for 24 years. Kathy is accountable for the management of the Medicaid contract in the State of Nebraska. She is responsible for overall direction, strategic development, growth and operations of UnitedHealthcare in providing innovative care to the populations served by Heritage Health. This position provides executive oversight and leadership so the needs of the members are met and contractual compliance is achieved. She holds the most senior leadership position having demonstrated experience in people leadership, strategic planning and operational excellence.

Kathy, a Nebraska native, originally joined UnitedHealthcare in 1987 and then again in 2010. She is a graduate from University of Nebraska with more than 35 years of industry experience. Kathy's experience includes health plan operations, finance, network development, commercial sales and marketing, Medicare, Medicaid and medical management. She has also served as President for a Third Party Administrator and as Chief Executive Officer for another Nebraska managed care company.

Kathy was a member of the State of Nebraska, Medicaid Reform Council. She has been recognized by the YWCA as a "Woman of Vision," Business/Entrepreneur. Kathy Mallatt has served as co-chair for the Heartland Ball for the American Heart Association; and as Honorary Chair for: the American Heart Association's Go Red for Women; the annual luncheon for the Women's Fund of Greater Omaha; and the Institute for Career Advancement Needs, Women's Leadership Conference.

Kenny McMorris, MPA, FACHE, CHCEF

Kenny McMorris is an accomplished professional with many years of experience in management and healthcare administration. Valued for his team management, leadership, and excellent problem solving skills, he has extensive expertise in business operations, policy and procedures, strategic planning, clinical administration, report drafting and review, training and development, fundraising and grant writing. His expertise in medical billing, revenue cycle management, managed care contracts, reconciliations, and invoice/billing management has made him stand out from his peers.

Currently, Kenny is the Chief Executive Officer of Charles Drew Health Center, Inc. where he coordinates business and clinical operations for the health center that includes over 150 employees, 12,000 patients, and 40,000 outpatient service visits. Under his leadership, the center has expanded to increase service locations from 4 sites to 13 sites including primary care, dental, pharmacy and behavioral health services with an emphasis on the underserved.

A native Omahan, Kenny previously served as Executive Director of the 100 Black Men of Omaha and Director of Marketing and Development for the Urban League of Nebraska. Kenny is active in both the professional and larger community. He is a Fellow of the American College of Health Care Executives, Community Health Centers Executives Fellow and member of Kappa Alpha Psi Fraternity Inc.

Thomas F. Murray, PhD

Tom Murray, Ph.D. brings over 34 years of academic experience to the Interim Provost position. Dr. Murray joined Creighton University as the Chair of the Department of Pharmacology in the School of Medicine in 2006. Prior to that appointment, he was at the University of Georgia, where he was Distinguished Research Professor and Head of the Department of Physiology and Pharmacology of the College of Veterinary Medicine. Dr. Murray was trained as a molecular pharmacologist at the University of Washington. He spent two years at the National Institute of Mental Health in Washington, D.C. as a Pharmacology Research Associate Program Fellow. Prior to assuming leadership of the Department of Physiology and Pharmacology at the University of Georgia, Dr. Murray served on the faculty of Colleges of Pharmacy at Washington State University and Oregon State University for 16 years.

Active in research, Dr. Murray has published over 180 publications in the areas of signal transduction and neuropharmacology and, as a co-investigator or principal investigator, has had continuous funding from the National Institutes of Health since 1986. He has served as an editorial board member for *Neuropharmacology* (1986-1992); the editor of *Critical Reviews in Neurobiology* (2002-2007); a member of the National Institute on Drug Abuse Biomedical Research Review Committee (Pharmacology II); an ad hoc member of the NIH IFCN Review Committee; and a current member of the National Institute on Drug Abuse Training and Career Development Committee. Dr. Murray's extensive administrative experience includes appointments as the Associate Dean for Research in the School of Medicine (2008-), as Associate Vice President for Health Sciences Research (2011-13) and as Associate Vice Provost for Research and Scholarship (2013-) at Creighton University. He has just completed his 19th year as a chair of an academic department.

Morgan Murphrey, BS

Morgan Murphrey is a third-year medical student at Creighton University, School of Medicine. She will complete a one-year Clinical Research Fellowship in dermatology at Northwestern University in Chicago, Illinois during the 2017-2018 school year. Afterward, Ms. Murphrey will return to Phoenix for the 2018-2019 academic year to complete her medical education.

Ms. Murphrey grew up in Sacramento, California. She completed her undergraduate education at California Polytechnic State University, San Luis Obispo, where she graduated Magna Cum Laude with a major in Biochemistry and minor is Psychology. Ms. Murphrey began her medical education in Omaha, Nebraska at Creighton University School of Medicine. She is completing her final clinical MS3 and MS4 years at Creighton's satellite campus in Phoenix, Arizona. Ms. Murphrey is concurrently completing her Masters in Healthcare Ethics at Creighton University and plans to pursue a career in dermatology.

Sherri Nared-Brooks, MA

Sherri Nared-Brooks has been with the Health Department for over 19 years and in the medical field for over 30 years. Mrs. Nared-Brooks is active in many community organizations including: President of the North Omaha Area Health (NOAH), a member of Black Families Health and Wellness Association, North Omaha Community Care Council, South Omaha Community Care Council, Methodist College of Nursing Advisory Board, Douglas County Correctional Facilities, among others. She provides workshops, community presentation, and individual consultation on such topics as HIV/AIDS, Sexual Transmitted Infections, Healthy Relationships, Abstinence, and many additional issues. She holds an Undergraduate and Graduate Degree from Bellevue University.

Martha Nunn, BS, MS, DDS, PhD

Dr. Martha Nunn is the Director of the Center for Oral Health Research and Professor of Periodontics in the Creighton University School of Dentistry in Omaha, Nebraska.

Dr. Nunn graduated from the School of Dentistry at the University of Tennessee Center for the Health Sciences in Memphis, TN. Following graduation, she was engaged in general dentistry private practice for eleven years before pursuing graduate studies in mathematics, statistics, management science, and biostatistics. Dr. Nunn completed an MS in industrial statistics at the University of Tennessee in Knoxville, TN and went on to complete an MS in biostatistics and a PhD in biostatistics at the University of Washington in Seattle, WA where she was supported by an NIDCR postdoctoral fellowship.

Dr. Nunn has published over 200 peer-reviewed manuscripts, abstracts, and book chapters. In addition, she has given invited lectures in Spain, Japan, and Korea, as well as throughout the United States. Dr. Nunn also has served as statistical reviewer for the *Journal of Periodontology and Pediatric Dentistry*, as well as serving on the editorial board of the *Journal of Clinical Periodontology*, *Journal of Dental Research*, and *European Journal of Dentistry*. She has also served on several NIH study sections, including Kidney, Nutrition, Obesity, and Diabetes (KNOD) study section, Oral, Dental, and Craniofacial Sciences (ODCS) study section, NIDCR secondary-data analysis and bio statistical special-emphasis study section, and NIDCR training grant special-emphasis study section. Dr. Nunn's primary research interests include development of dental prognosis and periodontal prognosis, extension of statistical methods to correlated outcomes as it applies to dental research (e.g., tooth loss, restoration failure), association of periodontal disease to chronic systemic diseases, and oral health disparities.

Ryan Sadler

Mr. Sadler is CEO & Plan President of Nebraska Total Care. Nebraska Total Care, which is a subsidiary of Centene Corporation, has hired more than 150 employees in Omaha and Lincoln, and is one of three Managed Care Organizations (MCOs) operating statewide in Heritage Health's Medicaid program. Nebraska Total Care exists to improve the health of its beneficiaries through focused, compassionate, and coordinated care. Prior to coming to Omaha, Mr. Sadler served as Vice President of Operations in Baton Rouge, Louisiana at Louisiana Healthcare Connections, another Centene company, in Washington D.C. at Medco (now Express Scripts) in the PBM and pharmacy business, and in several states throughout the southeast practicing law.

Mr. Sadler received degrees in International Business and Hispanic Studies from Spring Hill College in Mobile, Alabama, a law degree from University of Mississippi in Oxford, Mississippi, and a Master of Business Administration from Columbia University in New York, New York.

Jeffrey Smith, PhD, NCC

Jeffrey M. Smith, PhD., NCC, is currently, Associate Professor and Co-Director of Masters in School Counseling and Preventive Mental Health program in the Creighton University, Education Department and Graduate School. In addition to teaching courses in research, assessment, and diagnosis, he currently supports the Center for Promoting Health and Health Equality (CPHHE) and the School of Medicine's Health Sciences-Multicultural and Community Affairs (HS-MACA) through education and evaluation activities.

Dr. Smith works as the Evaluator for the CPHHE's Racial and Ethnic Approaches to Community Health (REACH) Grant as well as HS-MACA's Community Oriented Primary Care (COPC) Endowed Grant. Recently, he completed the design of an evaluation plan for Consortium for Omaha Area Community Health: Transdisciplinary Collaborative Center (COACH: TCC) Request for Funding (ROF).

Over the past three (3) summers, Dr. Smith taught research principles and mentored students in the HS-MACA Summer Research Project. He supported two (2) local elementary schools and one (1) local non-profit neighborhood community group to design and install orchards on their campus and community grounds.

John R. Stone, MD, PhD

Dr. John R. Stone is a physician and philosopher/bioethicist. His focus is on social justice and population group inequities in health and healthcare, especially unjust inequalities related to race and ethnicity. His efforts include teaching, scholarship/writing, and programs. Dr. Stone is Professor, Creighton University Center for Health Policy and Ethics (CHPE), Department of Interdisciplinary Studies; and Co-founder and Co-Executive Director, Creighton's Center for Promoting Health and Health Equality. He is Graduate Faculty for CHPE's Master of Science in Health Care Ethics.

Education and experience: BA Emory University, MD Johns Hopkins, Residency and Fellowship in Internal Medicine and Cardiology, United States Public Health Service, Cardiology practice, PhD (Philosophy) Brown University, Associate Professor--National Center for Bioethics in Research and Health Care, Tuskegee University, Alabama. Faculty at Creighton University since 2006. For further information see http://www.creighton.edu/chpe/people/facultystaff/johnstone/.

Melanie Surber, MNS, RN

Ms. Surber is currently the Director of Field Health Services for WellCare Nebraska. She leads a team of care managers spread across the state to provide coordination and support services to Medicaid members.

Ms. Surber obtained her Master's Degree in Nursing from Nebraska Methodist College and her Diploma from Bryan Memorial School of Nursing. She has over ten (10) years' experience in population health management. She has participated in the Medicare Shared Savings Program in both shared savings and risk models. Ms. Surber has shown financial savings and met quality measure thresholds in commercial and Medicaid full-risk products as well as Shared Savings Models and Direct to Employer Contracts.

Thomas Warren, Sr., MS

Mr. Thomas Warren is the current CEO of Urban League of Nebraska. The vision of the Urban League of Nebraska is to lead Nebraska in closing the social economic gap in the African American and other emerging ethnic communities and disadvantaged families in the achievement of social equality and economic independence and growth. Mr. Warren is also the former first African-American Police Chief of Omaha.

His personal achievements include being selected as a Fellow and being inducted into the National Academy of Public Administrators. Mr. Warren is a graduate of the FBI's National Executive Institute Leadership Development Training Program Session 30. He has received recognition for his community involvement and serves as a volunteer on various Boards of Directors including the Omaha Chamber of Commerce, Non-Profit Association of the Midlands, and the Durham Museum.

Lisa White, MD

Dr. Lisa White joined the Department of Health and Human Services (DHHS) division of Medicaid and Long-Term Care in late 2016. Her main responsibility is to provide oversight of quality involving the Heritage Health Medicaid Managed Care System implemented in January 2017. Dr. White provides guidance in many areas, such as safety, utilization, care management, pharmacy, credentialing, medical policy and clinical best practice development. Participation in many collaborations within and outside of the DHHS highlights the department's goal for transparency and engagement in the community to help people live better lives.

Undergraduate training was completed at the University of Michigan in Ann Arbor, Michigan and subsequent medical school graduation from Wayne State University School of Medicine in Detroit, Michigan. Residency in pediatrics at Children's Hospital of Michigan was completed in 1997 and she is board certified by the American Board of Pediatrics. With twenty (20) years of experience in medical education, Dr. White also currently serves in a part-time role as Co-Director of Resident Education and Director of Medical Student Education in the Division of Pediatric Emergency Medicine at Children's Hospital. Between 2013-2015, Dr. White developed and taught courses in health disparities and cultural diversity, patient safety and quality improvement, as well as anatomy and physiology for the University of South Dakota. Clinical experience includes years in primary care, hospital medicine, and pediatric emergency medicine, with a focus on the care of underserved children.

Jeffrey Williams, MBA

A lifelong resident of Omaha, Jeffrey Williams attended Marrs Elementary/Middle School, graduated from Creighton Preparatory School, and received his Bachelor of Science Business Administration degree in Banking and Finance from the University of Nebraska at Omaha, as well as an MBA from Bellevue University.

Mr. Williams works with the Urban League of Nebraska, located at 3040 Lake Street in Omaha, Nebraska, under the Whitney Young Jr. Academy (WYA)/Project Ready program as a Project Ready Program College Specialist. The Whitney Young Jr. Academy is both a leadership and collegiate-preparatory program designed to assist students prepare to enter post-secondary education and explore career, social, and civic-engagement opportunities. Previous positions include that of a detections analyst/OFAC Compliance Analyst at PayPal, a former Vice-President of Operations with the EPA Superfund Project, and a group field compensation administration senior distribution analyst with Mutual of Omaha.

Community involvement includes that of a founder of J's Braintrust Consulting Services Inc., a 501c3 nonprofit that teaches middle-school students the tenets of time management, financial literacy, and entrepreneurship. Mr. Williams is also a current member and former Area Governor for District 24 Toastmasters International as well as a life member of the Great Plains Black History Museum. He served as a high-school/college basketball official for 23 years. Jeffrey Williams is a Health Ambassador for the REACH program.

Appendix III: Evaluation

Were the conference objectives met?

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree
Recognize what Policies, Systems and Environmental (PSE) changes mean.				
Discuss how to evaluate, develop and implement new PSE's.				
Recognize PSE outcomes after changes have been made.				
Discuss policies for Nebraska Medicaid coverage, its process and sustainability				

Overview of Success of the Center for Promoting Health and Health Equality (CPHHE) in Community Academic Partnerships 2016-2017; Doris Lassiter, BS, CEO, Doris Lassiter Consulting, LLC, CPHHE Chairperson

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Presented Information Clearly					
Teaching Aids used Effectively					
Useful Information					
Relevant to Profession					

Changing Policy, System, Environment (PSE): National Best Practices; Ali S. Khan, MD, MPH, Dean, Department of Epidemiology, UNMC

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Presented Information Clearly					
Teaching Aids used Effectively					
Useful Information					
Relevant to Profession					

Changing Policy, System, Environment (PSE): The REACH Program in Omaha; Richard Brown, PhD, FACHE

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Presented Information Clearly Teaching Aids used Effectively Useful Information Relevant to Profession					

Panel Discussion One: Development of Policies: Local and National
Moderator: Stephen Jackson, MPH, Douglas County Health Department
Please rate to which degree the following faculty presented useful information that was clear and relevant to your profession.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Willie Barney, BA, Empowerment Network Deb Esser, MD, Chief Medical Officer, BlueCross BlueShield of Nebraska Sherri Nared, MD, Douglas County Health Department Brenda Council, JD, Women's Fund Adolescent Health Project Manager					

Panel Discussion Two: Policy, System, Environment (PDE) Changes in the REACH Program
Moderator: Doris Lassiter, BS
Please rate to which degree the following faculty presented useful information that was clear and relevant to your profession.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Evelyn Gould, Health Ambassador, Zion Baptist Church Eric Burgin, Health Ambassador, Crown Tower Jeffrey Williams, MBA, Nebraska Urban League Rev. Portia Cavitt, Clair Memorial United Methodist Church Jeffrey Smith, PhD, NCC, PLMPH, REACH Program Evaluator					

Panel Discussion Two: Policy, System, Environment (PSE) Changes in the REACH Program-Comments
Practical Ethics for Health Policy; John Stone, MD, PhD

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Presented Information Clearly Teaching Aids used Effectively Useful Information Relevant to Profession					

Keynote Address
Achieving Health and Well-being for All; Denise Koo, MD, MPH, Community Health & Health Systems, Consultant, former Advisor to the Associate Director for Policy, CDC

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Presented Information Clearly Teaching Aids used Effectively Useful Information Relevant to Profession					

Panel Discussion Three: Measuring Policy, System, Environment (PSE) and Sustainability in Nebraska: Medicaid Approach
Moderator: Kenny Morris, MPA, FACHE, CHCEF, CEO Charles Drew Health Center
Please rate to which degree the following faculty presented useful information that was clear and relevant to your profession.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Kathleen A. Mallatt, CEO, United Healthcare Community Plan Ryan Sandler, CEO and Plan President, Nebraska Total Care Melanie Surber, MNS, RN, Director of Field Health Services, WellCare of Nebraska Lisa White, Medical Director, Nebraska Medicaid Program					

Case Studies Breakout - Solutions

Group One - Lead Contamination in Omaha

Please rate to which degree the following faculty presented useful information that was clear and relevant to your profession.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Thomas Warren, Facilitator Joel Dougherty, COO, OneWorld Community Health, Recorder					

Group Two - Sexually Transmitted Diseases

Please rate to which degree the following faculty presented useful information that was clear and relevant to your profession.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Stephen Jackson, MPH, Facilitator Roselyn Cerutis, BS, PhD, Recorder					

Group Three - Discussion on Tobacco in Omaha

Please rate to which degree the following faculty presented useful information that was clear and relevant to your profession.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	N/A
Donna Polk, PhD, LMHP, Facilitator Martha Nunn, BS, MS, DDS, PhD, Recorder					

Community Poster Presentations

	Yes	No
Did you attend the poster presentations?		

Did you have enough time to view the poster presentations? Did you find value in the poster presentations?		

Was disclosure information provided on all speakers and planning committee members?
Yes
No

Did you receive new information you can apply to your profession?
Yes, please explain _____
No

Will you do anything differently in your profession because of information gained at this conference?
Yes, please explain _____
No

What attitude, strategy, or skill related to inter-professional collaborative practice did you take away from this educational activity?

What were the determining factors for registering for this conference? Please check all that apply.
Content
Date
Location
Faculty
Schedule
Fee
CEU's
Other _____

What barriers do you anticipate in implementing the information gained at this conference?
Administrative Policies
Insurance Costs / Reimbursement Rates
Need Resources / Technology
Facilitating Patient Behavior Change
None
Other _____

Did you like the program design (sessions, breaks, panels, Q & A)?
Yes _____
No _____

Was there pharmaceutical or equipment company bias?
Yes, please explain _____
No

Facility - Creighton University Hixson-Lied Science Building Auditorium

	Yes	No
Was the meeting room satisfactory?		
Was there adequate signage to direct you to the meeting room?		

Did this program touch on areas of professionalism that are relevant to you? Check all that apply.
Patient-centered care _____
Health care policy or advocacy
Sensitivity to diverse populations
Professional responsibilities
Adherence to ethical principles
Other _____

Category 1
Creighton University Health Sciences Continuing Education designates this live activity for a maximum of 7 AMA PRA Category 1 Credit(s) TM. Physicians should claim only the credit commensurate with the extent of their participation in this activity. AAPA accepts AMA category 1 credit for the PRA from organizations accredited by ACCME.

Nurse CE
Creighton University Health Sciences Continuing Education designates this activity for 7.0 contact hours for nurses. Nurses should claim only the credit commensurate with the extent of their participation in this activity. Nurses licensed in Iowa and California: This activity was planned and developed in accordance with the continuing education standards of the American Nurses Credentialing Center (ANCC). The Iowa Board of Nursing and the California Board of Nursing will honor ANCC continuing education credits for face-to-face programs held outside Iowa and California, or for ANCC-approved on line recorded courses taken in a self-study format.

Pharmacy
Creighton University Health Sciences Continuing Education (HSCE) is accredited by the Accreditation Council for Pharmacy Education (ACPE) as a provider of continuing pharmacy education. This live activity, Addressing Health Disparities: Effects of Policies, Systems and Environments in Preventing and Improving Chronic Diseases is assigned Universal Activity Number (UAN) # 0839-0000-17-044-L04-P and accredited for 7.0 hour(s) for attendance of all CE sessions on April 29, 2017. The Addressing Health Disparities: Effects of Policies, Systems and Environments in Preventing and Improving Chronic Diseases is a knowledge-based CE activity.

Appendix IV: Post Baccalaureate Reflection Papers

10th Annual Health Disparities Seminar Reflection

Abraham Robles

As an underrepresented minority, I can relate to many of the addressed health disparities during the seminar. When the void is so great from achieving health equality and equity among underrepresented communities, creating this kind of dialog helps healthcare providers, professional school students, and university administration understand why it is important to gap the inequalities of health disparities. As, Dr. Koo said during her presentation, “Healthy community requires multi-sector collaboration.” Also, the healthiest communities are safe, thriving, have strong healthcare, educational, housing, transportation, food, and economic systems." Furthermore, Dr. Koo explained how housing impacts health. Many people have the misconception that homelessness can only affect the less fortunate. The data shows otherwise, many will experience homelessness regardless of social class status. This is something that is very avoidable when there’re strong social support centers that provision the community when encountering social issues. Someone that suffers from homelessness will automatically increases their social factors and health outcome significantly than someone that didn’t have to endure homelessness. For instance, someone that that is suffering from homelessness will have a more difficult time attending school or work, thus more likely to suffer from chronic stress, heart disease, and hospitalization. Moreover, the homelessness dilemma can cause an array of social factors which lead to negative health outcome and correlates with an increase of morbidity and mortality. Furthermore, social services can help take you out of social misery but in Los Angeles, for instance, 10% of the homeless population accounted for 55% of the public cost. This means that health services alone will not lead to significant health improvements.

When Dr. Koo gave her statistics from King Country, Washington, it really hit home as my home is Washington State. The data was truly shocking that the correlation of where the census tract the highest rates of poverty, no high school degree, and higher obesity were among the same zip codes totaling the opposite of where the wealthy families lived. What’s frustrating about this topic is that all citizens pay tax dollar proportionate to their salary but the reciprocation for an environment that prevents and improves chronic disease is not from our social leaders. Moreover, many politicians in charge of creating policies that effects how healthcare and other important social systems don’t fully understand the difference between equality and equity. We need both working in partnership to strive as a society because equality just guarantees being treated equally and equity is granting equal access. When equality and equity work in conjunction the systemic barriers are overcame without relying on the support or accommodations for social justice.

Overall, effects of policies, systems, and environment in preventing and improving chronic diseases is a tough matter to deliberate because it’s an area of social affairs that requires a lot of work and funding to make noteworthy advancements. As the honoree keynote speaker discussed the various adversities that come when achieving health and well-being it can become a burden to obtain. The outdated policies need to be reviewed and replaced with the current needs of the community as opposed to just amending policies that no longer apply to the public. However, the reality is that many American

individuals and families will never accomplish it due to the various ineffective policies discussed in the seminar that hinder their ability to gain good health and well-being. In conclusion, this African proverb says it best when encouraging our policy makers to get things done, “If you want to go fast, go alone. If you want to go far, go together.”

10th Annual Addressing Health Disparities Seminar

Alex Flores

During my time at the Addressing Health Disparities Seminar I was refreshed on a lot of the main ideas of health disparities and was able to gain even more insight on the latest trends, statistics, and unexplored causes of disparity amongst Latino/Hispanic and African-American/Black communities. Although a lot of the information was not particularly new to me, there was still plenty of relevant information and unique perspectives that were presented and enhanced my understanding of health disparities within the Nebraska community. There were three speakers particularly who stood out to me the most and provided the most engaging and insightful information regarding healthcare and the positive course it is taking towards closing the health disparity gap between minorities and those of a privileged or entitled status. I was enjoyed and learned the most from the presentations held by Morgan Murphrey, Willie Barney, Dr. Koo, and Dr. Khan. These speakers were the most engaging to me due to their strong characteristics of passion and dedication in the pursuit of solutions to the issue of healthcare inequality.

The 3rd Year medical student, Morgan Murphrey, was right on point in her discussion of implicit bias amongst healthcare professionals and its contributions to disparity. Morgan addressed the fact that we as individuals are quite often unaware and unconcerned with our own unconscious biases that are a product of our unique upbringings and environments. The beauty and diversity of people also come with its share of cons as well. Our environment, culture, family, friends, community, peers, mentors, etc. have a significant impact on our identities, schemas, and what we define as norms, values, acceptable, etc. as we develop over time. Unfortunately, some negative cultural or environmental biases can be carried for life and affect others directly or indirectly. As Morgan mentioned, white women are far more likely to receive better care and treatment than women of minority groups in healthcare settings. This can partially be attributed to implicit bias because many working physicians are unable to become truly open-minded and continue to stereotype certain patient groups based on commonly occurring disease and risks within their communities. Healthcare professionals along with all individuals need to be able to address and challenge their own implicit biases for the good of patient care and society in general.

Dr. Khan was definitely my favorite speaker of the day. His work and vision at UNMC College of Public Health is for it to help transform Nebraska into “the healthiest and most equitable state in the Union as a national and global model for wellness.” His presentation revolved around the “paradox” of healthcare and how health disparities have simply become legitimized since 1985. He touched on the crucial role of environment on health disparities. He suggested that “zip code may be a better predictor of health than the genetic code” by mentioning the effects of SES, neighborhoods, etc. on the individual. For example, he mentioned the 12-year life expectancy difference between North Omaha and West Omaha. He then discussed the higher rates of infant mortality seen in the African-American, American Indian, and Asian Pacific Islanders. He also mentioned the Hispanic paradox which entails that Hispanics have the lowest death rate due to cardiovascular and cancer per 100,000 people in Nebraska. Since the minorities are soon to become the majority over the next few decades. By mentioning this he wants to see the Affordable Care Act continue to pursue health improvement

rather than available health care. Dr. Khan also made a distinction between equality and equity. Equality focuses on giving everyone equal opportunity while equity focuses on providing more or changing something for those who need it in order to be on the same playing field. For instance, Dr. Khan stated that certain neighborhoods and minority subgroups, such as the LGBT community, need more equity. Dr. Khan also touched on the recent decrease in the life expectancy of white women between the ranges of 25-35 years old. He then finished his discussion off by mentioning the 9 SE factors linked to the most common 4 health behaviors seen in underserved and disadvantaged communities and suggested that we should all strive to create healthier communities that view the whole person rather than just the current condition or symptoms at hand.

Dr. Koo touched on achieving health and well-being for all through her own perspective on epidemiology. Her take on epidemiology is that it should serve to be more than just a "band aid" for patients and seek the root causes of a condition by seeing the person as a whole and product of his or her environment. She is striving to achieve good public health as opposed to public healthcare. Health is preferred because is refers on individual well-being as opposed to healthcare which focuses on simply access to care or treatment. Her discussion touched on how healthcare is just not enough and that professionals must be able to factor in housing quality, housing security, affordability, and neighborhood context as determinants of health. For example, she stated that something as basic as housing cost burdens can lead to poor educational outcomes, which can ultimately lead to a decrease in mental health. She too touched on the idea of equality vs. equity and claimed that equity poses the question of "What can you do to change the outcome?" while equality simply provides the same platform or opportunity, which is not always enough for disadvantaged communities. Dr. Koo was passionate about the idea of empowering disadvantaged communities to understand why and how certain factors shape their health statuses. According to one of her images provided in her presentation, socioeconomic factors affect 40% of overall health, which is why she is adamant about focusing on the areas of greatest need with the collaboration of different aspects of the community. She claimed that the greatest intervention often are a result of focusing and balancing aspects of socioeconomic factors, the physical environment, health behaviors, and clinical care.

Dr. Koo then made distinctions between the Health Delivery Systems over time. Health 1.0 or Sick Care System (1900-1950s) defined health as the absence of disease in order to improve life expectancy. Health 2.0 or Coordinated Health Care System (1950s-present) focused on the reduction of chronic disease in order to reduce disability. Health 3.0 or Community Integrated Health System (beginning around 2000-present) focused on creating capacities to achieve goals and satisfy needs to optimize health. This transitioned to the four behaviors that account for 40% of all deaths: lack of physical, poor nutrition, tobacco use, and excessive alcohol use. Tobacco is responsible for 12 types of cancer and 40% of cancers diagnosed in the United States, while excessive alcohol consumption results in 1 in 10 deaths among working-age adults. She suggests that the action that must be taken should include comprehensive cancer control programs, more available tobacco cessation treatment, tobacco-free environments, and increased alcohol prices and taxes in order to reduce consumption, motor vehicle crashes, STDs, violence, and mortality.

The 10th Annual Addressing Health Disparities Seminar was a learning experience that I have never had before. It was inspiring to here from some of the greatest minds in healthcare and feel their passion for improving healthcare and decreasing health disparities in Nebraska and other communities. Being a part of today really showed me that my future work as a healthcare professional should and will always extend beyond a clinical setting for the sake of improving a community as much as possible. It takes a team to make a difference and inspire the next generation of healthcare professionals. I can sincerely say that the time spent during the seminar was informative, productive, and motivating for me. As a future physician I hope to accomplish some of the great things several of the presenters have and hope to positively impact the communities I serve with an open mind set in order to make the most of my knowledge, skills, and passions for improving overall public health.

10th Annual Addressing Health Disparities Seminar

Florence Osei

Health Disparities in the United States has been a long-standing challenge to address and continues to be one of the leading problems with the healthcare system today. Disparities have affected low-income groups, women, children, older adults, various races, etc. As an aspiring medical student, it was a rewarding experience to attend the 10th annual addressing Health Disparities Seminar. Being able to understand the importance behind the effects of policies, systems, and environment in preventing and improving chronic diseases, will impact my decision making as I continue my journey into medical school. The key points of the seminar that stood out to me was the discussion of implicit bias, rewriting our national narrative: health equity as a central theme, and the keynote speaker: Dr. Denise Koo on achieving health and well-being.

During the conference, I was fascinated on the discussion of implicit bias presented by Morgan Murphrey. Before the seminar, I didn't know this was a topic that affected the health care system. Implicit bias is the unconscious bias that people care with them about different races, culture, genders, etc. When looking at implicit bias, it is important to understand that it uncontrollable, unintentional, and everyone has them. Most people do not know that they have these tendencies. In order to address the problems that are seen with implicit bias, we must as individuals and future health care professional be interested in reducing the disparities to provide the best care for patients, increase the awareness for the concern, and participate in interventions to discover the ones that you have.

As the population in America becomes more diverse, the conversation of addressing health disparities becomes more important when rewriting our national narrative: Health Equity as a central theme. Dr. Ali Khan started out by discussing the history behind health inequalities and how Thomas Malone in 1985 started a single report on minority health issues. One thing that he talked about that stood out to me was how a person's zip code is a predictor of their health. He stated that in the Omaha area within a 20-mile radius there is either a decrease or an increase seen in life expectancy. He estimated about a 12-year gap in outcome of life. The huge difference in the outcome of health is due to four behaviors that are linked to early deaths. They are lack of physical activity, diet, substance use and binge drinking, and tobacco use. He also made an interesting point on how we must look at the composite data to actually see if we are improving in health disparities. To accurately see the improvements in the community, you must look at each area and not the whole to make an affective plan for a healthier community. Through Dr. Koo's presentation, we were able to learn how to achieve health and well-being for all through policy making. She started her speech by defining some of the terminology that we use in everyday language to address health disparities. It was informative to understand the difference between population health, public health, and community health in order to properly have open discussion about the topics. Without the proper knowledge and use of words the affective policies that must be implemented in the system ultimately mean nothing. In the discussion on what policies have to do with it, we heard the panel talk about how implementing the systems into the various churches in Omaha is really what has made the difference. Being able to have a written law that you can go back to really helps stick and make a healthier community. Through this

seminar, I was able to hear about the policy initiatives involved with health disparities and understand how through discussion, we can as individuals impact the community.

10th Annual Addressing Health Disparities Seminar

Garrick Hayashi

The purpose of this seminar was to gain knowledge and skills regarding the effects of policies, systems and the environment in addressing health disparities. The central points of the seminar were; Equity in healthcare, multi-sector collaboration to build a healthy community, recognizing policy, systems and environmental improvements, and re-thinking what social disparity means. A lot of the information presented today was very eye-opening. It provided me with a new perspective of tackling health disparities. A few of the speakers that resonated with me was Morgan Murphrey, Dr. Khan, and Dr. Koo.

Morgan Murphrey presented on implicit bias amongst healthcare providers and recipients, and how it contributes to health disparities. Implicit Bias refers to "unconscious and relatively automatic features of prejudiced judgment and social behavior". Morgan spoke on the fact that as physicians we need to be aware that we all have implicit bias. These implicit biases are formed from the environment and people we surround ourselves with, and has a significant impact on our identity, and values. An example that Morgan gave of implicit bias in physician-patient interaction is when an obese person walks into your obese. For many people, it is easy to assume that the person has hypertension, is lazy, and does not care about their health. The interaction goes both ways to. For instance, a patient may have an implicit bias about physicians. For instance, when a physician mispronounces a patient's name, the patient may think that the physician does not care about their health.

A few points that Dr. Khan made that stuck with me was that; Disparities still exist 30 years later, zip code as a predictor of life expectancy, and that we must rethink what social disparity means. In his presentation, Dr. Khan mentioned the 1985 Heckler Report. This report was the product of a comprehensive study of the health status of minorities in the early 1980s. However, based on recent data, it appears that the same health disparities that existed 30 years ago, are still prevalent today. These disparities range from racial to ethnic, and sex. Another point Dr. Khan made, was that zip code is a predictor of life expectancy. The example he used, was that if we were to pick a random child from 20 miles away in Millard West, and one in North Omaha, the Millard West child would have a longer life expectancy by 12 years. I found this really shocking, because it shows how much of an effect socioeconomic status has on our health. It also shows that one's health is the culmination of numerous factors such as physical environment, social and economic factors, access to and quality of care, and health behaviors.

Dr. Koo build on this in her presentation with her "public health 3.0" initiative. Dr. Koo focused on multi-sector collaboration to promote healthy communities. Dr. Koo defined Public health as "what we as a society do to assure the conditions in which people can be healthy". One picture that really stood out to me was the image of Seattle King County. Even though Seattle King County is one of the healthiest places in America, there is still a sharp distinction of health issues in certain areas. For example, obesity, diabetes, adverse childhood experiences, etc. were all high in the same area, and low in others. This shows that health disparities exist everywhere, even in some of the healthiest areas.

The 10th annual Addressing Health Disparities Seminar was great learning experience. I felt privileged to hear from experts in the public health field, and to hear what people are doing in the Omaha community to eliminate health disparities. The

information I learned today showed me how much more work and advocacy needs to be done to eliminate health disparities.

Health Disparities Seminar: Effects of Policies, Systems, and Environment in Preventing and Improving Chronic Diseases

Gavin Hayashi

The Health Disparities Seminar brought to my attention many of the ideas that we have been exploring throughout the year in Common Ground and Diversity Dialogue. In particular, the seminar focused on the effects of policies, systems, and environment from multiple perspectives. The main concept that was prevalent in many of the presentations was the idea of a multi-sector collaboration to create a healthier community. This seminar provided me with a new perspective into the world of public health and not only problems in the Omaha community but also on a broader national level.

One of the speakers that was particularly interesting to me was Morgan Murphrey. Morgan is a third year medical student and won the Dr. Frank T. Peak Memorial Health Disparities Essay Award. The concept of implicit bias was interesting to me because throughout the year we have been learning about cultural competency. Implicit Bias is the idea that our unconscious/subconscious biases are in contrast with our conscious values. Many of us are not aware of these biases which are formed from our environment and have an impact on how we interact with others. This concept is especially important for physicians and other health care professionals who interact and treat their patients. As Morgan stated in her presentation skinny people are often treated better by physicians compared to those who are fat or obese. There are also other examples regarding the treatment of minorities in terms of race and culture. Not only do those who work in the health care setting have to be aware of their implicit biases but people in general as well.

The keynote address by Dr. Denis Koo on Achieving Health and Well-being for All was also interesting to me. Dr. Koo's presentation focused on what influences health, what we can do to improve the health of our communities, and social determinant initiatives. As an epidemiologist her perspective was not about just the quick fixes but rather looking for the root of the problem and starting from there in order to create a healthier community. Dr. Koo's main points where that achieving health and well-being is not a problem that can be solved by only improving health care but rather it requires a multi-sector collaboration. Health care alone is not always associated with health outcomes. In fact, the United States spends two times more than other countries per individual on health care but we also have the lowest life expectancy. More than just health care impacts health. There are factors such as socioeconomic factors, clinical care, health behaviors, and the physical environment. In order to improve health, it needs to be a collective effort based on partnerships with people in the community. This includes faith-based corporations, businesses, education, government, public health etc. but the main point is that it's not about trying to fix the community but rather working with the community. Another emphasis of her presentation was Social determinants of health. The conditions in which people are born, live, and work. This includes economic opportunity, housing, transportation, education, and safe neighborhoods etc. which all effect an individual's health. What I found interesting is that the reason why social determinants have such an impact that others may not realize is that people who live in poor housing conditions have to focus their attention on keeping a place to live. This in turn leads to an increased amount of stress which can lead to health problems. Often times we are so used to looking at disease and health issues through a scientific lens. For example, we can talk about diabetes in terms of type 1 and type 2 and what drugs can be prescribed to help the individual.

However, what can actually help the individual is something as simple as changing their diet or going for a short walk every day.

The Health Disparities Seminar was an eye opening experience to truly see how people in the community can come together and make a change. Creighton University Health-Sciences of Multicultural and Community Affairs, The Center for promoting Health and Health Equality (CPHHE), and REACH clearly exemplify the concept of a multi-sector collaboration to create a healthier community. Listening to all the presenters and gaining an understanding and appreciation for what they do in the community was not only a tremendous learning experience but also inspiring.

10th Annual Addressing Health Disparities Seminar

Kelsey Anderson

It was a great opportunity to attend the 10th Annual Addressing Health Disparities Seminar with leaders within the healthcare community and the Omaha community. After attending and getting a chance to reflect on how I can be an advocate and become more aware of the policy, system and environmental changes, and how to respond and recognize these outcomes.

To begin the presentation on implicit bias introduced the potential unconscious biases that are present in the healthcare field. Implicit bias was described in the presentation as unconscious, unintentional and uncontrollable thoughts about race, gender, ethnicity, etc. Often these biases are in a disagreement with our conscious values. After learning about this, I became interested in what can be done to fix these biases and steps I can take as a future healthcare provider. The first takeaway for improving implicit biases was increasing awareness and increasing concern. Another way to improve implicit bias was to recognize your own personal biases through implicit association tests and encourage those to participate in interventions aimed at ending implicit biases. After taking time to reflect about the importance of implicit bias, it is essential for me to be aware and raise awareness to my future colleagues and patients.

In addition to the presentation on implicit bias, Dr. Khan's presentation on the health disparities within Omaha and even across nations. I was in shock at one of his statistics stating that in just 20 miles across Omaha, there is a 12-year life expectancy. In addition to this, he also stated that compared to the national average, Nebraska has a very low infant death rate of 5.2 infant deaths per year. This low death rate and low life expectancy in some areas of Omaha and across Nebraska are inconsistent, and show obvious discrepancy within the zip code you live in. These statistics are alarming as a future healthcare provider and being aware of these discrepancies can help all providers improve quality of care, open free clinics, and be proactive in fixing these divides.

In addition to the Omaha statistics, Dr. Kahn also discussed the discrepancies between the United States and Canada. One statistic being that those in Canada with cystic fibrosis live an average of 13 years longer than compared to the United States; the main factor being access to care. The main claim he made in order to fix these alarming statistics were the four behaviors that often lead to early death. Those being: exercise, substance use, tobacco use, and diet. With this in mind as a future health care professional it is crucial to be aware of the geographical limitations and the lifestyle changes that promote a long healthy life instead of just treating symptoms and illnesses.

All in all, this seminar addressed some major healthcare concerns and gave the attendees information on the policy changes, how to be a proactive leader to combat discrepancies and how to prevent chronic diseases. I am grateful for the opportunity to have attended and gained such valuable information on sensitive subjects that will ultimately make me a far more culturally competent provider. The panel, key note speaker and representatives from the community offered valuable insight on a huge concern in healthcare that I will carry with me throughout my studies and practice someday.

Johnny Aldan

On Saturday April 29, 2017 I attended the 10th Annual Addressing Health Disparities Seminar on Policy System Environments. This seminar focused on the effects of policies, systems, and the environment in preventing and improving chronic diseases. Throughout the seminar I listen to a host of professional speakers, from a plethora of backgrounds that ranged from medicine to community program directors for health, fitness, and well-being. Out of all the presentations discussed, Dr. Denise Koo was quite remarkable and her work interesting.

Just as a brief background to Dr. Koo, she is a recently retired Advisor to the Associate Director for Policy at the Center for Disease Control and Prevention (CDC). With a love for science and willingness to help people, Dr. Koo studied biochemical sciences at Harvard University and went on to complete her medical degree at University of California San Francisco. She mentioned almost giving up on her medical degree, but she was reminded through a course on epidemiology that she could make a bigger impact on her community by preventing non-communicable diseases through awareness, planning, and education.

Her career as a preventative medicine physician and epidemiologist, has made her a titan amongst her colleagues in her field. Her presentation focused on determinants of health, what we can do as to improve health as a community, and environmental scan of selected social determinant initiatives. The main points that I took away from her presentation was how every single aspect that defines society's infrastructure plays a role in the bigger picture of community health. She discussed that there also needs to be a clear understanding of equity and equality. Equity and Equality illustrates how community resources can be construed when certain communities are left to "fend for themselves." She pointed out that it is important to understand that for an entire community to thrive and become successful, in preventing the emergence of disparities, resources need to be shared and a shared community mindset needs to be established.

What I found most unique about her talk was how she explained the idea of Public Health 3.0. Dr. Koo addressed key components and discussed the drive toward the success of public health. That it is the leadership and workforce, the essential infrastructure placement, creation strategic partnerships with reliable individuals, the importance of data analytics and metrics, and maintaining a flexible and sustainable funding resource. The world of public health and its importance to every community can be define in simple statement she made when she introduced 3.0, "What we do together as a society to ensure the conditions in which everyone can be healthy."

Her talk was quite inspiring, it made rethink my position as me and my entire class near the end of the post-baccalaureate program. With my MCAT scores still in need of work and medical school out of reach for the time being, I asked myself what can I do to continue the drive that makes me want to help people and improve their health. Medicine extends far more from the bedside and prescriptions. Dr. Koo's presentation reminded me that this is no one way to achieve your goals. For me, my goal will be reached by some other means or how Dr. Kosoko-Lasaki puts it, "the longer path to a career in medicine."

I've always admired the field of public health its initiative to drive policy creation that drives the healthcare industry, but its use of epidemiology is a powerful combination

that shows a great deal more beyond the normal the hospital setting. It is the “in the trenches” type of career that looks at the nitty gritty and the factors that affect community health. This is something that I would be most interested into researching more about and possibly be a slight but suitable alternative as I work toward gaining entry into a medical school.

Health Disparities Seminar

Karina Bethea

This year I was fortunate to attend the 10th Annual Health Disparities Seminar. This seminar covered the effects of policies, systems, and the environment in preventing and improving chronic diseases. This purpose of this event was to increase the knowledge, skills, and the ability of those in academics and the community regarding these topics. In this conference, we were able to engage and voice concerns about developing health associated concerns within our community. There were several speakers who gave insightful information.

One of the speakers I was able to listen to was John R. Stone, MD, PhD. Dr. Stone is a physician, philosopher, and bioethicist who focuses on social justice and inequalities in healthcare especially relating to race and ethnicity. He is also a professor of Creighton University and Co-Executive Director and Co-Founder of Creighton's Center for Promoting Health and Health Equality. Health is encompassing medical care, personal behavior, living and working conditions in homes and communities, and economic opportunities and resources. The ethical framework of health is centered on justice, equality, respect, democratic deliberation, collaborative advocacy. I learned that through respect we are able to empower and give input about concerns. Democratic deliberation is presenting information in terms that everyone can understand. Collaborative advocacy is how community leaders can collaborate effectively. The living and working conditions that individuals live in can be determining factors for your health. Through voicing concerns and representing graphs, research is able to show that those with good air and water have generally better health. Those with sidewalks are also better to maintain their weight and showed decreased rates of moral obesity. Communities should now implement programs, education, and incentives to promote proper health care. His presentation regarded checking policy with a criteria of meeting four areas. Location, evidence, input and voice, and research.

Another speaker I was able to learn a lot from was the key note speaker. Denise Koo, MD, MPH, is the former Advisor to the Associate Director for Policy Center for Disease Control and Prevention. She was the chief navigator for the CDC community health improvement. The topics she presented on were the influences of health, how to improved health in our communities, and a scan of environmental social determinants. One key point that she focused on was that health and healthcare were not the same and that many times people confuse the two. Another important key point was that healthy communities require multi-sector collaboration. She stated in her presentation, "The healthiest communities are also safe and thriving, with strong healthcare, educational, housing, transportation, food, and economic systems." I also learned the difference between population health, public health, and community health and that are all intertwined. In her discussion, she mentioned that healthcare alone is not enough and that one area that needs focusing on is housing and health. Quality, security, and affordability all contribute to our overall health. In our communities, we need to focus not just on equality but on equity for all to promote better lifestyle. Dr. Koo also discussed Public Health 3.0 and how it has transition over the years. Public Health 3.0 has implemented goals to satisfy need to optimize health for all. This initiative works with community empowerment, engagement, integration, information and measurement, and financing approaches to better our health care system. There were four leading

behaviors that occluded to 40% of all deaths. These included lack of physical activity, poor nutrition, tobacco use and excessive alcohol consumption. Due to these health risks, the prevention institute has issued a spectrum of prevention that influences the policy, legislation or organizations and practices. It also focuses on educating providers, promoting community education, and strengthening the knowledge and skills or the families and communities.

Overall the Addressing Health Disparities Seminar was a great learning experience for me. I did not know much of what all went into the health and healthcare of our community, but after hearing several speakers and learning about different initiatives and concerns I am now aware. I have learned that it takes a great team of people, from communities, social workers, educators, and practitioners to educate and support the well-being of the community. I learned that it's important for us to get involved and to be knowledgeable about our community.

Reflection Paper

Kyla Combs

Did you know that your race or ethnic group; religion; socioeconomic status; gender; age; mental health, cognitive, sensory, or physical ability, sexual orientation or gender identity, geographic location, or other characteristics are all linked to the value and level of care that you may receive are your next doctor's appointment? A health disparity is defined as a difference in health outcomes across subgroups of the population. Health disparities are often linked to social, economic, or environmental disadvantages. Many health concerns, such as heart disease, asthma, obesity, diabetes, HIV/ AIDS, viral hepatitis B and C, infant mortality, and violence, disproportionately affect certain populations. With a goal to bring awareness in preventing and improving chronic diseases and addressing health disparities, the 10th Annual Addressing Health Disparities Seminar provided an opportunity for each attendee to gain the skills and knowledge to impact their community.

Morgan Murphy, Dr. Frank T. Peak Memorial Health Disparities Essay Award Contest Winner, presented on the topic of *Implicit Bias*. Implicit bias is defined as associations outside conscious awareness that lead to a negative evaluation of a person – uncontrollable; unconsciously held and often in disagreement with conscious values. In contrast, explicit bias is intentional, conscious, and controllable. There is a relationship between implicit bias and patient care. This relationship is the leading disparity in healthcare. An analog that corresponds to implicit bias would be smudge glasses – it affects the way we see things, but not aware that it's there. The speaker then presented on the Implicit Association Test, which an individual is supposed to sort pictures and words into groups as quickly as possible – and the results will to tell you, your thoughts and feelings outside of conscious awareness and control. The speaker than interjected on the mitigation process of implicit bias – afternoon training sessions and strategies to diminish its effects.

Dr. Ali Khan presented on *Changing Policy, System, and Environment (PSE): National Best Practices*. Nebraska is ranked 32nd in Health Disparities with Hispanics having the lowest rats of cardiovascular and cancer deaths. By 2020, the speaker predicts that there will be more minorities than majorities. We can promote shared responsibility of the health of the community. Reducing disparities in health will give everyone a chance to live a healthy life and improve the quality of life for all Americans.

A panel discussion was presented on the topic Development of Policies: Local and National Focus. One of the attributes towards this topic was bringing an awareness to the STD rates presented within Douglas County. Douglas County far exceeds the US rate of Chlamydia – 2,284 individuals between the ages of 15 to 24 yrs. age; that's roughly 50% of individuals within the age range. Overwhelming percentage of chlamydia among blacks are more likely to attract Chlamydia. Moreover, gonorrhea affects nearly 1,000 individuals in the Black community - detected because of throat swab. Becoming an issue due to anti-biotic resistance strains. Preventive measures presented included to test more people and make an awareness. Increase access to barrier free health care access. I am more than thankful to not only be of attendee to such an aspiring event, but also to know how much I have gained from the conference as well. I want to be an individual that not only has the skills to provide preventive measures for patients, but I also want to be someone that is aware and alert of the disparities that occur within a community.

10th Annual addressing health disparities seminar

Patrick Hooke

Attending the 10th Annual addressing health disparities seminar was a wonderful opportunity because it allowed me to learn about myself and about the direction in which healthcare travels as communities and organizations fight to decrease and diminish health disparities from different areas. By taking part in this year's health disparities seminar, I have the opportunity to learn about various topics and trends: differences between implicit and explicit bias, the difference in life expectancy between men and women, education of African American in the past years.

Explicit bias "refers to the attitudes and beliefs we have about a person or group on a conscious level". We are aware when we demonstrate explicit bias or observe someone performing explicit bias. However, as demonstrated in Morgan Murphrey's presentation, implicit bias occurs at the unconscious level. Common implicit bias deals with gender, age, mental illness, weight, AIDS patients, etc. Research has shown that as physicians deal with certain patients, they are more likely to associate that patient's illness to one of these common implicit biases. Making these associations prevent a physician from providing optimal care to a patient and leads to disparities in healthcare. For example, research has shown that female patients were less likely than males to receive four to five types of physical exam. This difference in the amount of physical exam administered occurred because of the implicit biases that were unconsciously held and often in disagreement with conscious values. As a future black male physician, it was also interesting to learn that implicit bias is prevalent in physician of all racial groups except for African American.

But although implicit bias is not present among African American physicians as opposed to other racial groups based on research, combating implicit bias requires a group effort. As stated by Ms. Murphrey, to combat implicit racial bias, we should continue to increase awareness of implicit bias, recognize implicit personal biases with the use of Implicit Association Test (IAT), facilitate and participate in interventions aimed at mitigating implicit bias. Intervention can be an afternoon training session, educating participants on implicit bias, and providing daily strategies to diminish its effect.

In addition to learning about the implicit bias and its connection to health disparities, I took away from this annual event interesting data and trend concerning gender and specifically the African American community. Firstly, the life expectancy for white men and specifically white women has decreased throughout recent years. On the other hand, the life expectancy of black men and women has increased. We cannot attribute this difference to a single factor. However, staying healthy is a major contributes.

Furthermore, it was exciting to see data representing an increase in African American acquiring a bachelor. Although the values were below whites, the main message points to an increase in African American seeking a higher education. Because of this increase in higher education among blacks, the number of black own businesses has increased/doubled over the years. But the main question now is, how do we improve from here? The answer to that question will come from the current generation of African Americans that are acquiring higher education and holding powerful positions in various fields and studies.

As stated previously, this annual health disparity event was an opportunity for me to learn about healthcare and myself issues as I enter into medical school. But most

importantly, Ms. Murphrey's comment about everyone demonstrating some form of implicit bias impacted me significantly. The comment resonated with me and caused me to reflect on my thought process and belief.

Annual Health Disparities Seminar
Praise Setodji

The subjects related to health disparities is relevant in today's reality and requires awareness mostly from those that devote their daily life in serving others in their community. Most of subjects if not all, were pertinent during the seminar and few that sparkled my interest are the subjects related to implicit biases and how it affects patient care; as well the topic of Changing Policy as, System and Environment presented by Dr. Ali S. Khan.

Implicit bias is an unconscious source of bias that may be affecting the way we interact with others. It is often in disagreement with one's own conscious values. Being conscious of this biases and learn how to avoid them or redirect them in a more beneficial way can help in decreasing health disparities component associated with them.

It is normal to have an opinion on people when you meet them. The next thing is how we react to opinions we have. Implicit bias is prevalent in the healthcare setting. I liked the fact that Morgan pointed out that there is a relationship between implicit bias and patient care, and that the relationship lead to disparities in diagnostic workup and treatment plans. It is crucial that as a future healthcare providers we understand that unconscious biases do influence the assistance we provide to others.

We must also accept the fact that another reason why there are differences whether due to how people look like or where they come from, is associated with what we know or learned and how we integrated those into what consider as perfect behavioral model.

Morgan proposed action toward the issue. Her proposed solution is to increase awareness and recognize personal implicit biases. She also proposed the Implicit Association Test as a perfect tool to recognize personal implicit biases.

The subject presented by Dr. Ali Khan also did touch base with the biases and most specifically with healthcare disparities. During his presentation, Dr. Khan supported the fact that there where evidence that point out to implicit and explicit biases among doctors. I believed that majority of medical schools today are diligently working toward forming good care providers and should also emphasized on this aspect. Personally hearing about these biases from a medical student and then from a physician, was a reminder to go beyond my impression and bias toward others.

Dr. Khan also explained disparities in healthcare by touching on some key points which include: social determinant of health, geographic location. I was more surprised by the fact that location of an individual or Zip code can be a better predictor of life expectancy than genetic code. This simply mean that sociocultural, race and ethnicity do influence how good individual live their life or not, and how they are being treated. It is clear the notion of Health Equity as mention by Dr. Khan is still to be improved otherwise the health expectancy will decrease as they are showing right now.

In final, the practical ethic for health policy as presented by Dr. Stone presented an umbrella that covered both aspect that I liked during the presentations at the seminar. Dr. Stone said that "Health care is about people and organizations working together to empower the community to be able to implement the behaviors of changes that will impact health, to promote justice and equity as well as a collaborative advocacy which is the fair and respectful exchange when it comes to policy that we are trying to implement.

REFLECTION

Silvia Nweze

On the 29th of April 29 2017, the tenth annual Addressing and Health Disparities Seminar was held at the Hixon-Lied Building of Creighton University. Several topics discussed include Health Disparities, effects of policies, systems, and environment in preventing, improving chronic diseases, and sex education. They were all great topics and sparked a lot of interests and suggestions, and the topic that stood out the most to me was the issue on sex education with the younger population. About last week ago, I found out that Omaha has one of the highest rates of Sexually Transmitted Disease in the United States. So, it was interesting to hear discussions on sexual activities being brought up by Omaha local health organizations at the seminar. I, myself, got to take a lot of knowledge away from that session. I heard several of the speakers mention the lack of communication between children and their parents. I agree and believe that sex education should indeed begin at home because that is where learning and trust is formed. However, I did not agree with the easy access to contraceptive. If anything, there should be a line drawn on education verses easy access to contraceptives. As teenagers see this easy access, they get the impression that it is ok if they had sex whenever they pleased. Thus, I feel that sexual education should be mandatory, but giving contraceptives should be cautionary. The teenagers should be educated on morals as well and made to understand that even though there are options in protecting themselves, they should abstain until they are mature enough to be able to make educated decisions on their own.

Another thing I admire is how representative the Seminar was. They represented several minority organizations and gave them the opportunities to voice their opinions. I remember the woman sitting next to me feeling very concerned about the governments' benefits available for the elderly and could ask the speakers about the matter. Also, the crowd was diverse. It included students, youths, faculty, and the elderly. I feel that everyone was given the chance to be heard, as well as participate in interesting activities. It was also strategic to have the breaks in between, the workout session, and the workshop.

The breaks gave people the chance to get to know people around them as well as to take a bathroom break or simply grab a snack. Speaking of which, the meal provided was nice. It was a great effort on the path of the event planners. The choice was simple, yet enjoyable. I liked the chicken wraps, chips and fruits the most. Everyone came hungry and left happy. I also enjoyed how anonymous the question sessions were. People could write their answers on a green sheet without the focus of everyone on them. This allowed people to ask what they truly felt needed answers or were an issue. So, it was an inclusive and holistic process.

In conclusion, the seminar was well thought out and I applaud the people that made the event possible. People were given the opportunity and a voice. I feel like events like those make an impact especially for the minority groups who need to be heard and educated.

Health Disparities Seminar

Yemi Ajayi

The 10th annual seminar addressing health disparities cover various aspects of community health and education. There were variations of people well versed in research along with leaders in communities who spoke of the importance of maintaining health. Some spoke of their studies and current ways of educating the community or keeping them active while there were panels with people of different career backgrounds with a common goal.

There were numerous speakers whose topic of discussion captured the attention of the audience. For example, Dr. Brown who spoke on changing policy and system environment through the REACH program in Omaha. Dr. Brown spoke of ways they keep the community engaged becoming more active by starting off small with goals set for individuals. He also spoke about understanding that community outreach in regards to living a healthier life style should be tailored to the group at hand. Emphasis was made on promoting health and health equality and now referred to as equity. The goal is not to remain at a local level but to educate and reach out to so many on a national level.

The panels and discussions at the conference provoked thought and kept everyone intrigued as too many things we all overlook but affect the vast population. An example would be the panel for development of policies local and national focus. This panel had medical officers, employees of Blue Cross Blue Shield and an STD/HIV prevention specialist. All aspects of healthcare professionals could benefit from learning the basis of this panel's discussion. Aspects of medicine were discussed in regards to STDs and children who are not educated on protecting themselves and their by spreading STDs. The major point made circled around how people are treated for their STDs but do not know how to protect themselves and contract it again but now possibly having an antibiotic resistant strain due to the virus evolving after exposure to medications used to get rid of it the first time. In regards to antibiotics prescribed this applies to those in pharmacy or interested in anything pharmaceuticals related. Some of the diseases mentioned were contracted orally which ties into dentistry's preventative aspect. The panel also touched on the fact that most of these issues can be avoided through educating people which brings in the aspect of public health and anyone interested in that sector of healthcare. Surprisingly it was stated that pre-teens and teenagers where the intended group to educate since they were affected the most.

Another panel that captured a lot of audience member's attention was based off of Policy, System, and Environment (PSE) Changes in the REACH Program. This panel was led by Mrs. Lassiter; this group discussed strides they have made in churches and in the community where they keep the elderly active. They discussed variations of activities that keep people busy ranging from Zumba classes, tracking daily steps, and gardening. The mission is to gradual get the community active and not count out the adults who may no longer be as active. The panel also discussed advertising techniques that are used to appeal to the youth, elderly and those in church.

The conference had many aspects of health disparities that were discussed but something key about this conference is not only were people becoming informed of the health of the community and statistics but in addition ways to get involved and make a difference.

AJ Scarborough

Having the opportunity to attend common ground and healthcare disparity lectures throughout this last year has dramatically opened my eyes to a new area of medicine that I was not fully aware of before coming to Creighton. Through growing up in a near all-white town in the upper middle class and attending a private university in South Dakota, I was not fully exposed to these issues. Although I have always been curious in learning about healthcare disparity, especially regarding the homeless and lower class, it is not until now that these issues have fully resonated with me, leaving me with a profound desire to assist these communities as a physician in the near future.

Two talks that really stuck out to me were the LGBTQ panel and the common ground regarding homelessness, as talked about by the Stephen's Center and Youth Emergency Services. Also, prior to coming to Creighton, I don't think I fully understood the stigma associated with the homeless or HIV/AIDS patients. My ignorant view was that the majority of the homeless had to be lazy and I had no clue that almost all HIV/AIDS patients suffer from severe depression as a result of the stigma, displayed by our society, revolving around the disease. After I took the Adverse Childhood Experiences (ACE) assessment and scored a zero, I really began to realize that many of the homeless people I see on daily basis around Omaha are not lazy, but rather were never given a fair chance. With the average homeless person's ACE score being 6 or above, I can't help but think I would be in the exact same situation as them if I were dealt a different hand at birth.

The LGBTQ panel opened my eyes to the micro-aggressive/subtle comments that people from this community are faced with. With two homosexual doctors on the panel, it was especially interesting to hear the struggles they've faced regarding patient and coworker comments and actions. This talk will definitely help me in the future to stand up for people of the homosexual community when they are faced with adverse situations that could be potentially detrimental to their well-being.

I think that in order to eliminate healthcare disparities in the United States people need stop generalizing/stereotyping other groups and begin to understand and listen to the underserved community. Listening and understanding to the people which fall victim to healthcare disparity means truly having empathy and being considerate of how their life is different from our own. As cliché as it may sound, not being able to genuinely put yourself into someone else's shoes, and failing to realize that you are just what they would be under similar circumstances, creates a whirlwind of problems. We must begin to understand the stories of the underserved. Treating everyone fairly, on an equal playing field is where we must begin.

Health Disparities Seminar Reflection

Jessica Pierce

In the 10th Annual Addressing Health Disparities Seminar, there were a few topics that I found intriguing and particularly educational as a future healthcare provider. These included implicit/explicit bias, why we need to continue to address health disparities, and finally the STD rates in Douglas County. I feel that these are important topics and had the most impact on myself.

One of the first presenters was Morgan Murphrey, an M3 at CUSOM. She discussed implicit bias (unintentional) and explicit bias (intentional) and their impacts on not only patients but the entire communities as well. In a healthcare setting, we see implicit bias in a healthcare provider unknowingly giving better care towards someone of their ethnic/racial background, for example a white doctor giving better, more personal care towards a patient who is white, and less time with someone who is Hispanic. In the community, Morgan talked about how we can see this implicit bias even in judges who tend to give African Americans longer sentences, even though they are under oath and swear not to be bias towards or against anyone. Even in this last election, Hillary Clinton said that implicit bias could be found in everyone at some point. I thought her presentation was important in the idea that we can subconsciously have bias and treat people differently without even recognizing what we are doing, and that is very important to remember as a healthcare provider that we do not treat patients differently based on their ethnicity, race, religion, socioeconomically status, or even gender.

Next towards the middle of the morning presentations we heard from Dr. Ali Khan, the dean from UNMC. He spoke on the HSS Heckler Report, legitimization of health disparities as an area of research and focus on biomedical factors in 1985. More importantly however he made it a point that 30 years later these health disparities still exist, and how we have to keep working to decrease them because we should not be having these conversations 30 years from today. What I thought was most intriguing about his presentation was that our zip codes are far better indicators of your life expectancy than your genetics, from which he pointed out that west Omaha residents have an outstanding 12 year life expectancy difference from residence in east/northeast Omaha. So just driving across town the life expectancy changes over a decade. Dr. Khan also discussed how American healthcare is great compared to third-world countries, however we still have an average infant mortality rate that is triple of what some other countries such as Norway are regularly achieving, so we still have a lot of work to do when you look at it that way. He also reminded us to basically not forget about the white people, in health disparities we mainly focus on improving the health and living conditions of minority populations, but we can't forget about the Caucasian population either. He brought up several statistics to support this, such as the fact that white women age 20-30 have the highest suicide rate and white women have seen the biggest decrease in their life expectancy recently, which I found shocking and a good point too that health equality means everyone not just focusing on minority populations.

Finally, I thought the presentation over STD's was very educational for all of us in the audience. Children are experimenting/learning sexual relations at earlier and earlier ages, and we need to start implementing ways to educate them about safe sex and the consequences to their actions. Several statistics were pointed out, such as Douglas County having STD rates that are much higher than the state or even national average.

Chlamydia is the most commonly reported, and Hispanic women are twice as likely to have it/contract it. Gonorrhea is the biggest worry however, with African American women being 10 times more likely to have it or contract it, and is becoming a big issue because we are starting to see antibiotic resistant strains of gonorrhea. Going back to the need for education in kids, it was also mentioned that the age group of 10-15 had an alarming contribution to the overall statistics of both chlamydia and gonorrhea, and that should be a sign that we need to develop educational programs for that age group.

In conclusion, the discussions of implicit bias, why we need to continue addressing health disparities, and the alarming STD rates in the Omaha area were the three presentations that I felt had the most impact and were very important to us as future healthcare providers. The only thing that I did note was that Native American, Asian, and Pacific Islanders were often not mentioned in these presentations. This is understandable as the majority of the underserved population here in Omaha is Hispanic, African American, and then some Karen and Somalian. I do know of several programs that the Omaha and Winnebago tribes have implemented over the last decade to address health disparities that affect the native population, such as those to address exercise/wellness, diabetes, drug addiction, (meth and alcohol). We did have a common ground that discussed the dietary issues often seen among Asian cultures, with their children often being malnourished when they are living in America. While I agree that living in Omaha we should focus on the disparities of African Americans and Hispanics since they are the majority minorities, it would be beneficial to keep the discussions such as in common ground that we have had over Native Americans and the Asian disparities as well, because most of us will go on to be healthcare providers in areas other than Omaha and it would be good to have exposure to disparities of all minority populations so that if we do end up in an area with Asian, Pacific Islander, or Native American populations that we have at least some exposure to their cultures as well.

Appendix V: References

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