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Program Planning on Social Determinants of Health for Rural Nebraska

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Abstract

Social determinants of health (SDOH) are non-health factors that impact health in both direct and indirect ways. Research into SDOH and their effects has been extensive in recent years and has been further documented by the COVID-19 pandemic. Despite the wealth of the literature on the SDOH, awareness of these important factors is not prevalent among community residents. Rural communities are as subject to the impact of SDOH just as their urban counterparts and experience additional complexities related to geography and topography.

This capstone project aims to raise awareness, provide education, and assist with tools and resources, to empower rural communities to address the SDOH from within through a two-phased protocol, which was piloted in one rural county in Nebraska. The first phase included a session to raise awareness and educate on the SDOH, followed by a facilitated session where the facilitator worked with the audience on the prioritization of one to three determinants they wanted to address. Once the determinants were selected and prioritized, a logic model, and evaluation plan was developed for implementation at the completion of year one of implementation. The expectation is to see the resolution of the priority issues, identify barriers and successes and determine the next steps if applicable.

Chapter 1

Introduction

The constitution of the World Health Organization (WHO) defines health as "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," adding that obtaining the highest standard of health is a fundamental right for all human beings regardless of race, religion, political belief, or socioeconomic condition (World Health Organization, 2022). Social determinants of health (SDOH) are defined as "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." The social determinants of health can affect the health of individuals and communities in complex ways, and they heavily influence the existence of health disparities and engagement in health promoting behaviors both directly and indirectly (Adler et al., 2016).

The U.S. Department of Health and Human Services (USDHHS) categorized the SDOH into five domains: 1) economic stability, 2) education access and quality, 3) healthcare access and quality, 4) neighborhood and built environment, and 5) social and community context. Each domain includes a specific set of factors. For example, the economic stability domain includes factors such as income and employment; and the social and community context domain includes discrimination and neighborhood safety. Other factors include transportation, safe housing, education, access to healthy food, access to opportunities for physical activity, water and air quality, violence, social belonging, and integration (Holt-Lundstad, 2022; Nutbeam & Lloyd, 2021; Richman et al., 2019; Sharma et al., 2018).

In understanding the repercussions of addressing these determinants, it is important to pay special attention to the role that geography and topography play in adding a layer of complexity in the impact of the SDOH (Reid, 2019). According to the Centers for Disease Control and Prevention (CDC), approximately 15 percent of the U.S. population, more than 46 million Americans, live in rural areas (CDC, 2017). Studies have documented important health outcome gaps between rural and urban Americans (Reid, 2019; Richman et al., 2019). The CDC (2017) states that rural Americans encounter higher mortality rates related to heart disease, stroke, chronic lower respiratory disease, unintentional injury, and cancer. Such disparities may be due to factors related to long travel distances required in the everyday lives of rural people and even longer distances to seek medical attention, whether for an emergency or regular primary care visits. Other geographical and topographical factors include exposure to environmental hazards, less leisure time for physical activity, higher rates of poverty, and higher proportions of people without health insurance (Cosgrave et al., 2019; Del Brutto et al., 2021; Reid, 2019).

During the past two years, the COVID-19 pandemic highlighted the disadvantages that rural communities face, including access to healthcare, issues with workforce retention by hospitals and clinics, lower educational attainment, and increased rates of poverty. These disadvantages are reflected in higher mortality rates due to COVID-19 in rural communities as opposed as their urban counterparts (Bispo-Morais, 2020; Paul et al., 2021; Singu et al., 2020).

Lack of education and limited awareness of the SDOH present a barrier to helping people understand why and when they get sick. Limited control of factors that influence health leads to chronic stress and willingness or tendency to let things lie. Understanding social and

geographical contextual influences on health, at individual and community level could bring better knowledge of how to address those factors.

This project was developed to fill a gap by increasing awareness and education on the SDOH and their impact on health and quality of life. It also provides tools to help people to mitigate obstacles related to the SDOH such as supporting community-level efforts to address the SDOH and working together to create an action plan to build ownership, buy-in, and establish a common language and understanding of intended outcomes.

Chapter 2

Background and Literature Review

Understanding the SDOH and how the conditions in which we are born, grow, work, live and age, have the potential to affect our short- and long-term health outcomes (World Health Organization, 2022) is crucial to exerting a positive change.

SDOH can be grouped in five domains including economic stability, access and quality in education, access and quality in healthcare, neighborhood and environment, social and community context. Economic stability has an impact on the things we can afford, such as healthy foods, healthcare, housing, and means for transportation. Education access and quality can influence the likelihood to have safe, high-paying jobs and the sense of control over their living conditions; research shows that people with higher education are healthier (Zajacova & Lawrence, 2018). The healthcare access and quality domain addresses whether people have what is needed to receive healthcare, like health insurance, culturally and linguistically appropriate services, access to a primary care provider, and preventive health screenings to cite few examples. The neighborhood and built environment play an important role in the health of individuals and is determined by the presence or lack of safety, safe air and clean water, walking or biking trails, and sidewalks. The social and community context domain involves the interactions and relationships from the micro to macro environment. Good relationships and interactions can provide social support and sense of belonging, prevent isolation and segregation, and build a social safety net to fight chronic stress (Health and Human Services, Healthy People 2030, 2021).

SDOH can be quite complex in a rural setting when including issues related to geography and topography, affecting largely health access and outcomes. Rural communities are thought as the "periphery" in a geographical, social, and political sense; they have a way of development, suited to fulfill more local needs, which differs when compared with urban areas. Geographical, political and social distance can make rural communities more susceptible to suffer from the challenges posed by SDOH. These rural determinants often go unacknowledged, and grow intertwined, consequently amplifying their negative health effect (Reid, 2018).

Understanding these determinants is just the beginning. The approach to addressing the SDOH needs to be intentional, because these conditions demand to be challenged rather than just understood (Sharma M., et al., 2018). To highlight this concept, when a person knows that they do not have access to healthy food, or that they live in a neighborhood where it is not safe to walk outdoors, that is understanding of the determinants. However, the lack of agency or control of such conditions is what needs to be challenged and changed. Raising public awareness, community mobilization, and common language creation; can all be achieved via awareness and education. Achieving this could be crucial for communities to press for policy change. Raising awareness and providing education brings common ground of the realities experienced by the members of a community. This knowledge can contribute to changing behaviors and attitudes and making more informed decisions contributing to improvement in their health and environment.

The use of audiovisual media has proven to be effective to channel knowledge into the brain via sight, hearing, and the process or rationalization of stories. Attractive learning media can achieve this because the spectator develops an increased interest in learning (Untung, 2020).

When we consider the internal factors that influence human behavior, such as knowledge, desires, interests, motivation, perceptions, and attitudes, it is easier to comprehend the power of storytelling presented in an audiovisual format, and how this receipt of new knowledge can be internalized, processed and adapted to the spectator's reality and then prime or reinforce attitudes and perceptions, with the goal to produce a change in behavior (Clarke, 2012). The use of storytelling via a documentary to create a common language and spark conversation towards SDOH and how it relates to a community's reality creates a baseline picture and fosters a collective common goal.

SDOH are a good topic for audiovisual storytelling, because they share the story about the living conditions and realities that most people can relate to, whether it is the advantages or disadvantages we face throughout our lives.

Chapter 3

Methods

The main goal of this project is to raise awareness among organizations and community members on the determinants that affect health and promote a preventive approach. We intend to empower communities from within. I worked in partnership with the Central District Health Department (CDHD) in Grand Island using a two-phased approach to address SDOH in Merrick County.

Merrick County

Located in central Nebraska, Merrick County has an estimated population of 7,665 (U.S. Census Bureau, 2022). Merrick County receives public health services through the CDHD, which also serves other two counties (Hall and Hamilton). On their Community Health Assessment (CHA) report of 2021, the demographic composition of Merrick County was estimated as follows: 92% White, 0.3% Black, 0.8% American Indian & Alaska Native, 1% are Asian, 0.1% Native Hawaiian/Other Pacific Islander, and 5% Hispanic. Twenty one percent of the population are over the age of 65. Merrick County has the lowest median household income within the three-county district with $53,411, compared with $63,290 for the entire state. Approximately 14% of children live in poverty compared with 12% for the state.

The main leading causes of death in Merrick County are (per 100,000 population) cancer 160.9, heart disease 133.4, and unintentional injury 52.7, and it has one of the highest rates of Years of Potential Life Lost (YPLL) in the district, which is also higher than the state rate. In terms of obesity (BMI= 30+) rates, Merrick County has the highest rate in the district with 42%, and higher than the state rate of 33%; no leisure time physical activity rate for Merrick is 31%

ranks also as the highest within the district and higher than the 22% in the state. Merrick County has also the highest rate of diabetes within the district, 15% compared to the state at 10%.

According to the 2019 Community Resilience Estimates from the U.S. Census Bureau (2019), Merrick County has an estimated 24% of the population with three or more risk factors for vulnerability related to health, social, and economic impacts of disasters, compared with 18.7% of the total Nebraska population. The risks considered to assess vulnerability are income to poverty ratio, single or zero caregiver household, crowding, communication barrier(s), households without full-time, year-round employment, disability, no health insurance, age over 65, no vehicle access, and no broadband internet access.

Merrick County was selected for this pilot project because I have an active partnership with CDHD, through my work as Rural Prosperity Nebraska Educator with the Extension office for the University of Nebraska- Lincoln, specifically to find and assist with projects related to SDOH. Within the district, the only rural county facing high disparities related to SDOH is Merrick County. CDHD provided the funding needed to support this project.

During phase one, I worked with CDHD to host a session focused on increasing awareness and education about the SDOH, and the audience for this activity was composed by stakeholders who represented providers of community, school, health, and social services in Central City, in Merrick County, as well as members of the community. The first phase was initially intended to be inclusive of all communities of Merrick County and to be held during the month of October, but after my initial planning meeting with the City Administrator and the Director of Merrick County Community Foundation, we learned that October was not a viable option for members of smaller communities, because it was harvest month. Most of the

stakeholders from Merrick County communities would not be able to attend. I decided to make my program planning project to reflect the County seat community, Central City. The recruitment of participants was done by purposeful sampling, using snowball method. With the collaboration of the City Administrator, and handled by CDHD, we identified 15 key stakeholders who were very familiar with the social conditions, healthcare system, and needs of the community from their own areas of work. Stakeholders received a meeting invitation, explaining the purpose duration, and location of the session, and were asked to confirm attendance. Due to schedule conflicts, I offered a second session to ensure maximum attendance. Attendance for the first and second sessions was seven and one participant respectively, representing various areas of services in Central City: city government, county community foundation, healthcare system, local newspaper, University of Nebraska Extension, bank, and real estate industries. I used the 56-minute first episode "*In Sickness and in Wealth"* from the *Unnatural Causes*: *Is Inequality Making Us Sick?* documentary series (Adelman, 2008). The *Unnatural Causes* series, was created by California Newsreel and draws from germinal literature, including information and interviews provided by national subject matter experts in health disparities and social justice. The first episode in the *Unnatural Causes* series provides an overview of the concept of the SDOH and their effects on people's health and lives using real-life examples. It contains health literacy-appropriate definitions and description of the SDOH, as well as data to demonstrate the disparities and their impact on the lives of individuals who face different levels of challenges due to SDOH. *Unnatural Causes* provides a good ground to start conversations and make more intentional inquiries about the relationship between what was learned after watching the episode, and the audience's reality at the individual and community

level. Since *Unnatural Causes* was released in 2008, I searched for a more current video to use for this phase of the protocol, but I was not able to find one that offered the content and power of *Unnatural Causes*. I assessed that the information contained, and the delivery of the core messages were a perfect fit for this protocol and are still relevant to this day.

The *Unnatural Causes* series includes a facilitation guide, which I used in the group discussion following screening of the video. I used these questions as a model and narrowed to six questions:

- What is the difference between population and individual health?
- Why is health more than healthcare, personal behaviors, and genes?
- In what ways did the video confirm or challenge your ideas about health?
- What features of the video relate to the reality in your community?
- Whose responsibility is it to address inequalities in health and in society?
- If you had the power of changing one to three determinants in your community, what would you change?

Following the video and using the Technology of Participation (ToP) facilitation's **O**bjective, **R**eflective, **I**nterpretive, and **D**ecisional (ORID) method (Stanfield, 2000), I led a guided conversation to provoke critical thinking among audience members to relate their own and community experiences to those showcased in the documentary. The **O**bjective component provided the audience with the context of the issue or topic to be discussed, the **R**eflective is the stage where participants related their own situation to the issue(s), and the **I**nterpretive encouraged participants to have a deeper examination of the issue and the **D**ecisional stage is where participants were able to draw conclusions and decided future actions. I chose to use ToP

(Spencer, 1991), because it provided a sequential and progressive methodology of the human thinking process, keeping the audience engaged and on top of the issue or topic discussed.

The notes taken during the facilitation of the guided conversation are included in the appendix section of the program.

The responses to the questions: What features of the video relate to the reality in your community? And if you had the power of changing one to three determinants in your community, what would you change? were posted on the wall. The rationale to choose these two questions, was because they represent the identified issues to be addressed; then participants were asked to vote to select the top three for the drafting of an action plan.

The intended outcome of the guided discussion was to prompt the group to reach consensus and select one to three determinants to address and work together to draft an action plan.

The second phase included the development of a logic model, implementation plan, and evaluation plan for the project. With the leadership of CDHD, we gave a summary of the issues they previously identified during phase one of the project, and proceeded to the development of a logic model, where participants decided how many and which issues, they wanted to act on, who needed to be involved, and how that needed to be addressed. I assisted with ideas on how to evaluate the results of their action plan, and participants decided what they considered more appropriate to determine success.

Chapter 4

Results

The top responses for the question "What features of the video relate to the reality in your community?" were: 1. Access to affordable healthy foods, 2. Not having options for early childhood education, and 3. Lack of education and awareness around behavioral health. For the second question: "If you had the power of changing one to three determinants in your community, what would you change?", participants chose: 1. Promote and destigmatize behavioral health, 2. Support affordable healthier food choices, 3. Increase early childhood education. Then they chose which issues they would like to address in one year, selecting: 1. Promote and destigmatize behavioral health, and 2. Support affordable healthier food choices.

With the participants' input, I assisted to create the logic model (table 1). They chose two determinants to draft goals, objectives, corresponding activities, outputs and short-, mid- and long-term outcomes.

Table 1-

Logic Model

Central City SDOH Logic Model					
Goal 1: In one year, promote and educate on behavioral health services in Central City.					
Objective:	**Resources**	**Activities**	**Outputs**	**Short-term outcomes**	**Mid to long term outcomes**
People will increase their knowledge and access to behavioral health.	Central District Health Department, Region 3 Behavioral Health, Mid-Plains Center for Behavioral Health, Central City Medical Clinic, Faith	**1.1** Provide four educational sessions in one year about behavioral health issues, including, but not limited to: what they are, prevalence in Nebraska and Central City, what services and resources	**1.1.1** One educational session will be provided per quarter in Central City. **1.1.2** At least 50% of the participants will increase	**1.1** Increased knowledge and confidence in accessing behavioral health services. **1.2** Behavioral health messages become more	Central City residents seek more behavioral health services.

	Based Organizations	are available and promotion of hotlines for behavioral emergencies. **1.2** Develop a community coalition to promote behavioral health messages and services in places like public schools, clinics, and faith-based organizations.	knowledge and awareness about behavioral health. **1.2** Coalition will promote messages to diverse groups in Central City.	familiar and destigmatized.	
Goal 2: In one year, assess and improve availability and access to healthy food choices in Central City.					
Objective:	**Resources**	**Activities**	**Outputs**	**Short term outcomes**	**Mid to long term outcomes**
1. Improve access and availability of healthier food options.	Central District Health Department, Nebraska Extension food and nutrition program, local retail store owners, Central City Government office, SNAP program, WIC program, USDA.	**1.1** Assess the availability and accessibility of healthy foods in Central City by using a tailored version of the CDC's Healthier Food Retail Assessment tool or USDA Food Security module. **1.2** Develop a home gardening education and skill building program. **1.3** Seek grant opportunities related to access to healthy foods.	**1.1** Report about the availability and accessibility of healthy fresh foods in Central City. **1.2** 20 people will participate in a home gardening training. **1.3** One grant application will be submitted.	**1.1.1** Barriers to access to healthy foods are identified. **1.2** Increased number of people who have developed or increased their gardening skills. **1.3** Grant funded program developed to include activities that improve access and availability to healthy foods.	Increased availability and accessibility to healthy foods in Central City. Increased practice of home gardening in Central City. Increased consumption of healthy food choices. Increased number of programs to support access to healthy foods.

Evaluation

The evaluation tools for this program focus on the outcomes dictated by the activities in the logic model. To assess knowledge gained, a pre and post-test will be completed by

participants, the questions will center on the level of confidence the participant experience with the content of the training as opposed with the full content knowledge of the topic and using a 5-point Likert Scale.

For Goal 1, we will evaluate knowledge about behavioral health, and how confident participants feel accessing these services by using the mental health literacy scale (O'Connor, 2015). Goal 2 has two components to be evaluated. First, the community's availability and accessibility of healthy foods which will be achieved by comparing a baseline and 1-year post-intervention assessment using the CDC's Healthier Food Retail Assessment tool USDA Food Security Module Survey. The home gardening component will be evaluated, also via a pre and post survey will be determined by the Extension educator for food and nutrition program.

Table 2-

Outcomes and Measures

Outcome	**Measures**
Goal 1	
Increased knowledge and access confidence about behavioral health	Knowledge and confidence pre and post survey- Mental Health Literacy (MHLS)
Goal 2	
Community's availability and accessibility of healthy foods	Baseline and post intervention assessment results (CDC's Healthier Food Retail Assessment tool and USDA's Food Security module tool).
Increased skills to home gardening	To be determined by Extension food and nutrition program educator.

Chapter 5

Discussion

Community mobilization because of active engagement can prove beneficial to address health-related disparities. Bringing members of the community to participate in the assessment, development, implementation, and evaluation of programs to address local needs can be a way to sustain positive health impacts (Haldane, et al., 2019). This two-phased program was designed to address issues identified by the community, first bringing awareness of the SDOH, facilitating prioritization of issues to be addressed, and formulating an action plan. In this case, the action plan is the two-issue specific blueprint for this community to be able to visualize a big picture of the solution, measure progress, identify barriers and acknowledge their success and potential next steps. Because this project is centered on issue prioritization and potential for solutions related to the SDOH, I needed to include people with the power to exert change in the community and bring ideas to the table based on their strengths and resources. During phase 1, I used the first episode: *In Sickness and in Wealth* of the *Unnatural Causes: Is Inequality Making Us Sick?* documentary created by California Newsreel to tell the story of the SDOH with the depiction of real examples. This documentary laid the ground to establish context for the objective component of ORID's ToP facilitation method, followed by reflecting on how their own community relates to the issue, interpreting and allowing for better understanding to enable the group to make decisions or draw conclusions. During this first phase, participants selected two priority items: promote and destigmatize behavioral health and support affordable healthier food choices.

During phase 2 we reconvened, and I shared a summary of what we learned and brought back the issues previously identified. We talked about action steps and drafted an action plan playing to the strengths already available in the community and the realistic approaches to yield results. The participation of stakeholders gave a strong foundation to identify the resources and already available services within the community. Identifying assets is a supplementary component to the identification of needs, providing a better understanding of the community capacity. It also allows for community members to use the resources already available and strengthen them (Green, G. P., & Haines, A., 2016).

The 1-year action plan is not ambitious but was rather approached by the stakeholders as baby steps or self-testing their collaboration. Two goals were selected to address the top issues related to behavioral health, and access to healthier food, and with input from stakeholders, I drafted a logic model and evaluation plan.

The logic model includes behavioral health and gardening educational activities, a community assessment of availability and accessibility of healthy foods done before and after intervention, and the development of a community coalition to promote behavioral health. Knowledge gained, increased access and skill gained will be evaluated via pre- and post-survey where participants will state their level of confidence about these topics.

This program is expected to increase access to behavioral health services and healthy food in Central City via education and awareness. It is also my aim, to mobilize community participation and enable communities to draw change. The advantages of change that is driven from within the community can range from having a better understanding of the continuum of conditions, assets, and limitations that determine its wellbeing; it also allows for flexibility to

work around solved or newly emerging needs, because the community maintains a constant and close check (Bridger, J. C., & Luloff, A. E.,1999).

Addressing access to both, behavioral health services and healthy foods, will represent collective milestones for the community. This can be the steppingstone to strengthen the collaborative capacity in Central City and create a template for program planning on future issues in the community. It could build a strong foundation based on collaboration and strengths, and have a better understanding of the social, environmental, political and developmental dynamics of the community.

It is important to highlight that this project was possible due to the key partnerships developed, which allowed the proper identification and connection with key stakeholders in Central City. The strengths of this program planning project reside in the collaboration and support of Central District Health Department, and the wealth of knowledge and expertise provided by its director. She ensured that this project had the local data, resources and support needed. The partnership with the city administrator provided with a better understanding and direct connection via referral of the key stakeholders in Central City. The *Unnatural Causes: Is Inequality Making Us Sick?* was a powerful resource for this project because of the content and delivery of messages.

This project had one main limitation faced were related to the harvest season, which limited participation from many members of Merrick County communities. With this limitation in mind, I had to adapt my approach and based my project in only one community. Another limitation was the need to offer a second session for Phase 1, that additional session was attended by only one stakeholder.

For future reference, it would be important to consider activities and events that go on within the communities, to avoid facing attendance barriers, and ensure adequate participation. This project could have benefitted from having more pre- work time to learn about the community, more venues to promote recruitment of participants and the provision of incentives.

Human Subjects

IRB was not required for this project.

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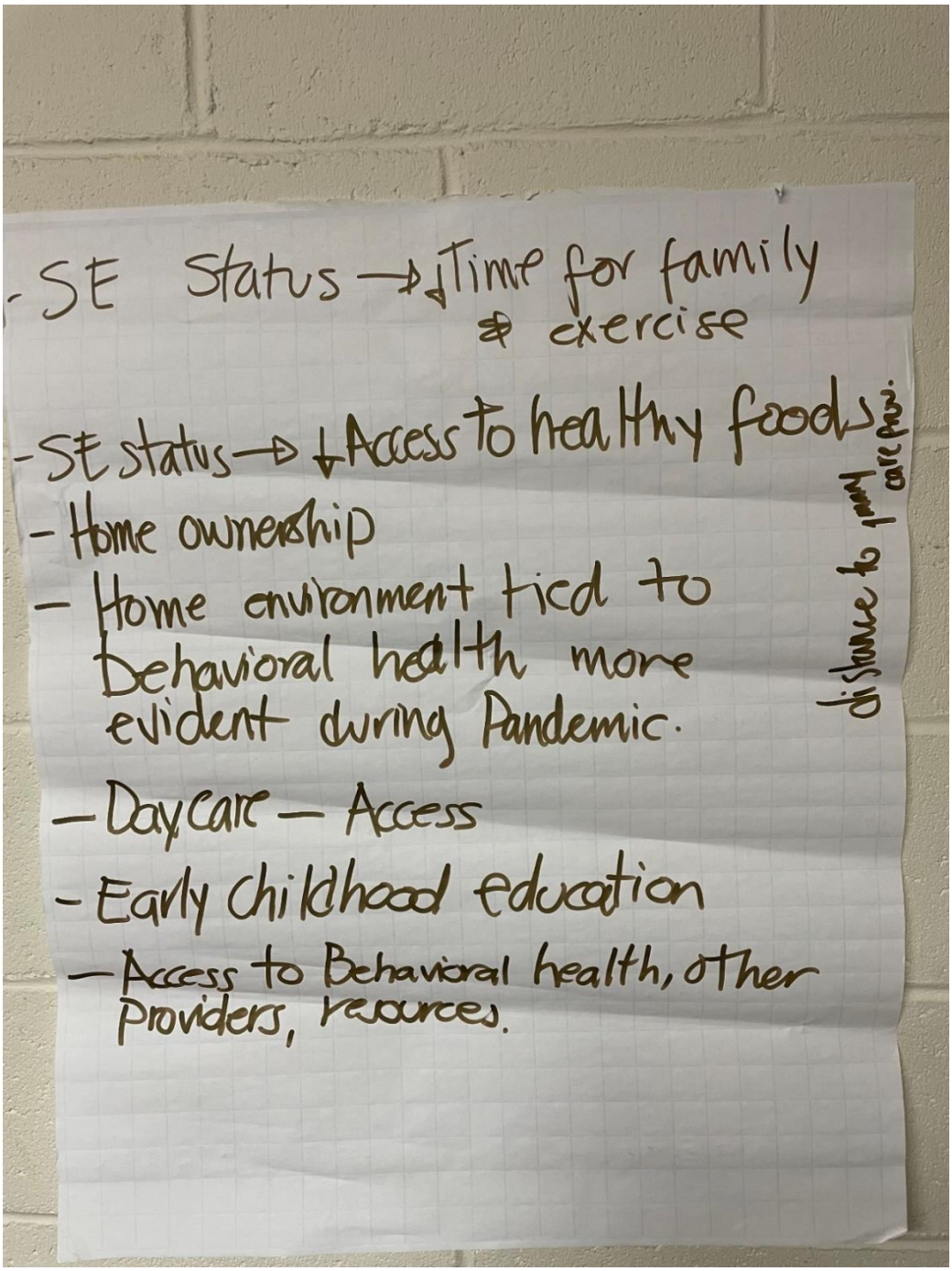
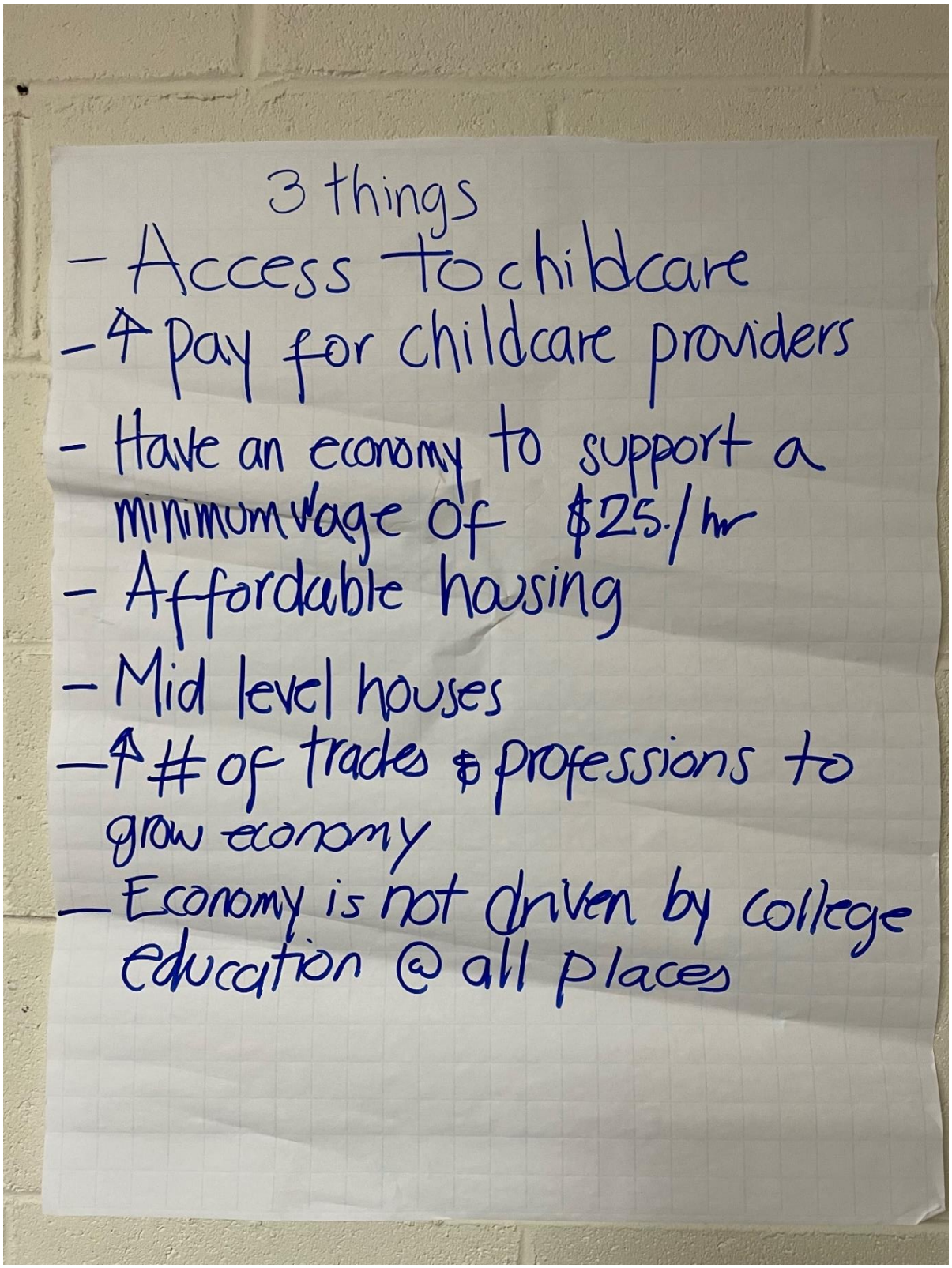
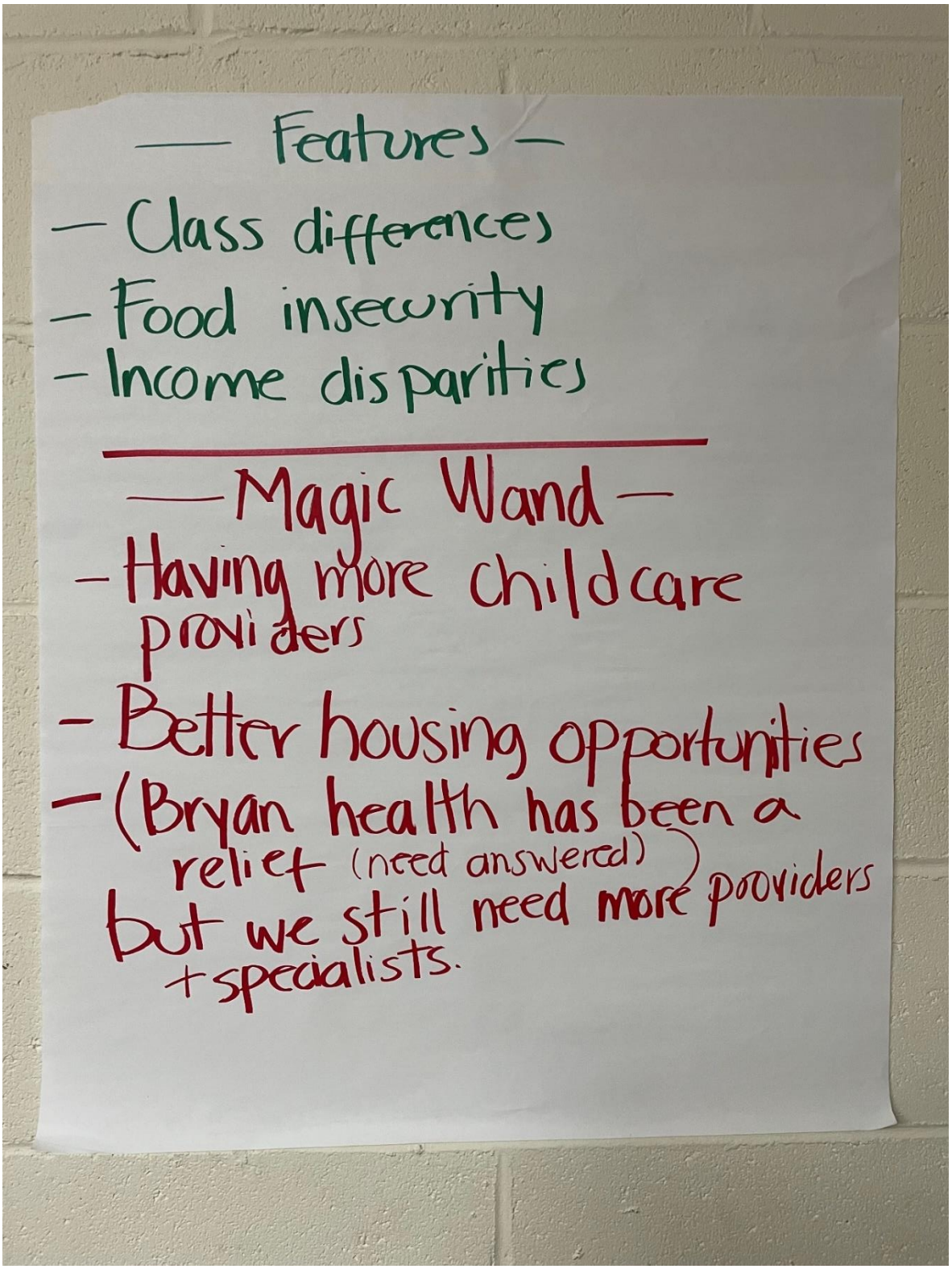
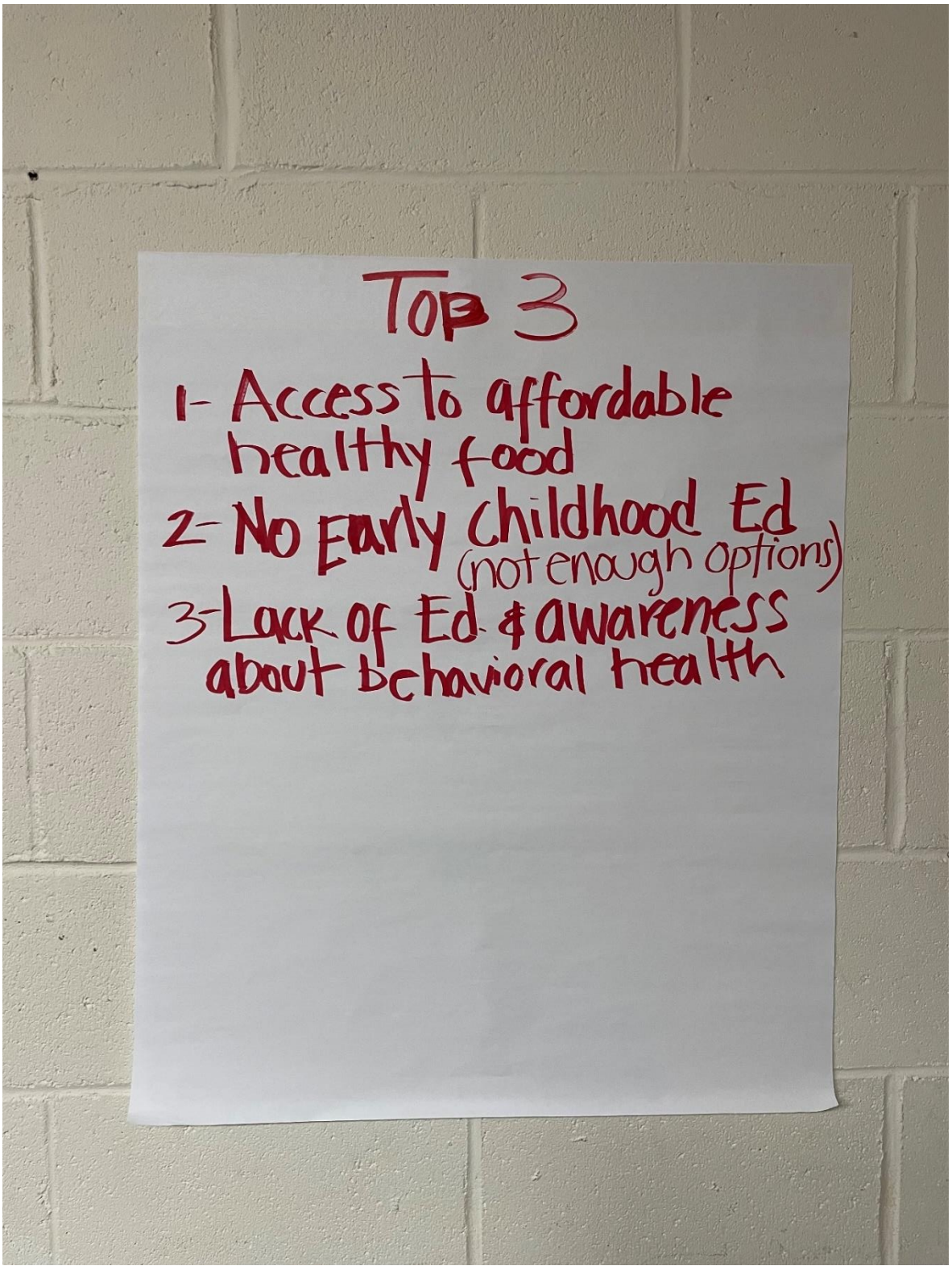
Appendices

Appendix A- Meeting notes




3 things
- Access to childcare
- ↑ pay for childcare providers
- Have an economy to support a minimum wage of $25./hr
- Affordable housing
- Mid level houses
- ↑ # of trades & professions to grow economy
- Economy is not driven by college education @ all places


— Features —
- Class differences
- Food insecurity
- Income disparities
— Magic Wand —
- Having more childcare providers
- Better housing opportunities
- (Bryan health has been a relief (need answered) but we still need more pooriders + specialists.


Top 3
1- Access to affordable healthy food
2- No Early Childhood Ed (not enough options)
3- Lack of Ed & awareness about Behavioral health

Appendix B-

Mental Health Literacy Scale

The purpose of these questions is to gain an understanding of your knowledge of various aspects to do with mental health. When responding, we are interested in your degree of knowledge. Therefore, when choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely

Unlikely = I think it is unlikely but am not certain

Likely = I think it is likely but am not certain

Very Likely = I am certain that it IS very likely

1
If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have **Social Phobia**

Very unlikely Unlikely Likely Very Likely

2
If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry and had physical symptoms such as having tense muscles and feeling fatigued then to what extent do you think it is likely they have **Generalized Anxiety Disorder**

Very unlikely Unlikely Likely Very Likely

3
If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep then to what extent do you think it is likely they have **Major Depressive Disorder**

Very unlikely Unlikely Likely Very Likely

4
To what extent do you think it is likely that **Personality Disorders** are a category of mental illness

Very unlikely Unlikely Likely Very Likely

5
To what extent do you think it is likely that **Dysthymia** is a disorder

Very unlikely Unlikely Likely Very Likely

6
To what extent do you think it is likely that the diagnosis of **Agoraphobia** includes anxiety about situations where escape may be difficult or embarrassing

Very unlikely Unlikely Likely Very Likely

7
To what extent do you think it is likely that the diagnosis of **Bipolar Disorder** includes experiencing periods of elevated (i.e., high) and periods of depressed (i.e., low) mood

Very unlikely Unlikely Likely Very Likely

8
To what extent do you think it is likely that the diagnosis of **Drug Dependence** includes physical and psychological tolerance of the drug (i.e., require more of the drug to get the same effect)

Very unlikely Unlikely Likely Very Likely

9
To what extent do you think it is likely that in general in the US, **women are MORE likely to experience a mental illness of any kind compared to men**

Very unlikely Unlikely Likely Very Likely

10
To what extent do you think it is likely that in general, in the US**, men are MORE likely to experience an anxiety disorder compared to women**

Very unlikely Unlikely Likely Very Likely

When choosing your response, consider that:

- Very Unhelpful = I am certain that it is NOT helpful
- Unhelpful = I think it is unhelpful but am not certain
- Helpful = I think it is helpful but am not certain
- Very Helpful = I am certain that it IS very helpful

11
To what extent do you think it would be helpful for someone to **improve their quality of sleep** if they were having difficulties managing their emotions (e.g., becoming very anxious or depressed)

Very unhelpful Unhelpful Helpful Very helpful

12
To what extent do you think it would be helpful for someone to **avoid all activities or situations that made them feel anxious** if they were having difficulties managing their emotions

Very unhelpful Unhelpful Helpful Very helpful

When choosing your response, consider that:

- Very unlikely = I am certain that it is NOT likely
- Unlikely = I think it is unlikely but am not certain
- Likely = I think it is likely but am not certain
- Very Likely = I am certain that it IS very likely
- 13

To what extent do you think it is likely that **Cognitive Behavior Therapy (CBT)** is a therapy based on challenging negative thoughts and increasing helpful behaviors

Very unlikely Unlikely Likely Very Likely

14

Mental health professionals are bound by confidentiality; however, there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:

If you are at immediate risk of harm to yourself or others

Very unlikely Unlikely Likely Very Likely

15

Mental health professionals are bound by confidentiality; however, there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:

if your problem is not life-threatening and they want to assist others to better support you

Very unlikely Unlikely Likely Very Likely

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
16. I am confident that I know where to seek information about mental illness					
17. I am confident using the computer or telephone to seek information about mental illness					
18. I am confident attending face to face appointments to seek information about mental illness (e.g., seeing the GP)					
19. I am confident I have access to resources (e.g., GP, internet, friends) that I can use to seek information about mental illness					

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
20. People with a mental illness could snap out if it if they wanted					
21. A mental illness is a sign of personal weakness					
22. A mental illness is not a real medical illness					
23. People with a mental illness are dangerous					
24. It is best to avoid people with a mental illness so that you don't develop this problem					
25. If I had a mental illness I would not tell anyone					
26. Seeing a mental health professional means you are not strong enough to manage your own difficulties					

27. If I had a mental illness, I would not seek help from a mental health professional					
28. I believe treatment for a mental illness, provided by a mental health professional, would not be effective					

Please indicate to what extent you agree with the following statements:

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
29. How willing would you be to move next door to someone with a mental illness?					
30. How willing would you be to spend an evening socializing with someone with a mental illness?					
31. How willing would you be to make friends with someone with a mental illness?					
32. How willing would you be to have someone with a mental illness start working closely with you on a job?					
33. How willing would you be to have someone with a mental illness marry into your family?					
34. How willing would you be to vote for a politician if you knew they had suffered a mental illness?					
35. How willing would you be to employ someone if you knew they had a mental illness?					

Scoring

Total score is produced by summing all items (see reverse scored items below). Questions with a 4-point scale are rated 1- very unlikely/unhelpful, 4 – very likely/helpful and for 5-point scale 1 – strongly disagree/definitely unwilling, 5 – strongly agree/definitely willing

Reverse scored items: 10, 12, 15, 20-28

Maximum score – 160

Minimum score – 35

Appendix C-

U.S. HOUSEHOLD FOOD SECURITY SURVEY MODULE:

THREE-STAGE DESIGN, WITH SCREENERS

Economic Research Service, USDA

September 2012

Revision Notes: The food security questions are essentially unchanged from those in the original module first implemented in 1995 and described previously in this document.

September 2012:

- Corrected skip specifications in AD5
- Added coding specifications for "How many days" for 30-day version of AD1a and AD5a.

July 2008:

- Wording of resource constraint in AD2 was corrected to, "…because there wasn't enough money for food" to be consistent with the intention of the September 2006 revision.
- Corrected errors in "Coding Responses" Section

September 2006:

- Minor changes were introduced to standardize wording of the resource constraint in most questions to read, "…because there wasn't enough money for food."
- Question order was changed to group the child-referenced questions following the household- and adult-referenced questions. The Committee on National Statistics panel that reviewed the food security measurement methods in 2004-06 recommended this change to reduce cognitive burden on respondents. Conforming changes in screening specifications were also made. NOTE: Question numbers were revised to reflect the new question order.
- Follow up questions to the food sufficiency question (HH1) that were included in earlier versions of the module have been omitted.
- User notes following the questionnaire have been revised to be consistent with current practice and with new labels for ranges of food security and food insecurity introduced by USDA in 2006.

Transition into Module (administered to all households):

These next questions are about the food eaten in your household in the last 12 months, since (current month) of last year and whether you were able to afford the food you need.

Optional USDA Food Sufficiency Question/Screener: Question HH1 (This question is optional. It is not used to calculate any of the food security scales. It may be used in conjunction with income as a preliminary screener to reduce respondent burden for high income households).

HH1. [IF ONE PERSON IN HOUSEHOLD, USE "I" IN PARENTHETICALS, OTHERWISE, USE "WE."]

Which of these statements best describes the food eaten in your household in the last 12 months: —enough of the kinds of food (I/we) want to eat; —enough, but not always the kinds of food (I/we) want; —sometimes not enough to eat; or, —often not enough to eat?

[1] Enough of the kinds of food we want to eat

[2] Enough but not always the kinds of food we want

[3] Sometimes not enough to eat

[4] Often not enough to eat

[ ] DK or Refused

Household Stage 1: Questions HH2-HH4 (asked of all households; begin scale items).

[IF SINGLE ADULT IN HOUSEHOLD, USE "I," "MY," AND "YOU" IN PARENTHETICALS; OTHERWISE, USE "WE," "OUR," AND "YOUR HOUSEHOLD."]

HH2. Now I'm going to read you several statements that people have made about their food situation. For these statements, please tell me whether the statement was often true, sometimes true, or never true for (you/your household) in the last 12 months—that is, since last (name of current month).

The first statement is "(I/We) worried whether (my/our) food would run out before (I/we) got money to buy more." Was that often true, sometimes true, or never true for (you/your household) in the last 12 months?

[ ] Often true

[ ] Sometimes true

[ ] Never true

[ ] DK or Refused

HH3. "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that <u>often</u>, <u>sometimes</u>, or <u>never</u> true for (you/your household) in the last 12 months?

[ ] Often true
[ ] Sometimes true

[ ] Never true
[ ] DK or Refused

HH4. "(I/we) couldn't afford to eat balanced meals." Was that <u>often</u>, <u>sometimes</u>, or <u>never</u> true for (you/your household) in the last 12 months?

[ ] Often true

[ ] Sometimes true

[ ] Never true

[ ] DK or Refused

<u>Screener for Stage 2 Adult-Referenced Questions:</u> If affirmative response (i.e., "often true" or "sometimes true") to one or more of Questions HH2-HH4, OR, response [3] or [4] to question HH1 (if administered), then continue to ***Adult Stage 2;*** otherwise, if children under age 18 are present in the household, skip to ***Child Stage 1,*** otherwise skip to ***End of Food Security Module.***

<u>NOTE:</u> In a sample similar to that of the general U.S. population, about 20 percent of households (45 percent of households with incomes less than 185 percent of poverty line) will pass this screen and continue to Adult Stage 2.

<u>Adult Stage 2: Questions AD1-AD4</u> (asked of households passing the screener for Stage 2 adult-referenced questions).

AD1. In the last 12 months, since last (name of current month), did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

[ ] Yes

[ ] No (Skip AD1a)

[ ] DK (Skip AD1a)

AD1a. [IF YES ABOVE, ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

[ ] Almost every month

[ ] Some months but not every month

[ ] Only 1 or 2 months

[ ] DK

AD2. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

[ ] Yes

[ ] No

[ ] DK

AD3. In the last 12 months, were you every hungry but didn't eat because there wasn't enough money for food?

[ ] Yes

[ ] No

[ ] DK

AD4. In the last 12 months, did you lose weight because there wasn't enough money for food?

[ ] Yes

[ ] No

[ ] DK

Screener for Stage 3 Adult-Referenced Questions: If affirmative response to one or more of questions AD1 through AD4, then continue to ***Adult Stage 3;*** otherwise, if children under age 18 are present in the household, skip to ***Child Stage 1,*** otherwise skip to ***End of Food Security Module.***

NOTE: In a sample similar to that of the general U.S. population, about 8 percent of households (20 percent of households with incomes less than 185 percent of poverty line) will pass this screen and continue to Adult Stage 3.

Adult Stage 3: Questions AD5-AD5a (asked of households passing screener for Stage 3 adult-referenced questions).

AD5. In the last 12 months, did (you/you or other adults in your household) ever not eat for a whole day because there wasn't enough money for food?

[ ] Yes

[ ] No (Skip AD5a)

[ ] DK (Skip AD5a)

AD5a. [IF YES ABOVE, ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

[ ] Almost every month

[ ] Some months but not every month

[ ] Only 1 or 2 months

[ ] DK

Child Stage 1: Questions CH1-CH3 (Transitions and questions CH1 and CH2 are administered to all households with children under age 18) Households with no child under age 18, skip to ***End of Food Security Module.***

SELECT APPROPRIATE FILLS DEPENDING ON NUMBER OF ADULTS AND NUMBER OF CHILDREN IN THE HOUSEHOLD.

Transition into Child-Referenced Questions:

Now I'm going to read you several statements that people have made about the food situation of their children. For these statements, please tell me whether the statement was OFTEN true, SOMETIMES true, or NEVER true in the last 12 months for (your child/children living in the household who are under 18 years old).

CH1. "(I/we) relied on only a few kinds of low-cost food to feed (my/our) child/the children) because (I was/we were) running out of money to buy food." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

[ ] Often true

[ ] Sometimes true

[ ] Never true

[ ] DK or Refused

CH2. "(I/We) couldn't feed (my/our) child/the children) a balanced meal, because (I/we) couldn't afford that." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

[ ] Often true

[ ] Sometimes true

[ ] Never true

[ ] DK or Refused

CH3. "(My/Our child was/The children were) not eating enough because (I/we) just couldn't afford enough food." Was that <u>often</u>, <u>sometimes</u>, or <u>never</u> true for (you/your household) in the last 12 months?

[ ] Often true

[ ] Sometimes true
[ ] Never true

[ ] DK or Refused

<u>Screener for Stage 2 Child Referenced Questions:</u> If affirmative response (i.e., "often true" or "sometimes true") to one or more of questions CH1-CH3, then continue to ***Child Stage 2;*** otherwise skip to ***End of Food Security Module.***

<u>NOTE:</u> In a sample similar to that of the general U.S. population, about 16 percent of households with children (35 percent of households with children with incomes less than 185 percent of poverty line) will pass this screen and continue to Child Stage 2.

<u>Child Stage 2: Questions CH4-CH7</u> (asked of households passing the screener for stage 2 child-referenced questions).

<u>NOTE:</u> In Current Population Survey Food Security Supplements, question CH6 precedes question CH5.

CH4. In the last 12 months, since (current month) of last year, did you ever cut the size of (your child's/any of the children's) meals because there wasn't enough money for food?

[ ] Yes

[ ] No

[ ] DK

CH5. In the last 12 months, did (CHILD'S NAME/any of the children) ever skip meals because there wasn't enough money for food?

[ ] Yes

[ ] No (Skip CH5a)

[ ] DK (Skip CH5a)

CH5a. [IF YES ABOVE ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

[ ] Almost every month

[ ] Some months but not every month

[ ] Only 1 or 2 months

[ ] DK

CH6. In the last 12 months, (was your child/were the children) ever hungry but you just couldn't afford more food?

[ ] Yes

[ ] No

[ ] DK

CH7. In the last 12 months, did (your child/any of the children) ever not eat for a whole day because there wasn't enough money for food?

[ ] Yes

[ ] No

[ ] DK

END OF FOOD SECURITY MODULE

(1) Coding Responses and Assessing Household Food Security Status:

Following is a brief overview of how to code responses and assess household food security status based on various standard scales. For detailed information on these procedures, refer to the *Guide to Measuring Household Food Security, Revised 2000,* and *Measuring Children's Food Security in U.S. Households, 1995-1999.* Both publications are available through the ERS Food Security in the United States Briefing Room.

Responses of "yes," "often," "sometimes," "almost every month," and "some months but not every month" are coded as affirmative. The sum of affirmative responses to a specified set of items is referred to as the household's raw score on the scale comprising those items.

- Questions HH2 through CH7 comprise the U.S. Household Food Security Scale (questions HH2 through AD5a for households with no child present). Specification of food security status depends on raw score and whether there are children in the household (i.e., whether responses to child-referenced questions are included in the raw score).
    - For households with one or more children:
        - Raw score zero—High food security
        - Raw score 1-2—Marginal food security
        - Raw score 3-7—Low food security
        - Raw score 8-18—Very low food security
    - For households with no child present:
        - Raw score zero—High food security
        - Raw score 1-2—Marginal food security
        - Raw score 3-5—Low food security
        - Raw score 6-10—Very low food security

  Households with high or marginal food security are classified as food secure. Those with low or very low food security are classified as food insecure.

- Questions HH2 through AD5a comprise the U.S. Adult Food Security Scale.
    - Raw score zero—High food security among adults
    - Raw score 1-2—Marginal food security among adults
    - Raw score 3-5—Low food security among adults
    - Raw score 6-10—Very low food security among adults

- Questions HH3 through AD3 comprise the six-item Short Module from which the Six-Item Food Security Scale can be calculated.
    - Raw score 0-1—High or marginal food security (raw score 1 may be

considered marginal food security, but a large proportion of households that would be measured as having marginal food security using the household or adult scale will have raw score zero on the six-item scale)
    - Raw score 2-4—Low food security
    - Raw score 5-6—Very low food security

- Questions CH1 through CH7 comprise the U.S. Children's Food Security Scale.
    - Raw score 0-1—High or marginal food security among children (raw score 1 may be considered marginal food security, but it is not certain that all households with raw score zero have high food security among children because the scale does not include an assessment of the anxiety component of food insecurity)
    - Raw score 2-4—Low food security among children
    - Raw score 5-8—Very low food security among children

(2) Response Options: For interviewer-administered surveys, DK ("don't know") and "Refused" are blind responses—that is, they are not presented as response options, but marked if volunteered. For self-administered surveys, "don't know" is presented as a response option.

(3) Screening: The two levels of screening for adult-referenced questions and one level for child-referenced questions are provided for surveys in which it is considered important to reduce respondent burden. In pilot surveys intended to validate the module in a new cultural, linguistic, or survey context, screening should be avoided if possible and all questions should be administered to all respondents.

To further reduce burden for higher income respondents, a preliminary screener may be constructed using question HH1 along with a household income measure. Households with income above twice the poverty threshold, AND who respond <1> to question HH1 may be skipped to the end of the module and classified as food secure. Use of this preliminary screener reduces total burden in a survey with many higher-income households, and the cost, in terms of accuracy in identifying food-insecure households, is not great. However, research has shown that a small proportion of the higher income households screened out by this procedure will register food insecurity if administered the full module. If question HH1 is not needed for research purposes, a preferred strategy is to omit HH1 and administer Adult Stage 1 of the module to all households and Child Stage 1 of the module to all households with children.

(4) 30-Day Reference Period: The questionnaire items may be modified to a 30-day reference period by changing the "last 12-month" references to "last 30 days." In this case, items AD1a, AD5a, and CH5a must be changed to read as follows:

AD1a/AD5a/CH5a [IF YES ABOVE, ASK] In the last 30 days, how many days did this happen?

_____ days

[ ] DK

Curriculum Vitae

María H. Cantu Hines

Experience

Assistant Educator, Rural Prosperity Nebraska- University of Nebraska- Lincoln- Extension Office- Institute of Agriculture and natural Resources
May 2022 – Current
Duties:

Outreach and Education on Rural Prosperity Nebraska's 6 focus areas.

Community Health Educator at Nebraska Department of Health and Human Services
July 2020- April 2022
Duties:

Outreach and Education for the Office of Health Disparities and Health Equity, Nebraska 3rd Congressional District.
Disease Investigator and Contact Tracer for COVID-19.

Health Program Manager at State of Nebraska- Office of Health Disparities and Health Equity, Nebraska Department of Health and Human Services
January 2009 – July 2020
Duties:

Administration of Health Equity public health programs including planning, organization, implementation and evaluation.

Coordination of services with other State, local and Federal agencies, health professionals, and service agencies. Monitoring and reporting grant activity and program budgets to ensure fiscal and grant objectives /responsibilities are met.

Collection and compilation of statistical, economic, demographic and/or administrative data to determine the needs of the target population served by the programs, assessing effectiveness of services and for purposes of long-range planning. Identification and resolution of problems that impair the effectiveness of health programs.

With knowledge of: State and Federal legislation and administrative regulations relating to the programs administered; the organizational structure, functions, policies, procedures, goals and mission of the agency; the structure, functional relationships and administrative processes of the executive and Legislative branches of State government; the scope and impact of the operations of assigned programs and their relationship to other programs within the Health Department.

Facilitator at the Pandemic Flu Tabletop exercises conducted throughout Nebraska through Center for Disease Control and prevention funds.

Surveillance interviews: Collaboration with State Epidemiologist and CDC's Epidemiology Field Officer during the Pandemic Flu outbreak in Madison County in 2009.

Facilitator of workshops: Health Equity, Social Determinants of Health, Demographics in Nebraska, Culturally and Linguistically Appropriate Services (CLAS) training and Technical Assistance, Cultural Intelligence (People, are People, are People or P3 training) and BARNGA.
Master Trainer for Stanford University's: "Chides bien/ Tomando Control de su Salud" (Chronic Disease Self-Management Program for Hispanic audience).

Instructor for the Medical Interpreter Course at Central Community College
August 2006 - June 2010
Duties:

Developed and implemented the medical interpreter curricula including topics such as: Scope of practice, code of ethics, medical terminology, interpreter settings, interpreter roles, dealing with unusual / difficult situations, health beliefs, cultural awareness as an interpreter, culture broker, systems of the human body, general information on health diagnosis and treatments.

Health Educator at Central District Health Department
July 2006 - December 2008
Duties:

Plan and implement public health educational activities materials and tools for the Tri-County (Hall, Hamilton and Merrick) service area.

Create and maintain partnerships with Education institutions, Community Based Organizations, Faith Based Organizations, local, State and Federal government agencies and their representatives.

Workforce wellness and prevention education on: Physical activity, nutrition, health screenings, occupational infections, childhood infections and restrictions, among other topics.

Collaboration on the Center for Disease Control and prevention investigation: "Epidemiologic Investigation of Immune-Mediated Polyradiculoneuropathy among Abattoir Workers Exposed to Porcine Brain".

Environmental Services, assisting with the Limited English Proficient (in Spanish) outreach and inspections for restaurants and vendors in the area, as well as with environmental services education for the public.

CATCH Kids Club Facilitator.

Interpreter Manager- Interpreter Services at Saint Francis Medical Center
November 2004 - July 2006
Duties:

Schedule interpreter staff sessions, market and sell interpreter services with healthcare providers and clinics.
Terminology and situational updates for staff, plan annual budget for department, approval of payroll, client satisfaction and stakeholder's feedback, grant reporting.
Certified Car Seat Technician with the National Child Passenger Safety program through Safe Kids.

Interpreter at Interpreter Services- Saint Francis Medical Center
October 2003 - November 2004
Duties:

Providing interpretation to inpatients and outpatients at Saint Francis Medical Center and the Grand Island Nebraska area clinics.

Medical Practice at Centro Quirúrgico Nogalar
January 2000 - April 2002
Duties:

Doctor in charge during the corresponding shifts for Emergency Room admissions, inpatients and outpatient services during clinic hours.

Intern with the Preventive Services Clinic at Universidad Autónoma de Nuevo León (UANL) "Dr José Eleuterio González" Hospital
June 2000 – May 2002
Duties:

Tuberculosis (TB) and Human Immunodeficiency Virus (HIV) Clinic- Epidemiology doctor for detection and surveillance of TB and HIV cases, collection of data including contacts and potential outbreaks.
Responsible for weekly surveillance report of inpatient and outpatient Hospital services.
Faculty Aide for the Preventive Medicine I and II classes and extramural outreach and immunization projects for students of the School of Medicine.
Vaccination campaign leader for Sabin immunization mass campaign.

Intern with the Department of Legal Medicine at Universidad Autónoma de Nuevo León (UANL) "Dr José Eleuterio González" Hospital
January 1999 - July 2001
Duties:

Faculty Aide for the Legal Medicine classes for students of the School of Medicine
Assisted Medical Pathologist at the Forensic Department, obtaining and processing samples for diagnosis and legal documentation.

Prepared autopsy reports for legal records and to be submitted to the district attorneys and the legal records archive.
During my internship I implemented the use of digital photos to become part of the legal documents by inserting the photographic evidence into the file and save it as an electronic record.
Research project: Frequency of HIV and Hepatitis B as post-mortem findings on autopsies performed at the Medical Forensic Services. PI: Dr Alberto Niderhauser García (FM SA 252-99). Funded by the Federal Support to Scientific and Technological Research Program (Programa de Apoyo a la Investigación Científica y Tecnológica [PAICYT 1999]).
*Frecuencia de VIH, Hepatitis B y Tuberculosis como hallazgos de autopsia en cuerpos estudiados post-mortem en el Servicio Médico Forense. Dr Alberto Niderhauser García (FM SA 252-99). Programa de Apoyo a la Investigación Científica y Tecnológica [PAICYT 1999]

Volunteer Experience

Board Member for Adult Board of Education (Central Community College), Grand Island, NE
January 2003 - January 2005

Board Member for Third City Community Clinic, Grand Island, NE
January 2004 - January 2006

Board of Health member at Two Rivers Public Health Department (representing minorities in the 3rd Congressional District)
January 2013 - January 2015

Wish granting volunteer team member and Interpreter at Make a Wish Foundation
January 2004 - December 2007

Languages
Spanish (Native language with special proficiency on Medical and Public Health terminology) Advanced High Spanish level certified by the American Council on the Teaching of Foreign Languages (ACTFL) - 2019
English (Proficient with emphasis on Medical and Public Health terminology)

Trainings

Master in Public Health – University of Nebraska Medical Center (expected graduation date: Fall 2022)

Great Plains Public Health Leadership Institute – UNMC year 11
2015-2016

National Incident Management System training
2010
Certificate of completion for IS 100, IS 200 and IS 700

Stanford University
Master Trainer, Chronic Disease Self-Management Program- Cuídese Bien, 2009 – 2009

Child Passenger Safety Certified Technician
2004

Cross Cultural Health Care
Trainer, Medical Interpreter, 2004 – 2004

Central Community College
Medical Interpretation/ Medical Assistant, 2004 – 2005

Medical Degree- US Equivalency: First Professional Degree in medicine (Doctor in Medicine)
School of Medicine, Universidad Autónoma de Nuevo León, Monterrey, México 1991 - 1999
http://www.medicina.uanl.mx/
US Equivalency evaluated by World Education Services (WES)- evaluation available upon request.

Activities and Societies

Student Board Treasurer: School of Medicine UANL 1997

Medical School Student representative
January 1996 to July 1998
UANL Medical Student's Class of 1998
Selected during two consecutive years as student representative.

Universidad de Málaga, Spain
IFMSA clerkship, Hospital Universitario Virgen de la Victoria, Orthopaedic Surgery, 1998 – 1998

Reviewer:

Federal Grants:
Innovation Challenge (CMS [Centers for Medicare and Medicaid Services])
Exchange Navigator (CMS [Centers for Medicare and Medicaid Services])

State Grants:
Minority Health Initiatives (Nebraska DHHS Office of Health Disparities and Health Equity)
Adolescent Health (Nebraska DHHS Maternal Child Adolescent Health)

American Public Health Association abstracts:
Community Health Worker Section
Community Based Public Health Caucus

Honors, Acknowledgements and Awards

Acknowledgment of participation during a CDC project: "Epidemiologic Investigation of Immune-Mediated Polyradiculoneuropathy among Abattoir Workers Exposed to Porcine Brain".

The Nebraska State Patrol Public Service Award for the 2012 – 2013 In-service Training program for the Nebraska State Patrol.

Certifications

Cardio Pulmonary Resuscitation, First Aid and AED certification
1994-1999 and 2006- 2008

National Child Passenger Safety
National Highway Traffic Safety Administration April 2004 to July 2006

Lean Six Sigma White Belt Certificate 2016

Lean Six Sigma Yellow Belt Certificate 2017

Process Improvement Foundations 2017

Memberships

Public Health Association of Nebraska
2007 to 2014

American Public Health Association

2010 to 2011 and 2015 to 2016

Presentations at Conferences, Publications

University of Nebraska Kearney Youth Leadership Conference (2007)

The Center for Preparedness Education Symposia (2009)

University of Nebraska Omaha OLLAS Latino Cumbre (2010)

Missing Links (2010)

Multicultural Coalition One Day Conference (2012)

Nebraska Lay Health Ambassador Summit -P3 Cultural Intelligence (2013)

Nebraska Association for Translators and Interpreters (2014 and 2015)

University of Nebraska Omaha CLAS Standards workshops for Office of Continued Education – Social Work. 2018-2022

Nebraska School Nurses Association Conference- CLAS Standards – 2022

Co-facilitator for Rebuilding Together Strategic plan – 2022

Co- facilitator for City of Columbus Budget prioritization, Technology of Participation -2022

Other

American Public Health Association section and caucus memberships
Community Health Planning and Policy Development Section
Community Health Workers Section
Community Based Public Health Caucus

Nebraska Community Health Worker Coalition
February 2015
Member of the Steering committee and co-founder of the Community Health Worker Coalition in Nebraska.

Burt Brent, MD Medical Guest at El Camino Hospital in Mountain View California
2001 and 2002
Guest by invitation to Dr Brent's performance of approximately 30 ear reconstruction surgeries, mostly for pediatric patients with microtia.

University Competitive Swimming Team
September 1992 to 1998
Facultad de Organización Deportiva y Rectoría UANL
Member of the female swimming team representing UANL School of Medicine during six consecutive years.