Cooperative Extension's National Framework for Health and Wellness

March 2014

Committee Members

Bonnie Braun, Karen Bruns, Linda Cronk, Linda Kirk Fox, Sonja Koukel, Suzanne Le Menestrel, Lily Monroe Lord, Cindy Reeves, Roger Rennekamp, Carol Rice, Michelle Rodgers, Javiette Samuel, Ann Vail, Tamara Warren

Table of Contents

Introduction……………………………………………………………………………………….p. 2

Cooperative Extension National Framework……………………………………………….p. 3

Assessment of National Trends…………………………………………………………….....p. 5

Cooperative Extension Strategic Analysis……………………………………………………p. 10

Priorities for Cooperative Extension………………………………………………………...p. 12

Outcome Indicators…………………………………………………………………………………p. 13

Potential Partners……………………………………………………………………………………p. 14

Recommendations………………………………………………………………………………...p. 15

    Strengthen Organizational Functioning………………………………………………p. 15

    Enhance Leadership and Professional Development……………………………p. 16

    Increase Strategic Marketing and Communications…………………………….p. 18

    Build Partnerships and Acquire Resources…………………………………………p. 18

References…………………………………………………………………………………………....p. 21

Cooperative Extension's National Framework for Health and Wellness
ECOP Health Task Force

"Lifestyle choices we are making in this new century threaten to undo all the medical advances of the last one. " U. S. Surgeon General David Satcher

We have long known that the primary determinants of an individual's health status are lifestyle, environment, and genetics. Health care is only responsible for 10 percent of an individual's overall health. Yet, approximately 90 percent of the national health budget is dedicated to health care.

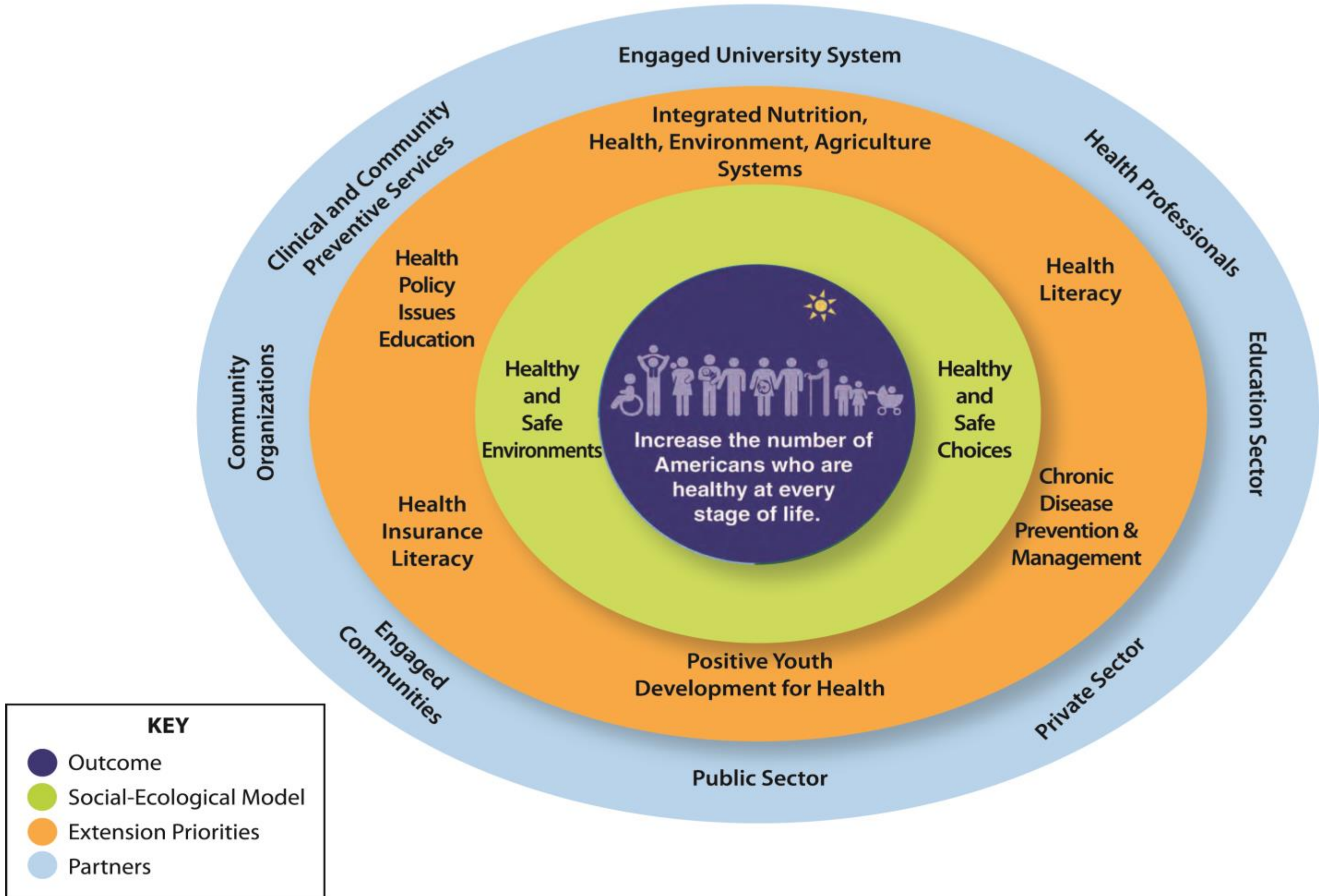
Meanwhile, individuals and families looking to embark on the road to a healthier life face a myriad of social, economic, and environmental factors that reinforce their current behaviors. As a result, the United States continues to spend more on health care ($8,600 per person) than any other nation but has among the worst health outcomes of any developed nation.

America's land-grant universities have the knowledge and expertise needed to help address this issue. Through county Extension offices, universities have the community presence and local credibility needed to influence the social, economic, and environmental determinants of health. Evidence-based interventions, deployed in ways that are respectful of community individual and family norms, beliefs, and current practice have been shown to keep people healthy, and delay or prevent the need for medical care.

This year, 2014, marks the 100th anniversary of the signing of the Smith-Lever Act which created the Nation's Cooperative Extension System. This "Extension" model arose at a time when American agriculture was largely inefficient and only marginally productive. The consequences of the agricultural practices of the time were endangering our Nation's economic, environmental, and personal health. A century later, American agriculture is without equal in its contributing food to a growing world population. We, and others, believe that this same system of Extension can do for the nation's health what it did for American agriculture.

Given the national trends in health, and the current assets of Extension, including the ability to be responsive to emerging needs, it is a critical time to create a new programmatic focus.

Figure 1.



Based on the National Prevention Strategy Action Plan, U.S. Department of Health & Human Services

Cooperative Extension's National Framework for Health and Wellness

In December, 2012, the ECOP Health Task Force was established and charged by 2013 ECOP Chairman, Daryl Buchholz, to complete three goals over the course of calendar year 2013:

I. Identify priorities for Cooperative Extension health programs for the next 3-5 years.
II. Identify outcome indicators for each priority; and
III. Identify potential partners, public and private, including non-traditional partners, to be engaged in resource development, program implementation, and outcomes reporting.

Development of the Model Framework

After considerable review of health priorities, both internal and external to Cooperative Extension, the Task Force determined that it was essential to align Cooperative Extension's national framework for health and wellness with the U.S. Department of Health & Human Services' National Prevention Strategy: Strategic Directions. By aligning Cooperative Extension with the National Prevention Strategy, we accomplish a mutually beneficial engagement of both public and private partners and a national strategic direction that can both increase awareness of the value of prevention across multiple sectors and further support a comprehensive approach to preventing illness and disease by promoting health and wellness. Therefore, in direct alignment with the National Prevention Council model, the overall goal for the Cooperative Extension health and wellness framework is to, "Increase the number of Americans who are healthy at every stage of life." (Figure 1.)

The U.S. Department of Health & Human Services National Prevention Strategy identifies four strategic directions for all prevention efforts:

1) Healthy and Safe Community Environments;
2) Clinical and Community Preventative Services;
3) Empowered People; and
4) Elimination of Health Disparities.

These four directions work towards the improvement of overall health and wellness for the U.S. population and include recommendations that are needed to develop a prevention-oriented society. (U.S. Health and Human Services, 2012).

Additionally, the Cooperative Extension framework utilizes the Social- Ecological model (Bronfenbrenner) as its theoretical base. This model considers the complex interplay between individual, community, and societal factors. The factors recognize an individual's attitudes, beliefs, behaviors and choices. The community and societal factors include both the settings in which people

live and work, as well as the social and cultural norms such as economics, educational and social policies and inequalities. We recognize the Social-Ecological aspect in the next ring of our model framework on health as including “healthy and safe choices” and “healthy and safe environments,” and the interplay between these factors. (Figure 1.)

Assessment of National Trends

As the Task Force worked to narrow down the priorities found in the third ring of the model framework (Figure 1.), we identified a number of national trends that informed the decision-making process around the selection of priorities for health for Cooperative Extension nationally. A brief summary of these trends follows:

A. Public Health Policy Shifts

- There has been a movement from dependence on health care providers to personal and family care-giving and community-based resources; increased access to health care has been occurring through access to health insurance.
    - From 1999 to 2010 the percent of people who have failed to acquire medical care because of cost increased; from 4.3% to 6.9% (Centers for Disease Control and Prevention/ National Center for Health Statistics, National Health Interview Survey).
    - Over the same 10-year period, there has been an increase in the proportion of health centers that have been nationally documented as Patient Centered Medical Homes from 1% to 25%. (U. S. Department of Health and Human Services, HHS Strategic Plan Appendix B-2: Performance Measures (Detail Report)).
    - The development of new health centers, new satellite sites, and the greater capacity at current health centers has increased the number of patients served. Health centers attended to 19.5 million patients in FY 2010, which is 0.7 million more than in FY 2009 (18.8 million) and 2.4 million more than the 17.1 million served in FY 2008 (U. S. Department of Health and Human Services, HHS Strategic Plan Appendix B-2: Performance Measures (Detail Report)).

- Implementation of the Affordable Care Act is currently changing the U.S. health care environment.
    - In the 2011 National Health Interview Survey, the percentage of reported uninsured was 17. 3% (45.9 million) for persons under age 65; 21.3% (40.7 million) for 18–64 year olds; and 7.0% (5.2million) for children under age 18.

    (Centers for Disease Control and Prevention/ National Center for Health Statistics, National Health Interview Survey).

  - Health insurance marketplaces are a critical component of the Affordable Care Act. The FY 2015 target is for 93% of legal residents to have insurance coverage. (U. S. Department of Health and Human Services, HHS Strategic Plan Appendix B-2: Performance Measures (Detail Report)).
  - The Affordable Care Act identifies community-based health connectors as 'Health Extension Agents.' The term 'Health Extension Agent' means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources (ACA Title V Subtitle E Section 5405).

B. Health Conditions

- There has been a shift from acute and infectious disease to chronic and non-communicable diseases.
  - Chronic health conditions have serious consequences for disease, premature death, and health care costs. Nearly half (45%) of American adults report that they live with one or more chronic health conditions. From 2002 to 2009, the age-adjusted percentage with two or more chronic conditions increased from 12.7% to 14.7% ($P < .001$), and the number of adults with two or more conditions increased from approximately 23.4 million to 30.9 million. (Ford, Croft, Posner, Goodman, & Giles, 2013).
- Food insecurity impacts health. Food insecurity hovers around 15% with very low food security increasing.
  - In 2012, approximately 14.5% of American households had low food security; 5.7% of households had very low food security-- this was basically unchanged from the 2011 percentage. There were 10% of households, or 3.9 million, with children reported to be food insecure (Coleman-Jensen, Nord, & Singh, 2013).
- There is an Increase in age-related health challenges.
  - Nearly 33% of men and women's lifetime expenditures for healthcare are spent during middle age; approximately 50% of their total lifetime spending for healthcare is during the senior years (Aleayehu & Warner, 2004).
- Translational research is increasingly emphasized by the National Institutes for Health.

- Since its creation in 2006, the NIH Clinical and Translational Science Awards Program has grown from 12 sites to 61 sites located at academic health centers and various institutions across the U.S. The National Center for Advancing Translational Sciences understands that community engagement is a significant factor in all phases of clinical and translational research and necessary to bring innovative and improved treatments to patients across the Nation. (Institutes of Medicine, 2013). http://www.iom.edu/Reports/2013/The-CTSA-Program-at-NIH-Opportunities-for-Advancing-Clinical-and-Translational-Research.aspx

C. Health Disparities

- The combined costs of health inequalities and premature death in the United States totaled $1.24 trillion between 2003 and 2006 (The Economic Burden of Health Inequalities in the United States).
- According to a 2009 study by the Joint Center for Political and Economic Studies, eliminating health disparities for minorities would have lowered direct medical care expenditures by $229.4 billion and reduced indirect costs associated with illness and premature death by approximately $1 trillion during 2003–2006. (http://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a2.htm?s_cid=su6203a2_e)
- The leading health indicators have demonstrated little improvement in disparities over the past decade (Healthy People, 2010). Significant racial and ethnic health disparities continue to permeate the major dimensions of health care, the health-care workforce, population health, and data collection and research.
- Health disparities, differences in health outcomes, arise from genetic, biological, and social factors affecting individuals across their lifespans. Social determinants of health are the conditions in which people are born, grow, live, work and age that can contribute to or detract from the health of individuals and communities Marked difference in social determinants, such as poverty, low social-economic status, poor educational attainment, and lack of access to care, often exist along racial and ethnic lines.
- Individuals, families and communities that have systematically experienced social and economic disadvantages face greater obstacles to optimal health.
- Suboptimal health care quality and access exists, especially for minority and low-income groups. Overall quality is improving, but access is getting worse and disparities are not changing. (National Healthcare Disparities Report, 2012).
- Fundamental to reducing health disparities is a comprehensive intentional effort to advance health equity and provide people with tools and information to make healthy choices.

D. Economic Situation

- The Current Population Survey data show that 15 percent of Americans, 46.5 million people, live at or below the government-defined poverty line (DeNavas-Walt, Proctor, & Smith, 2013). Twenty-two percent of all children under age 18 (16 million) live in families with incomes below the federal poverty level (Addy, Engelhardt, & Skinner, 2013).
- The U.S. has experienced a significant rise in the costs of health care. In 2007, health care costs accounted for 16 percent of the U.S. Gross Domestic Product (Centers for Disease Control and Prevention, 2013). These costs are passed on to insurance companies and patients.
- Nearly half of bankruptcies are attributed to major medical reasons (Himmelstein, Warren, Thorne, & Woolhandler, 2005). Medical reasons include illness and injury, uncovered medical bills and a lapse in health insurance coverage.
- There has been a decline in government funding for education. A recent report by the Center on Budget and Policy Priorities noted that states are providing less per-student funding for kindergarten through twelfth grade than they were six years ago (Leachman & Mai, 2013). About one-third of states started the 2013-14 school year with less funding for schools than a year ago (Leachman & Mai, 2013).
- Economic inequalities also contribute to health disparities. A recent Gallup well-being study found that those living in poverty in the United States are more likely to face chronic health problems including depression (Brown, 2012). The National Center for Children in Poverty at Columbia University found disparities between poor and non-poor children in five domains of health, including environmental health, health insurance coverage, access to health care, health outcomes and behavior (Seith & Isakson, 2011), although they note that the relationship between poverty and poor health is a reciprocal one.

E. Population Changes

- The U.S. population is rapidly aging. The last cohort of baby boomers turns 50 in 2014. Between 2000 and 2010, the U.S. population under age 18 grew at a rate of 2.6 percent, whereas the older population (ages 45 to 64) grew at a rate of 31.5 percent. The population aged 65 and older grew at a rate of 15.1 percent (Howden & Meyer, 2011).
- The U.S. Hispanic population grew rapidly in the past 10 years. The U.S. Census defines Hispanic or Latino as "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race." Between 2000 and 2010, the Hispanic or Latino population increased by 43 percent (Ennis, Rios-Vargas, & Albert, 2011).
- There is an increased diversity of immigrants with varying cultural experiences related to health matters. Pitkin Derose and her colleagues (2007) found that immigrants, overall, have lower rates of health insurance, use less health care, and experience a poorer quality of health care, though these experiences vary by a number of factors such as English proficiency, social-

economic status, and immigrant status. Immigrant eligibility for federal and state health benefits varies by state and depends on a number of different complex factors (Perreira et al., 2012).

F. Technology

- Electronic medical records are becoming the norm. The National Center for Health Statistics (NCHS) examined trends in the use of electronic health record systems among office-based physicians between 2001 and 2012. The use of electronic health record systems increased from 18 percent in 2001 to 72 percent in 2012. The percentage of physicians with an electronic health record system that met criteria for a basic system nearly doubled between 2009 and 2012. Passage of the 2009 Health Information Technology for Economic and Clinical Health Act provided incentive payments through Medicare and Medicaid to increase use of electronic health record systems (Hsiao & Hing, 2012).
- Use of electronic sources of health information has increased. For example, data from the National Cancer Institute's 2008 Health Information National Trends Survey (HINTS) indicate that of the 40 percent of the U.S. population that searched for cancer information, the two most frequently used sources of information were the Internet (55.3%) and health care providers (24.9%) (National Cancer Institute, 2010). Seventy-two percent of adult Internet users looked on-line for health information in 2012 (Fox, 2013).
- According to a study by the Pew Internet and American Life Project (Fox, 2011), adults use social networking sites to follow friends' health experiences (23% of social network site users and 11% of all adults) and obtain health information (15% of social network site users and 7% of all adults). Smaller percentages of social network site users are using the sites to raise money for a health-related issue (14%), post comments about health-related issues (11%) and start or join a health-related group on a social networking site (9%).

G. Health Literacy

- Only 12% of U.S. adults tested in the National Assessment of Adult Literacy are fully health literate; the majority is at or below basic levels of functioning.
    - The National Assessment of Adult Literacy, which works to monitor and measure health literacy, found that 36% of U.S. adults have limited health literacy: 22% (47 million) of respondents had basic health literacy and 14% (30 million) had below-basic health literacy. The survey found that the majority of U.S adults (53%, 114 million) had intermediate health literacy. Only 12% (25 million) of the persons surveyed had proficient health literacy. (Kutner, Greenberg, Jin, & Paulsen, 2006). Nine out of 10 adults have difficulty using everyday health information presented by health care facilities, retail outlets, media, local communities, and other sources (Institute of Medicine, 2004).

- Demands for health literacy are increasing along with the complexity of health- and financially-related issues.
    - The National Association of Insurance Commissioners (NAIC) estimates that the average family spends over $7,000 annually for various insurance coverage. Chronic health care education and financial education have similar educational foundations that entail the management of long-term conditions, avoiding possible problems, handling problems should they develop, and having regular checkups or check-ins about health or financial issues (Tennyson, 2006).
    - When a person does not understand the health information presented or how to self-manage chronic conditions, there is a higher likelihood that an individual will skip essential medical tests. There is a greater likelihood that the individual will visit the emergency room more often. If patients do not understand health information and directions, attempts to improve quality of care and reduce the cost of health care may not be successful. (Nielsen-Bohlman, Panzer & Kindig, 2004).
    - Poor health literacy is frequently associated with poor self-care management, increased use of emergency medical services, frequent hospitalizations, poor health outcomes, and high medical costs. It is estimated that poor health literacy costs the nation from $106 to $238 billion a year.
- Consumers dread making health insurance decisions and lack confidence in their decisions.
    - The ability to confidently apply knowledge gained is one indication that an individual understands a concept. When an individual self-reports that he or she is "not at all" confident or "not really" confident about insurance decisions, they have significantly lower average scores on the insurance quiz than other respondents ($t = 2.403$, $p = 0.0168$) indicating a relationship between knowledge of insurance and confidence in making the right insurance decision (Tennyson, 2011).

Cooperative Extension Strategic Analysis

A strategic analysis of Cooperative Extension strengths and limitations further informs recommendations for consideration by ECOP.

Assets

Cooperative Extension provides:

- A reputation developed over decades for strength in health and nutrition education with well-documented outcomes;
- 4-H youth development program that has included Health, the 4th "H" of 4-H since 1911;
- A nationally recognized 4-H Healthy Living mission mandate;

- Access to a trusted source of information and advice that develops into long-lasting skills and knowledge;
- Through the land-grant university system, a national network of access to expertise and knowledge in agriculture and food systems, and health and human health sciences;
- A venue and links to experts who can translate science into practice;
- Experience in effectively building partnerships and collaborations;
- Experience in community development and sustainable systems change;
- Skilled facilitation of community engagement and broad inclusion of many;
- Commitment to recruiting and training a strong volunteer base;
- Commitment to local presence and relevant programming particularly in underserved areas throughout the U.S.;
- A foundation in the U.S. Dept. of Agriculture, with strong linkages to other federal agencies effectively influencing positive health outcomes.

Limitations

Cooperative Extension is limited by:

- Lack of mission mandate, strategic priorities or common evaluation measures identified in adult health;
- Incomplete/inconsistent multidisciplinary approach to motivating and documenting behavior change;
- Incomplete/inconsistent multidisciplinary approach to addressing systemic social determinants of health;
- Inability to provide a system-wide approach and focused leadership to strengthen Cooperative Extension's capacity to address national health issues;
- Limited recognition by health care professionals of Extension as a vital partner;
- Few program and evaluation models that capture social-ecological theory;
- Only some engagement as a reciprocal and mutually beneficially partner of co-creation with clientele and community-based organizations, depending upon individual state focus;
- Underdeveloped linkages with colleges and schools of health sciences;
- Staff expertise/capacity:
    - Undocumented capacity relative to expertise in the discipline of health sciences, likely due to limited staffing;
    - Limited understanding of viewpoint/perspectives of physicians, nurses, clinical and public health professionals;
    - In the majority of states, limited integration of programming partnerships with health care professionals and organizations;

- Limited opportunities for support of strategic projects with an interdisciplinary partnership of agriculture and health;
- Limited capacity to be successful in the interdisciplinary competitive grants environment addressing health;
- Lack of agreement among county, state, and federal funding partners and the universities as to Cooperative Extension's role in health and health care system changes.

I. Program Priorities for Cooperative Extension Health Programs for the Next 3-5 Years

The six Strategic Program Priorities, found in the next outer ring of the model framework (Figure 1) were developed following a review of trends and analysis of Cooperative Extension's assets and limitations relative to health programming:

1. **Integrated Nutrition, Health, Environment, and Agricultural Systems -** Improving the health of the Nation requires working across systems. For example, efforts to promote healthy eating are not likely to be successful without considering the process by which food is produced, distributed, and marketed. Likewise, both agricultural systems and health systems are influenced by the built and natural environments in which they exist. Land-grant universities have a unique capacity to support projects that span the boundaries of what some have viewed as closed and separate systems. We must facilitate intentional work across systems that yield higher-ordered wins for all parties.

2. **Health Literacy -** Health literacy can be defined as the ability to obtain, understand, and act on health information and services. For some, health information is readily available. But deciding what data sources to trust can be difficult, particularly when presented with conflicting recommendations. For others, the challenge is obtaining information in a form that they can understand. Having access to clear, easy-to-understand information is key to making good health decisions. The consequences of acting on bad information can be costly and even fatal. Health literacy is the result of interactions between individuals and systems. It includes the domains of fundamental, scientific, civic and cultural literacy. Increase health literacy will help improve both the health of individuals and the collective public health.

3. **Health Insurance Literacy -** The Affordable Care Act of 2010 gives individuals more options and more control over their health insurance. It also gives them greater access to preventive services and screenings. With more choice comes responsibility, as well as a need for information that will be of assistance in making decisions about plans and coverage. Health insurance literacy refers to the degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about health plans, select the best plan for their circumstances, and use the plan once enrolled. Extension has a long history of helping limited resource individuals and families obtain the services they need to manage in an increasingly complex world.

4. **Chronic Disease Prevention and Management -** While the nation's attention is presently focused on the cost and quality of health care and insurance, improvements in population health will require a renewed focus on prevention and staying well. The goals of chronic disease prevention and management are to prevent disease occurrence, delay the onset of disease and disability, lessen the severity of disease, and improve the health-related quality and duration of an individual's life (adapted from Doll, 1985). Prevention efforts traditionally involve interventions performed before the clinical onset of disease or early in the course of disease, while management efforts may occur later in the disease course and are often focused on reducing the undesired consequences of diseases (adapted from McKenna and Collins, 2010).

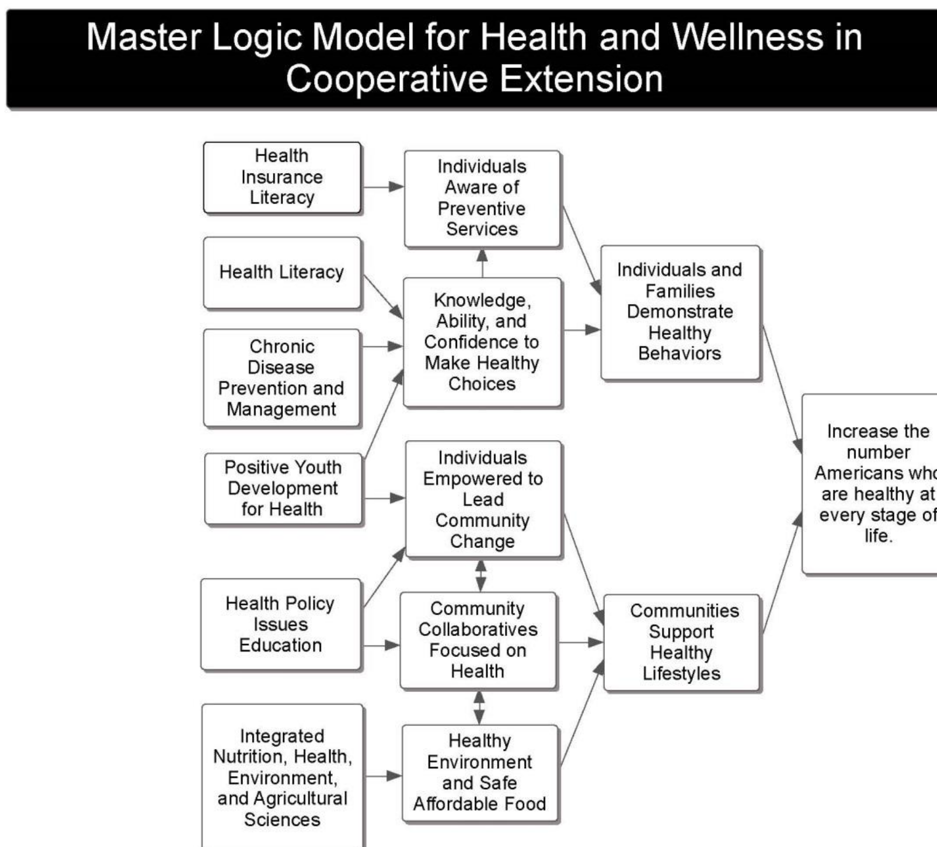
5. **Positive Youth Development for Health –** Organizations utilize positive youth development strategies that are focused on helping young people experience thriving trajectories and achieve key developmental outcomes. The ultimate goal is a successful transition to adulthood marked by health and wellbeing, economic stability, social success, and civic engagement. Research shows that positive youth development approaches work, producing young people who are physically, socially, emotionally, and spiritually healthy as well as free of problem behaviors such as a sedentary lifestyle, substance abuse, eating disorders, early sexual activity, bullying, and suicide.

6. **Health Policy Issues Education –** Improving population health will require collective resolve and action to address the social, economic, and environmental determinants of health. For Extension, it will also mean working in new ways to inform decisions about policy. It means working at the outer rings of a socio-ecological model, shaping the context in which people grow, learn, work, and play. Through health policy issues education, we inform and assist individuals and groups as they struggle to make decisions about the health issues that affect them and their communities.

II. Identify Outcome Indicators for Each Priority

As part of its process, the ECOP Health Task Force determined that this charge would be more appropriate for the Extension system to participate in developing. To this end, the Task Force has developed this model framework and identified the six priority areas, in order to provide a context for the further discussion and development of indicators for each of these priorities. The Task Force has developed a logic model based on the framework to guide the development of indicators for each priority (Figure 2.) Furthermore, the recommendations section provides a process to engage the system in determining indicators and a process for implementation.

Figure 2.



III. Identify Potential Public and Private Partners, Including Non-traditional Partners, to be Engaged in Resource Development, Program Implementation, and Outcomes Reporting

Cooperative Extension alone cannot accomplish the overall goal of the model framework to increase the number of Americans who are healthy at every stage of life, without continuing some pre-existing **partnerships** as well as adding new partners from both the private and public sector. The Task Force recognized Extension will also need to change ways of interacting with partners to address the extensive and complex nature of health. Extension may need to not only change partners but also how Extension partners with others. Partners identified as critical to the overall achievement of the goal as illustrated in the outermost ring of the model framework include (Figure 1.):

- An engaged University System
- Health Professionals

- Education Sector
- Private Sector
- Public Sector
- Engaged Communities
- Community Organizations
- Clinical and Community Preventive Services

IV. ECOP Health Task Force Recommendations Around ECOP Core Themes

The ECOP Core Themes serve as the guiding principles for the ECOP Health Task Force Recommendations. These recommendations interrelate and build upon each other for a comprehensive pathway to strengthening Extension's impact upon the health of Americans.

A. Core Theme: Strengthen Organizational Functioning

The following action provides direction and leadership to advance a national agenda for stronger organizational functioning in this area.

1. Establish a *Health Implementation Team* as a function of the ECOP Program Subcommittee.

Purpose: A 5-year ECOP standing committee to address the four ECOP Core Themes relative to the six Health Priority areas for Cooperative Extension.

Leadership of Implementation Team - ECOP

Timeframe: Establish in 2014, officially begin January 2015 to function through 2020

Implementation Team Membership: CES Directors who are not serving on ECOP could be identified as Champions for Health representing each region; six faculty/educators who are representative of land-grant universities staff resources and who can provide programmatic leadership in one of the six priority areas; two to three ECOP Program Subcommittee members identified to serve on the implementation team on a rotating basis; USDA National Institute of Food and Agriculture (NIFA) liaison representation; and Board on Human Sciences (BOHS) and Academic Heads Section (AHS) nominated representatives.

Who is Responsible: ECOP Executive Committee will work with regional Executive Directors/Administrators to recommend Director Champions and land-grant university representatives for each strategic area giving consideration to representation from across the country.

Time Frame: 2014

B. <u>Core Theme: Enhance Leadership and Professional Development</u>

The level of leadership and professional development varies in states related to health. A core group of individuals within states is needed to coordinate and provide leadership in health programming and to lead efforts to enhance the professional development of staff in states. The following actions will enhance the level of leadership and professional development.

1. **Expand personnel addressing health by establishing newly funded Health Extension positions in as many states as possible, phased in over the next 3 to 5 years.**

   *Purpose: T*o provide long-term sustainable leadership and content expertise in each state for implementing the Framework and basic resources to build each state's capacity to conduct health education and outreach.

   Funding: External source from a 5-year competitive grant to provide 50% of funding for the positions, matched by 50% from participating states.

   Who is Responsible: ECOP Health Implementation Team members (see D. below), National 4-H Council and/or other potential funders.

   Time Frame: 2014. Identify potential funding sources and obtain funding to be available for establishment of positions, to be phased in from 2015 through 2020.

2. **Coordinate with and capitalize on the existence of two current committees supporting the work of NIFA in these program topic areas, the National 4-H Healthy Living Management Team and the Nutrition and Health Committee for Planning and Guidance.** Committee membership would be open to these 50+ new positions to encourage their participation. Since both of the committees are composed mostly of the State Specialists in these topic areas, these committees could be approached to help operationalize this recommendation, e.g. by assisting in the planning for the National Health Outreach Conference(formerly Priester Conference), and by assisting in identifying candidates to serve on the ECOP Health Implementation Team. NIFA NPL's would continue to provide liaison and program leadership to the State Specialists, including these additional 50+ new positions, throughout the country in these topic areas.

   Funding: Already existing

   Who is Responsible: ECOP Health Implementation Team in coordination with USDA NIFA Program leadership as liaisons to existing program committees.

   Time Frame: 2014 - 2020

3. **Provide leadership and support for training and meetings on the health strategic priorities.**
   a. This should be done in partnership with the Cooperative Extension System.
   b. Training and meetings should include:

1. National health training, meetings and webinars with a focus on providing basic and advanced training to our state and county faculty to build their skills in health.
2. Sessions should be taught by experts in community and public health and evaluation of health interventions.
3. Emphasis should be on identifying internal and external sources of expertise to present high-quality training sessions via webinar or other technology-based systems.

Who is Responsible: ECOP Health Implementation Team in coordination with NIFA, as appropriate.

Time Frame: 2014 and on going

4. **Enhance leadership understanding of the core components of health programming by conducting a Health Summit Leadership Conference in 2014.**

   When: Pre-Joint Committees on Organization and Policies July 2014

   Purpose: Engage COPs leadership in advancing the vision of the framework. Sample Topics: Why Extension should be involved in Health Promotion and Prevention, Social- Ecological model; examples of best practices, care to prevention, community based, integrated extension research and academic programs, move from programmatic silos.

   Outcome: Directors identify team members to come to the National Health Outreach Conference in Georgia in 2015.

   Who is responsible: ECOP Health Task Force

   Time Frame: 2014

5. **To provide an outstanding professional development opportunity for internal and external audiences; implement a National Health Outreach Conference.** Formerly, the "Jeanne C. Priester" National Health Extension Conference, in which the "Priester" name will be retained and utilized for a keynote address, or some targeted aspect of the conference for ongoing memorial tribute, but rename the actual conference for the purpose of greater integration of health stakeholders and current cultural change.

Time Frame: Annually/Biannually as needed

May 2015: University of Georgia, hosting

Who is Responsible: Planning Committee-Implementation team and host state.
2015 Program Plan: Focus on the Six Priorities of the Framework as program tracks: Solicit best practices from educators/specialists in each track based on the following criteria: evidence based,

theory based, social-ecological model, and scalable to national level with external speakers on each track.

Participants: Joint COPs, state leadership, health education practitioners internal and external to extension.

2016: Virginia Tech, hosting. 2016 Program Plan to be determined.

C. Core Theme: Increase Strategic Marketing and Communications

Internal and external marketing of Extension's commitment to health programming is needed to advance our efforts and magnify potential impact.

1. Expand awareness of Extension's Health programming.

Work with eXtension staff to develop a marketing strategy for Extension's Health Program strategies and implement through eXtension and state communications offices.

Who is responsible: ECOP Health Task Force

Time Frame: June to December 2014.

2. Enhance communication among Extension employees working on health related strategies and focus areas.

Work with eXtension leadership to identify, enhance and build existing Community of Practice, and current resources on eXtension related to health. Develop and implement a plan with eXtension leadership to enhance and build that network that will expand the marketing and communication related to health programming.

Who is responsible: ECOP Health Implementation Team and eXtension leadership

Time Frame: 2014

D. Core Theme: Build Partnerships and Acquire Resources for Extension's Framework for Health

Central to the success of Extension's impact on Americans' health are partnerships and securing adequate resources to support the enhanced infrastructure and capacity needed to expand Extension's existing health programming. To do this, the following actions need to occur.

A. Partnerships: Extension's strength is skill, knowledge and commitment to partnerships that enable a strong ability to meet the needs of Americans. Our health partnerships need to focus in two areas:

a. Internal University Partnerships - Establish and/or strengthen relationships within land-grant universities to foster interdisciplinary and collaborative research, teaching and

engagement. Targeted efforts should be made to build the relationships between Extension and agricultural colleges and other university colleges and departments committed to human health. These include, but are not limited to Human Development/Human Ecology, Public Health, Health Sciences, Psychology, Sociology, Public Policy, Law and Life Sciences to foster interdisciplinary and collaborative health programs.

Who is responsible: ECOP Health Implementation Team

Time Frame: On-going

b. Community-based Partnerships - Establish and/or strengthen relationships between Extension and state health departments, federally qualified health centers, health plans, local health care providers and health-related private and public organizations. As the health care, food, and insurance industries adapt to a rapidly changing landscape, they are placing a greater emphasis on keeping Americans healthy. Land-grant universities and the Cooperative Extension System have the expertise and community presence needed by these industries to implement the community-based prevention strategies that improve health and delay or prevent to onset of chronic disease. Extension must engage in conversations with business and industry with the goal of establishing mutually beneficial public-private partnerships that bring financial resources to land-grant universities to support health Extension work.

Who is responsible: State and County Cooperative Extension leadership

Time Frame: On-going

B. Develop and Expand Funding Resources: Extension needs to provide focused efforts to develop new funding streams to support new health related programming.

a. Develop Policy and Legislative Committee understanding of ECOP Health Task Force priorities.
   - Presentation of the six priorities on ECOP leadership and appropriate committees they designate.
   - Policy and Legislative Committee propose the health agenda for the Board on Agriculture Assembly.

Who is responsible: ECOP Health Implementation Team and ECOP

Time Frame: 2014

b. NIFA support for a system-wide agenda on health priorities
   - It is recommended that ECOP facilitate a dialogue with NIFA leadership to suggest strategies to enhance funding and program support, such as:

1. Reallocating some existing NIFA capacity and/or competitive funds to support mission-related human health priorities.
2. Promoting alignment of NIFA program goals with the ECOP Model Health Framework and the ESCOP Science Road Map, Grand Challenge #5: Improve Human Health, Nutrition and Wellness in the Population, by developing a program goal within NIFA related to human health.
3. Establishing collaboration and coordination between the work of the ECOP Health Implementation Team and the existing Nutrition and Health Committee for Policy and Planning, and the National 4-H Healthy Living management team, and/or develop a new, health-focused guidance committee, related to the potential NIFA program goal in health, the ECOP Model Health Framework, and the ESCOP Science Road Map. This committee may also include representatives from critical health partners within the Department of Health and Human Service (DHHS) agencies such as National Institutes for Health (NIH), Centers for Disease Control (CDC) and Office of Disease Prevention and Health Promotion (ODPHP).

Who is responsible: ECOP Health Implementation Team

Time Frame: by fall 2014

C. Work with the National 4-H Council, university or 4-H foundations or other potential funders to identify and secure partners to help fund Health Extension positions in each state.

- ECOP should identify a task force of Cooperative Extension leaders charged with working with the National 4-H Council (and/or others as identified) to develop a funding strategy.
- Key leaders and Cooperative Extension Leaders should be identified to proactively pursue funding.
- Funding goals should be identified with a strategy for achievement. This should include short term funding goals (18 months) and long term (5 years).

Who is responsible: ECOP

Time Frame: June 2014 to ongoing.

References:

Addy, S., Engelhardt, W., & Skinner, C. (2013, January). Basic facts about low-income children: Children under 18 years, 2011. New York: National Center for Children in Poverty, Columbia University.

Aleayehu, B. & Warner, K. E. (2004). The Lifetime Distribution of Health Care Costs. Health Services Research, 39 (3), 627-642.

Brown, A. (2012). With poverty comes depression, more than other illnesses. Washington, DC: Gallup.

Centers for Disease Control and Prevention (2013). Rising health care costs are unsustainable. Atlanta, GA: Author.

Centers for Disease Control and Prevention/ National Center for Health Statistics (2012). National Health Interview Survey, 1997 – 2011, Family Core component. Accessed on January 2, 2014 from: http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201206_01.pdf

Coleman-Jensen, A., Nord, M., & Singh, A. (2013). Household Food Security in the United States in 2012. Economic Research Report No. (ERR-155). Washington, DC: United States Department of Agriculture. http://www.ers.usda.gov/publications/err-economic-research-report/err155.aspx#.UsrQUPvWvOt

DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2013). Income, poverty and health insurance coverage in the United States: 2012. Washington, DC: U.S. Census Bureau.

Ennis, S. R., Rios-Vargas, M., & Albert, N. G. (2011). The Hispanic population 2010. 2010 Census Briefs. Washington, DC: U.S. Census Bureau.

http://www.findyouthinfo.gov/youth-topics/positive-youth-development

Ford ES, Croft JB, Posner SF, Goodman RA, Giles WH. (2013). Co-Occurrence of Leading Lifestyle-Related Chronic Conditions Among Adults in the United States, 2002-2009.

http://www.cdc.gov/pcd/issues/2013/12_0316e.htm.] DOI: http://dx.doi.org/10.5888/pcd10.120316

Fox, S. (2011). The social life of health information, 2011. Washington, DC: Pew Research Center.

Fox, S. (2013). Pew internet: Health. Washington, DC: Pew Research Center.

Himmelstein, D. U., Warren, E., Thorne, D. & Woolhandler, S. (2005). Illness and injury as contributors to bankruptcy. Health Affairs, 63-73.

Howden, L. M. & Meyer, J. A. (2011). Age and sex composition: 2010. 2010 Census Briefs. Washington, DC: U.S. Census Bureau.

Hsiao, C. & Hing, E. (2012). Use and characteristics of electronic health record systems among office-based physician practices: United States, 2001-2012. NCHS Data Brief, 111. Hyattsville, MD: National Center for Health Statistics.

Institute of Medicine of the National Academies. (2013). The CTSA Program at NIH: Opportunities for advancing clinical and translational research. Report Brief. Washington, DC: Author.

Leachman, M. & Mai, C. (2013). Most states funding schools less than before the recession. Washington, DC: Center on Budget and Policy Priorities.

National Cancer Institute (2010). Health Information Survey National Trends Survey (HINTS) briefs, 16, Bethesda, MD: Author.

Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). The health literacy of America's adults: results from the 2003 National Assessment of Adult Literacy. NCES 2006483. U.S. Department of Education: National Center for Educational Statistics.

Nielsen-Bohlman, L., Panzer, A. M., & Kindig, D. A. (Eds.). (2004). Health literacy: A prescription to end confusion. Washington, DC: National Academies Press.

Perreira, K. M., Crosnoe, R., Fortuny, K., Pedroza, J., Ulvestad, K., Weiland, C., Yoshikawa, H., & Chaudry, A. (2012). Barriers to immigrants' access to health and human services programs. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Pitkin Derose, K., Escarce, J. J., & Lurie, N. (2007). Immigrants and health care: Sources of vulnerability. Health Affairs, 26, 1258-1268.

Seith, D. & Isakson, E. (2011). Who are America's poor children? Examining health disparities among children in the United States. New York: National Center for Children in Poverty, Columbia University.

Tennyson, S. (2011). Consumers' insurance literacy: Evidence from survey data. Financial Services Review, 20, 165–179.

U. S. Department of Health and Human Services. (2010) HHS Strategic Plan Appendix B-2: Performance Measures (Detail Report). Accessed on January 2, 2014 from:

http://www.hhs.gov/secretary/about/appendixb2.html

U.S. Health and Human Services. (2012). National Prevention Strategy Fact Sheet. Accessed on January 3, 2014 from: http://www.surgeongeneral.gov/initiatives/prevention/strategy/national-prevention-strategy-fact-sheet.pdf