Cooperative Extension's National Framework for Health Equity and Well-Being

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Introduction

The U.S. spends more on health care per capita than any nation in the world but ranks 49th out of 193 nations in average life expectancy at birth at just under 79 years (Worldometer, 2020). Our depressed global rank in life expectancy results from both personal health behaviors and contextual determinants that place lifelong health and well-being out of reach for many people.

There is much that we as individuals can do to improve our personal health such as increasing physical activity and eating healthier meals. Currently, only 23 percent adults engage in the minimum amount of recommended leisure-time physical activity (HHS, 2018) and only one in ten meet federal guidelines for fruit and vegetable consumption (CDC, 2017). Obviously, some people face barriers to implementing these healthy behaviors, making a personal commitment to improve health is an excellent start.

While we must all accept personal responsibility for doing what we can to maintain and improve our own health, we as a nation must act now to eliminate the unfair and unjust policies and practices that differentially impact health outcomes for Black, Indigenous and People of Color (BIPOC) and those in rural areas. Disparities in health outcomes were laid bare by the COVID-19 pandemic that devastated communities and differentially impacted those with preexisting health conditions. While projections suggest life expectancy in the U.S. will decrease by 1.13 years in 2020 due to the impact of the COVID-19 pandemic, that decrease may be as much as three or four times greater for Black and Latino populations (Andrafay and Goldman, 2021).

In this context, the need for a refreshed national framework to guide the Cooperative Extension System's (Extension) efforts to promote behaviors and create conditions which advance health and well-being has never been greater. Extension has civic and moral obligation to address health disparities and an important role to play in ensuring that all people have the opportunity to be as healthy as they possibly can be.

Historical Review of Health and Well-Being in the Cooperative Extension System

Extension has been working to advance population health since its inception. Much of the early work focused on ensuring that the people of rural America were able to be as healthy as their more urban counterparts. These early programs ranged from safely preserving food and basic sanitation to ensuring water quality for the large number of rural residents who obtained their drinking water from private wells.

Over time, the scope of health-related programming diversified, and its audience expanded. For example, Extension's work to promote the adoption of healthy eating guidelines such as the Daily Food Guide (1956), My Pyramid (1992), and My Plate (2011) was designed to reach into both suburban and urban neighborhoods. In 1969, Extension became responsible for delivering the Expanded Food and Nutrition Program (EFNEP) that has helped low-income families and youth achieve nutritional security wherever they may reside. Since its establishment in 1988, Extension has become the nation's largest provider of nutrition education for individuals and families eligible to receive food assistance benefits through a program called Supplemental Nutrition Assistance Program - Education (SNAP-Ed) (Yetter and Tripp, 2020).

Beyond nutrition education, Extension's portfolio of health-related work has evolved to include efforts related to agricultural safety, physical activity, chronic disease prevention and management, mental health, cardiovascular health, substance misuse prevention, stress management, food security, nutrition, water quality, skin cancer prevention, radon education, healthy aging, and more. Today, Extension is actively engaged in addressing environmental health, antibiotic resistant bacteria, and the unique health impacts stemming from the interactions between humans and animals. However, until recently, these activities were not considered or undertaken under a unified banner of "health". As a result, the magnitude of Extension's work in health is often understated, undervalued, or unnoticed.

Cooperative Extension's 2014 National Framework for Health and Wellness

In 2012, the Extension Committee on Organization and Policy (ECOP) made a public commitment to supporting Extension's work in health by appointing a National Task Force on Health. Following two years of work by the task force, Cooperative Extension's National Framework for Health and Wellness was approved by ECOP in 2014 (Braun et al., 2014) and action oriented teams were established to move forward its priority themes. With that unified banner now established, the Framework and resulting activities

have since been used to raise the visibility of Extension's health-related work, build capacity for high quality community engagement focused on improving the health status of communities, guide the development of new health related programs, and develop new partnerships.

ECOP appointed a new "Health Innovation Task Force" (Task Force) in 2020 to investigate, explore, and provide recommendations in support of Extension innovating for system level change in the area of heath. In support of this mission, and in recognition of Extension's responsibility to communities, members of the Task Force and subject matter experts convened to review the 2014 Framework and how it has been used.

This updated Framework is grounded in an examination of (1) major health-related events which have occurred since 2014, (2) changes within Extension that can be attributed to the original Framework, and (3) the concept of health equity as it relates to informing future work of Extension. Summaries of these in-depth examinations can be found in three Annexes found later in the document.

Stemming from those examinations are three core themes which are introduced in the sections which follow. The first core theme emphasizes the need for Extension to utilize an equity lens when framing and designing its work related to health and well-being. The second core theme expands upon the notion of context as a determinant of the overall health and well-being of individuals, families and communities. The third core theme raises up the notion of collective action as means of catalyzing changes in communities which advance health and well-being.

Core Theme: Health Equity

The 2014 Framework acknowledged the importance of equity in shaping the health and well-being[i] of individuals and communities but did not name it as a focus area for Extension's health related work. By naming health equity as a core theme, this Framework clarifies that Extension must move from treating health equity as something that is a tacitly underlying thread within its health-related initiatives to elevating it core focus area and central goal that activities are designed to achieve.

According to the Robert Wood Johnson Foundation (RWJF) health equity exists when "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. (Braveman et al., 2017, p. 2)"

When a group experiences sub-optimal health because of policies, practices, or conditions that are preventable, unfair or unjust, the deleterious effects on those groups

are referred to as health inequities. Long-standing inequities, including some that have been introduced and promulgated by federal, state, and local policies, have put some population groups at increased risk of experiencing illnesses, having worse outcomes when they do get sick, and worse overall health. Fortunately, many of these inequities are remediable. When a society is committed to health equity as a common value, people work together to ensure that everyone, regardless of race, neighborhood, or financial status, has fair and equal access to a healthy community of opportunity (PolicyLink, 2020).

Addressing inequities will require that Cooperative Extension approach its health-related work with a disciplined focus on identifying those groups experiencing suboptimal health, calling attention to the inequity, and committing resources toward closing the gaps which exist. This is referred to as “looking at a situation through an equity lens.” The goal of applying this lens is to ensure that no one is disadvantaged in achieving their full health potential because of any social or socially-defined circumstance (Brennan Ramirez et al., 2008).

Extension is well positioned to serve as a catalyst for community-based efforts to address health equity. It is essential that Extension aligns new national and local priorities with existing frameworks that advance equity and justice for individuals, families, and communities. This requires a paradigm shift in Extension’s strategic direction, but it is one that is long overdue and one that is critical to continue growing Extension’s role in community health prevention and promotion. This new direction will require greater flexibility in the traditional Extension model, with greater ability to see and do our work differently than we have in the past.

Consequently, a central and overarching theme of the updated framework is the importance of Cooperative Extension using a health equity lens when framing and prioritizing its health-related work.

Core Theme: Social Determinants of Health

In this updated framework, we continue to recognize that individuals live, learn, work, and play in a social system commonly depicted through a social-ecological framework. In general, such frameworks show how the daily lives of individuals are nested within and influenced by interpersonal relationships, families, schools, workplaces, communities, and societal norms and values. Efforts to improve health outcomes for individuals and groups must move away from placing the majority of the responsibility for health on the individual to creating contexts or environments that allow people and communities to thrive. We refer to the factors outside of the individual that have an influence on an individual’s health as the social determinants of health (SDoH). We can

influence the social determinants of health through efforts to change policies, systems, and environments (PSEs) which are standing in the way of individuals experiencing optimal health.

Contemporary population health frameworks draw from a growing, and well documented body of literature illustrating the multiple determinants of health extending beyond individual behaviors and health care. There are numerous models for grouping the many determinants of health into distinct categories. For example, The National Academies (2017) identify education, employment, transportation, social environment, public safety, physical environment, housing, wealth, and health systems as nine areas upon which systems change can focus. Healthy People 2030 groups determinants into health care access and quality, education access and quality, neighborhood and built environment, social and community context, and economic stability.

Community Commons (2020) suggests that meaningful work and wealth, basic needs for health and safety, belonging and civic muscle, lifelong learning, humane housing, reliable transportation, and a thriving natural world are the vital conditions necessary for intergenerational well-being. The County Health Rankings Model emphasizes the factors that determine how long and how well people live.

The 2014 Framework recognized the powerful influence of the social determinants of health but stopped short advocating that Extension engage in efforts to address them and instead identified six broad areas of educational programming that should be emphasized. The updated framework supports the positions of authors who suggest that work to promote the adoption of healthy behaviors across the general population must continue (Koukel et al, 2018) but also suggests that Extension must continually strengthen its capacity to support PSE changes for individuals and communities experiencing health inequities. Utilization of this "twin approach" (CDC, 2015) supports improved health for the larger population while also using targeted interventions to address barriers and challenges implemented through oppressive and discriminatory policies, systems, and environments.

So how might Extension actively engage in more precision-oriented efforts to address health disparities brought about by these contextual factors? First and foremost, it is necessary to understand what groups in a community are experiencing the worst health outcomes. Identifying those groups involves looking at data that is far more granular than that for an entire county. When data for groups that are thriving are included with data for groups that suffering, the overall profile may mask the health disparities experienced by particular groups.

Today collaborative efforts like the Places project have resulted in the production of tools that allow local Extension faculty and staff to access data down to the zip code or census

tract level. According to the CDC (2021), such granularity can help users of the data better understand how health outcomes are distributed within a county and the relative health burdens experienced by certain individuals and groups.

Using this data, Cooperative Extension and its partners can focus attention and resources on those communities and groups experiencing the poorest health outcomes. But education focused on individual behavior change is insufficient to create the type of change needed.

Accordingly, a central theme of the updated framework focuses on how Extension can address the social determinants of health and well-being that are preventing some communities and groups from experiencing optimal health.

Core Theme: Coalitions and Community Assets

Extension has a long and rich history of engaging in bilateral partnerships with schools, government agencies, and various community-based organizations to support the delivery of programs. Addressing the social determinants of health will require building and expanding on this history of partnership toward working with many partners simultaneously who are working toward a common goal. The 2014 framework identified partnership development as a key component in advancing Extension's health-related work and suggested a number of potential partners that Extension might pursue. However, it stopped short of defining Extension's role in promoting, establishing, and providing support for coalitions that represent the various complex sectors of a community and its diverse assets. It is through these coalitions that Extension and the community together can identify key inequities, and the social determinants of health that underlie them.

By incorporating community development expertise into all Extension health work and incentivizing agents and educators to look beyond their programmatic areas of focus, Extension can leverage its relationships and expertise to act as a community convener. In this role, Extension can promote the establishment of community-based coalitions aimed at improving health outcomes and addressing health inequities.

Coalitions are typically made up of multisector networks of health and human service providers who engage with racially and ethnically diverse communities (Anderson et al., 2015) in meaningful and significant ways. These coalitions can have a range of benefits on individual health outcomes and behaviors, as well as care delivery systems for racial and ethnic minority communities. They can be venues for power sharing, collaboration, and group decision-making, which will strengthen Extension's commitment to improving health equity.

Extension has experience in helping set up collaborative leadership models for community development and good governance that it can build upon and use to advance positive health outcomes and health equity. Extension can play a significant role in mobilizing community action that creates coalitions that, in turn, impact health outcomes (Buys & Koukel, 2018). The role of Cooperative Extension in coalitions is to leverage partners, organize and facilitate coalitions, and amplify our message; ideally co-leading, with a seat at table, and fostering leadership of others.

When coalition building is done right, Extension is embedded within it and can step back, nurturing the purpose of the coalition, and potentially returning to it as participant. In coalitions, Extension raises issues, convenes and partners, and builds leadership structure. The most effective coalitions arise from ongoing practice and coaching. For Extension, that means moving back and forth between being a teacher and learner, at times serving as a source of expert-based knowledge, but also listening and learning from the other voices at the table. Still, there are other times when we can serve as a connector to campus-based faculty who possess highly specialized knowledge of the issue at hand.

A community coalition, however, differs from an interagency council that only includes representatives of organizations which serve a particular neighborhood or group of individuals. Community coalitions include active participation from individuals with lived experience in that community. Additionally, Extension is well positioned to facilitate an intergenerational dimension to a coalition by bringing young people to the table as full partners in all phases of the coalition's work.

Unfortunately, some marginalized communities do not find Extension efforts, especially and specifically those that come from predominantly white 1862 Land Grant Institutions, to be deserving of their trust and engagement. This reticence is legitimate and earned given historic and, in some cases, ongoing experiences of exclusion and harm. Within these communities especially, authentic efforts to build coalitions must be coupled with ownership of harms inflicted and a demonstrated commitment to change. Only then can Extension build the trust required to create mutually beneficial relationships where they don't currently exist. Partnerships among 1862, 1890, and 1994 designated LGU are an ever-present opportunity to demonstrate trustworthiness and build community relationships as part of an overall approach to improve health equity.

Therefore, working through community coalitions to produce profound and lasting community change has emerged as a third central theme of the updated framework.

Cooperative Extension's Framework for Health Equity and Well Being

The graphic depiction of the framework illustrates how a focus on the core themes can inform Cooperative Extension's portfolio of work focused on achieving health equity and promoting the well-being of all people (See Figure 1). Some readers will notice the visual similarities to the 2014 model, particularly the utilization of a multi-layered, social-ecological model to show the relationships between the individual and the environments in which they live.

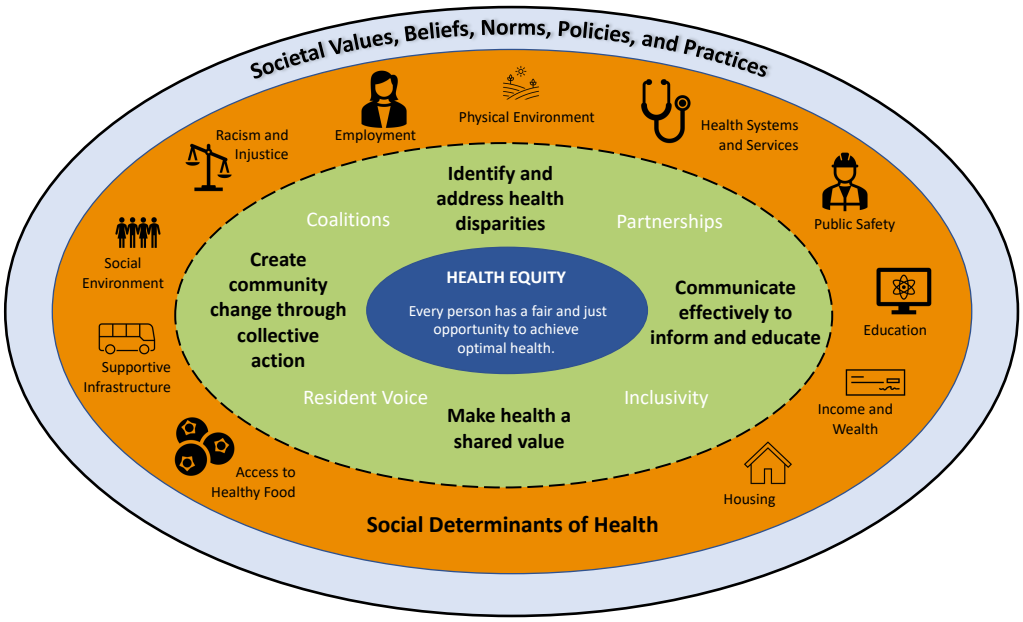

Figure 1. Cooperative Extension's Framework for Health and Well-Being.

The **light blue** outer ring of the diagram represents the powerful influence that societal values, beliefs, norm, policies, and practices have on the health assets and opportunities experienced by any community and its residents.

The relationships between the three core themes (health equity, social determinants of health, coalitions) of the framework are depicted by the three inner rings of the illustration. The **orange** ring includes the nine social determinants of health as defined by the National Academies of Sciences, Engineering, and Medicine (2017). Access to healthy food was added as a tenth determinant because of its centrality to the work of Cooperative Extension. Following the lead of many states, municipalities and the American Public Health Association, racism and injustice was added as an eleventh social determinant of health.

The **green** ring represents what Extension does with and through others to make health a shared value, identify health disparities, create community change, and effectively inform and educate others. Extension helps create community change by engaging with coalitions and amplifying the voices of residents. Its efforts to inform and educate others is often done in partnership with other organizations who, together ensure that their programs and services are inclusive and available to all.

At the center of the model is a **blue** ring which represents the overall goal of achieving health equity by ensuring that every person has a fair and just opportunity to achieve optimal health.

Recommendations

The Cooperative Extension National Framework for Health and Wellness makes the following **high-level recommendations** to the Cooperative Extension System and its partners:

1. **Advance health equity as a core system value** to ensure that all people have a fair and just opportunity to be as health as they can be.
2. **Utilize data-driven approaches and community driven needs assessment to identify and address health inequities** through a combination of tailored evidence-based strategies and community-engaged processes that influence the social determinants of health.
3. **Invest in the success and visibility** of Extension's health-related professionals, programs, and initiatives.
4. **Position health and well-being as an Extension-wide initiative** which engages Extension personnel from all program areas and multiple disciplines.
5. **Apply a community development model** to Extension's work in health equity and well-being to advance coalition building and collective action.

These high-level recommendations may be implemented through the following **detailed recommendations.** These detailed recommendations are organized by high-level recommendation and may be structural, relational, or transformational in nature. They are not listed in order of importance.

- **Structural**: Relating to research flows and types, staffing, policy, practice, program delivery, and other similar activity or organizational structure issues.
- **Relational**: Relating to relationships, connections, and power dynamics.
- **Transformational**: Relating to mental models, culture change.

Recommendation 1: Advance health equity as a core system value to ensure that all people have a fair and just opportunities to be as health as they can be.

It is essential that Extension align national and local priorities to advance equity and justice for individuals, families, and communities.

1.1 Create and adopt examples of Cooperative work in health that explicitly prioritizes health equity. Provide guidance on adapting those examples for use in more localized settings.

1.2 Adopt perspectives that frame racism as a public health issue which compels organizations and governmental units across the country to address the crisis in the broad, systemic ways similar to those used to address other threats to public health over time. These can include strategic initiatives in policies, practices, enforcement, education, and support services." (Cornell Health, 2020).

1.3 Prioritize hiring, retention, and development of a diverse and culturally competent workforce.

- **1.3.1** Evaluate staff retention and recruitment data with an eye to BIPOC, women, gender non-conforming, and people with disabilities. Create and implement clear and transparent plans for how the institution will improve their recruitment and staff retention.
- **1.3.2** Create opportunities in Extension's workforce for individuals who do not have advanced degrees, certificates, and credentials but do have valuable lived experience and community knowledge.
- **1.3.3** Address embedded issues within tenure track processes that disincentivize the creation of a diverse tenured faculty pool.

1.4 Create local and institutional equity action plans (informed by frameworks such as R4P) which communicate strategies and tactics for achieving equity goals.

1.5 Utilize existing frameworks from the field of implementation science(such as RE-AIM and Adaptome) to ensure a balance between program fidelity and contextual adaptations needed to ensure real-world effectiveness.

1.6 Collaborate with the National 4-H Council, 4-H foundations, USDA-NIFA, and other state and federal partners to embed conversations about health equity and the social determinants of health within 4-H positive youth development programs, particularly the Pathways Institute.

1.7 Embed structural mechanisms that drive new resources to chronically under-resourced Extension services and communities.

1.7.1 Appoint and resource a national health equity task force with diverse representation to build from the National Framework for Health Equity and Well-Being to identify national applicable measures for progress.

1.7.1.1 Conduct a national audit of Extension professional capacities in health equity.

1.7.1.2 Establish monitoring and evaluation standards that support consistent measurement of reductions in health inequities.

1.7.2 Demonstrate the value of equity and accountability in institutional culture from the top down through the development and use of land acknowledgments, accessibility statements, statements concerning Extension's responsibility for historical and current harms and the steps being taken to account for them.

Recommendation 2: Utilize data-driven approaches and community driven needs assessment to identify and address health inequities through a combination of tailored evidence-based strategies and community-engaged processes that influence the social determinants of health.

To narrow gaps in health disparities, and ultimately achieve health equity, Cooperative Extension must move past a "one-size fits all" model of community engagement to a more precision-oriented approach based on the unique characteristics of communities. Programs seeking to address individual health challenges must contextualize individual accountability, recommendations, curriculum, and lessons with the social determinants of health and efforts to promote policy, systems, and environment (PSE) change.

2.1 Establish and expand upon data sharing agreements so that Extension may access the demographic and health outcome information needed to accurately apply resources and develop programs.

2.2 Work with partners to access and use detailed demographic and health outcome data to map health disparities in consideration of the underlying systems, policies and environments that shape the social determinants of health.

2.3 Encourage and reward data- and community need-driven decisions, program development, implementation, and evaluation.

2.4 Create and distribute professional development, best practices, and learning resources to support effective and responsible use of data for decision making and program development.

2.5 Define Extension's role in addressing the social determinants of health while supporting PSE change.

2.6 Include discussion and consideration of the social determinants of health in Extension materials/programs alongside treatment of individual behaviors.

Recommendation 3: Invest in the success and visibility of Extension's health-related professionals, programs, and initiatives.

3.1 Increase the number and resourcing of Extension positions explicitly related to health and wellbeing in as many states as possible, phased in over the next 3 to 5 years.

3.2 Develop legislative and appropriations strategies that elevate and seek to resource Extension's health related work at the local, state, and federal level.

3.2.1 Increase the APLU BAA Policy and Legislative Committee understanding of health Extension and the ECOP Health Task Force priorities.

3.2.2 Focus effort with federal partners, foundations, and others to expand current and develop new funding streams and/or partnership opportunities for new, expanded, and resilient health related programming/staffing.

3.3 Provide sustained professional development focused on

(1) health equity and justice; (2) the importance of intersecting identities (including but not limited to race, gender presentation, socio-economic status, sexuality, religion); (3) the power of biases (including but not limited to those related to ability, anti-fat bias, English language proficiency, colorism, and racism) on individual

and community health access and outcomes; (4) the social determinants of health and Extension's role in addressing them; (5) coalition building best practices; (6) translational science tools and proficiencies; and (7) data science for health interventions.

3.4 Provide support for the National Health Outreach Conference.

Recommendation 4: Position health and well-being as an Extension-wide initiative which engages Extension personnel from all program areas and multiple disciplines.

4.1 Establish and strengthen relationships across Extension program areas.

4.1.1 Embed activities that tie together traditional health work (nutrition, physical activity, insurance literacy) with those that promote PSE change. For example, adding economic and financial dimensions of healthy and safe environments and choices, embedding financial perspectives within health education and outreach (Kiss et al., 2018) and supporting needs assessment processes, grant writing in communities, and communications with coalitions (Smathers & Lobb, 2017).

4.1.2 Integrate the work undertaken through the Expanded Food and Nutrition Education Program (EFNEP) and SNAP-Ed into state Extension plans so that the activities and personnel from those programs are connected to the broader health Extension portfolio.

4.2 Establish and strengthen relationships within individual LGUs to advance Extension's work in health. For example: connecting with colleges of public health, medical schools, and social work programs.

4.3 Establish and strengthen relationships amongst LGUs to share expertise, leverage limited resources, and build multistate strategies to advance health equity, precision health practices, consideration of the social determinants of health, and work through community coalitions.

4.4 Establish and strengthen relationships with external partners to foster interdisciplinary and collaborative health related research, teaching and outreach.

Recommendation 5: Apply a community development model to Extension's work in health equity and well-being to advance coalition building and collective action.

Extension's work in health is ultimately work in community development; every agent should see themselves as both an expert and a convener who has much to learn.

5.1 Learn from and follow the example of Extension services that have historically and consistently prioritized work in coalitions. Many of these will be 1890 and 1994 institutions.

5.2 Build a campus- and community-based workforce that is comfortable stepping away from a single point of contact expert-model pedagogy when working to advance health within a community.

5.2.1 Embed questions that relate to a person's willingness to challenge norms as described into interview and hiring processes.

5.2.2 Adapt position descriptions to attract individuals with expertise in community development and organizing.

5.2.3 Revise annual review processes to consider and value Extension work that goes beyond the delivery of discreet educational products.

5.2.4 Update and improve Extension onboarding activities and materials to demonstrate leadership's valuation of this competency.

5.3 Build the capacity and cultural competency of local volunteers to utilize Extension resources to support community-based work through the establishment of a health focused volunteer credentialing program like those that exist for 4-H or Master Gardeners. Health focused volunteers fit Cooperative Extension's traditional past in this way and should be considered part of the future, requiring a paradigm shift with volunteers as a strategy and not a program input or outcome (Washburn, 2017).

5.4 Incentivize and reward convening and coalition building activities that encourage community identification of issues alongside the strategies to address them. Such activities include but are not limited to securing spaces for groups to convene, designing and facilitating community dialogue, working with community leaders to develop partnerships and resources, or providing training and support for grant writing, needs assessments, and program development.

5.5 Compensate community members to partner with Extension as peer champions and community guides.

5.6 Require that Extension educators demonstrate awareness of who constitutes a community before designing an intervention. Educators must be informed by the community's history of interacting with state and local governments both before and throughout the process of launching health initiatives.

Annex 1: The Changing Health Landscape

Societal and environmental changes and realities have greatly influenced the landscape in which people live their lives. This section highlights key health topics that must inform how Extension evolves to meet current needs. These include the opioid crisis, mental health, coronavirus pandemic, climate change, food insecurity, and raising costs of health insurance and healthcare.

America's Opioid Misuse Health Crisis

Since 1999, more than 750,000 people have died from drug overdoses in the U.S. with two-thirds of those deaths involving an opioid (CDC, 2020) The opioid epidemic resulted from multiple factors, not the least of which was the over-prescription of highly addictive painkillers to reduce pain associated chronic health conditions. Communities experiencing poverty, joblessness, and low access to educational opportunities are among the hardest hit by the opioid crisis. For people of color, inequitable access to evidence-based prevention and recovery services, reliance on punitive approaches to control drug use, and ongoing economic disinvestment have created even deeper inequities in health-related use outcomes (Kunins, 2020; Donnelly et al., 2020).

Mental Health

During the summer of 2020, 41% of adults in the U.S. reported having an adverse mental or behavioral health condition with younger adults, racial ethnic minorities, and essential workers experiencing disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation (CDC, 2020). Similarly, researchers at Boston University discovered that prevalence of depression symptoms in adults was three times higher during COVID-19 with the highest burden falling disproportionately on those already at increased risk (Ettman, et al., 2020). Evidence suggests that mental issues may even be more prevalent in young people with

81% of teens say mental health is a major issue among young people with 71% experiencing mental health struggles of their own (Harris Poll, 2020). SAMHSA warns that effects are potentially long-lasting and very consequential for individuals and their families.

COVID-19

More recently, the emergence of the severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) spun the world into a global pandemic that resulted in more than 110 million people being infected by the virus and over 2.4 million deaths worldwide. We

know that those with pre-existing conditions or overall poor health were those hardest hit by the pandemic. In the United States "the coronavirus pandemic (COVID-19) revealed deep seated inequities in health and healthcare for communities of color and amplified social and economic factors that contribute to poor health outcomes" (SAMHSA, 2020). Most disadvantaged by these social and economic conditions were Black and Latinx individuals (Kaiser Family Foundation, 2020).

Climate Change

The National Academy of Medicine (2020) suggests that climate change will be one the most significant threats to human health in the 21st century and the negative impacts of the change "disproportionately affect the very young and the very old, people who are ill, impoverished or homeless, and populations that depend on the natural environment for survival." Long-standing racist policies such as racial segregation and locating waste disposal sites near low income communities will exacerbate the impact of climate change on people of color and impoverished communities(Rysavy and Floyd, 2020). Moreover, the United States Global Change Research Council suggests that the adverse health consequences of climate changes are projected to worsen with additional changes to our climate (USGCRP, 2018).

Food Insecurity

According to Feeding America, as many as 54 million people across the country may be food insecure (2020). Those who are food insecure are more likely to experience diet-sensitive chronic diseases such as diabetes and high blood pressure. Young people who are food insecure are also likely to experience significant delays in development. Food security does not exist in a vacuum, rather is it shaped by the unequal distribution of material, social and cultural resources and strengthened by existing inequities in the broader food system. Therefore, food insecurity cannot be changed by feeding people, but by changing the unjust and oppressive social structures, processes, and practices that put the ultimate control of power and wealth in the hands of the few (Borras & Mohamed, 2020).

Health Insurance

On the positive side, the number of uninsured in the U.S. dropped from nearly 46.5 million in 2010 to 28.79 million in 2019 as a result of the Affordable Care Act (KFF, 2020). Still, out of about 30 million uninsured individuals, about half of them are Black. Some of the states with the highest proportion of Black residents were also states that refused to expand Medicaid coverage under the ACA (Kirby & Kaneda, 2010). The rate of uninsured individuals has increased each year since 2016 due to the elimination of the ACA's individual mandate for coverage.

Annex 2: Cooperative Extension Evolves

This section summarizes a review of published literature since 2014 that used the initial framework and the degree to which the national framework has catalyzed change in Cooperative Extension. That review of literature is followed by anecdotal evidence of such change.

First and foremost, the review of literature revealed numerous examples of how the framework has raised awareness of key concepts of public health practice and healthcare including the influence of social systems on human health, the triple bottom line in healthcare, and the notion of building a culture of health (Andress & Fitch, 2016; Parisi et al., 2018; Rodgers & Braun, 2015; Smathers & Lobb, 2017). The release of the framework also sparked an increased focus on the six programmatic priorities identified by the authors as evidenced by a special issue of the *Journal of Health Sciences and Extension* in 2018 devoted exclusively to programming and scholarship emanating from the work of the Health Implementation Action Teams.

Extension Engagement with the Health Care Community

Several published works also emphasized the importance of establishing closer working relationships with the health care community. New models of health extension (Dwyer et al., 2017; Kaufman et al., 2017) advanced innovative strategies for creating closer working relationships with academic medical centers and primary care providers. It was pointed out in these articles that Cooperative Extension has a wealth of research-based programs that can help patients implement recommendations of physicians and other healthcare practitioners. Such programs can increase self-efficacy, help people improve their self-management of chronic conditions, and enhance the daily lives of adults as they age. Another study found the need to grow familiarity and understanding of Cooperative Extension among practicing physicians and allied healthcare providers (Khan et al., 2020) to facilitate future clinical practice-community connections.

Engagement with Clinical and Transformational Science

The literature review also revealed a growing interest across Cooperative Extension in working with the institutions that receive Clinical and Translational Science Awards (Gutter et al., 2020; Savaiano et al., 2017) to assist scientists in speeding up treatment innovations to reach patients sooner. Through such involvement, Cooperative Extension can leverage existing connections with academic health entities to establish new private and public partnerships for addressing large-scale national public health issues together (Rafie et al., 2019). New revenue for Cooperative Extension also looks promising as community-based programs become eligible to receive third-party reimbursement for health education (Contreras & Anderson, 2020).

Capacity Building and Professional Development

Cooperative Extension has turned to hiring many more individuals with formal training in health-related fields, including campus-based Extension specialists with advanced degrees in public health. Many state Extension services now include health as a named priority in their strategic plans; furthermore, every state has the opportunity to include human health initiatives in their annual plan of work for accessing federal Smith-Lever Act funds. This federal funding provides Cooperative Extension with a leverage point upon which other types of state, county, and competitive funding is built.

Additionally, a National Health Outreach Conference (NHOC) provides Cooperative Extension personnel from across the nation with an annual opportunity to engage in professional development sessions and network with others with similar interests. Braun and Rodgers (2018), however, advocate for increased participation of non-Extension speakers and audiences at NHOC. Specifically, Koukel et al., (2018) recommended professional development and training for Cooperative Extension on translation of clinical resources for the public.

The need for Cooperative Extension to engage in efforts that address social conditions and policy issues which influence health has also been identified (Andress & Fitch, 2016). Walsh et al., (2018) recommended an updated framework integrate health-focused work across program areas and policy work suggesting that Cooperative Extension is the multisector, national system capable of informing decision-makers at every level, especially county government and state policymakers.

Anecdotal evidence of this increased visibility of health-focused work across Cooperative Extension includes an increase in the use of the word “health” in the lexicon of Cooperative Extension. In some states, units that were previously referred to by program area names are reframing their work and adopting unit names that better reflect the inclusion of health-related work.

Partnerships and Investment in Cooperative Extension

Cooperative Extension is engaging more frequently in building strategic partnerships with other health-related colleges and academic medical centers. Today, partnerships between Cooperative Extension and colleges of public health, nursing, pharmacy, veterinary medicine, social work, medicine, and dentistry are commonplace. Jointly funded positions between these colleges and Cooperative Extension have become a way for Extension to obtain needed expertise and the partner college to expand their community outreach portfolio.

External partnerships with government, business, schools, and the nonprofit sector are also becoming more prevalent. In 2014, Cooperative Extension was provided with funding from the CDC to implement strategies in high-obesity communities to increase access to healthier foods and promote physical activity. Today fifteen states are involved in this program. In 2018 and 2019, Cooperative Extension received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop and disseminate training and technical assistance for rural communities on addressing opioid issues. Many of these partnerships were enabled by capacity and competitive funding made available by the USDA-NIFA.

Additionally, The Robert Wood Johnson Foundation has provided funding to the National 4-H Council for a “Well Connected Communities” Initiative through which Extension staff establish local coalitions that develop and implement action plans to address public health priorities. In addition to supporting coalition-building activities in communities across the nation, RWJF is also investing in systems change interventions across the Cooperative Extension System to support its work aimed at ensuring that all people have “a fair and just opportunity to be as healthy as possible.”

Major advances resulting from this initial investment by RWJF include the hiring of an Extension Health Director, identification of institutional contacts for health and well-being at each land grant institution, and the creation of an online professional community to facilitate collaboration and peer learning among Extension faculty and staff. Recently, a private gift from the Molina Foundation is supporting fellowships for two Extension professionals to work with the health director to further advance capacity-building efforts across Cooperative Extension.

Perhaps most important in efforts to achieve health equity are changes in the way that Extension interacts with community residents. The move from an expert model of program delivery to a model based on authentic community engagement is helping community members with lived experience become equal partners with agency professionals in the process of developing strategies and actions for community improvement. These participatory approaches are resulting in significant and lasting change in communities previously experiencing significant health disparities (Strayer III, et. al., 2020; Kidd, et. al., 2016; Ramirez-Andreottta, et. al., 2015; Meister and de Zapien, 2005).

Annex 3: Health Equity

Equity is an active term. It can only be achieved by clearly seeing and openly acknowledging the ways a person's lived reality is (1) informed by a web of interesting individual identities that include race, class, ethnicity, ability, gender identity and expression, sex, weight, veteran, marital, and documentation status, and more; and (2) shaped by a system of laws, policies, norms, and expectations that intentionally or unintentionally allow differing access to resources and opportunities. In this context, Extension's work to address individual and community health outcomes is incomplete when not coupled with the acknowledgement of systemic root causes, a recognition of inequity, and a commitment to shaping issue treatments to their broader contexts. This section provides additional context and provides a number of additional resources that you may turn to learn more.

It is important to note that some individuals may view health-oriented Extension programs that are designed to reach under-resourced or non-rural populations as being outside of Cooperative Extension's core work and mission. Not only is this historically inaccurate, as evidenced by the effectiveness of the chronically under-resourced 1890 and 1994 Land Grant Universities, it also does a disservice to the future potential of the Cooperative Extension System. 1862 Extension Services can and must learn from the robust knowledge, frameworks, and ways of working with marginalized communities that are central to the success of the 1890 and 1994 Land Grant Universities.

Recognizing Inequities

Examining life expectancy at birth across various geographic locales is one way to demonstrate the existence of health inequities. An individual born today in the U.S. can expect to live to 79 years of age Worldometer, 2020). But life expectancy can vary by as much as thirty years from one ZIP code to another.

Although length of life is an important and easy-to-measure indicator of health, it would be shortsighted, however, to make an assessment of one's overall health without consideration of the quality of life that an individual experiences across their lifespan. The contextual factors mentioned above influence quality of life as well as length of life. Recent studies have reported that more than 40% of the nation's population are suffering or struggling to achieve what they would describe as a state of well-being (Well Being Trust, 2020).

Rurality and its Relationship to Inequities

Health trends are showing non-Hispanic white people living in rural areas experiencing smaller declines in deaths from cancers and cardiovascular diseases and larger

increases in deaths from metabolic, respiratory, alcohol-related, mental and behavioral diseases, and suicides as compared to urban areas. But mortality rates for cancer and cardiovascular disease among Black, Indigenous, and Latinx populations have decreased an even slower rate than their white peers (Monnat, 2020). Many people who live in rural areas still lack many of the assets and fairly distributed resources needed to experience optimal health and well-being. These include broadband connectivity, a predictable source of healthy food, a quality education, steady employment, and access to health care.

Racism as Driver of Inequity

The National Academies of Sciences (2017) defines structurally-driven health disparities as those brought about by "the dimensions of social identity and location that organize or "structure" differential access to opportunities for health including race, ethnicity, gender, employment and socioeconomic status, disability and immigration status, geography, and more.

More recently, racism is increasingly being elevated as a dimension of social identity that deserves increased attention as this current point in time. At the time of writing, more than 30 states have declared racism as a public health crisis or emergency. However, it is important to frame racism not as a social determinant of health that is randomly distributed, but rather, as a fundamental cause that drives the social determinants of health. That is, many social determinants of health would be less influential if racism were eliminated. According to Hardeman and Karbeah (2020) "structural racism encompasses (a) history, which lies underneath the surface, providing the foundation for white supremacy in this country; (b) culture, which exists all around our everyday lives, providing the normalization and replication of racism; and (c) interconnected institutions and policies, they key relationships and rules across society providing the legitimacy and reinforcements to maintain and perpetuate racism."

Cornell Health (2020) suggests that "framing racism as a public health issue compels organizations and governmental units across the country to address the crisis in the broad, systemic ways that other threats to public health have been addressed over time. These can include strategic initiatives in policies, practices, enforcement, education, and support services."

In short, structural inequities, like institutional and systemic racism, and discrimination, drive systemic differences in access to social, economic, and environmental opportunities that influence health outcomes and observed health disparities across sub-population groups. To narrow gaps in health disparities, and ultimately achieve health equity, Cooperative Extension must consider the underlying systems, policies and environments that shape the social determinants of health.

Poverty as a Driver of Inequity

Poverty is a state or condition where an individual does not have the financial resources to achieve a minimum quality of life. Poverty is also associated with a number of other variables used to describe the human condition such as education, employment, housing, racism, and a supportive infrastructure. While the influence of poverty on health is immense, this framework does not include poverty as a social determinant of health. Instead, poverty is represented by a set of more actionable determinants with which it is closely related.

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The updated Framework uses “well-being” rather than “wellness” to align with terminology being used by the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, and Healthy People 2030. For example, Healthy People 2030 has chosen to use “well-being” in association with “health” to reflect an individual’s “ability to meet personal and collective needs under changing conditions in society. It entails being accepted into and belonging to a community, providing and receiving support from others, and acting as a legitimate contributor to a common world” (Pronk et al. 2019, page #). Well-being also aligns more closely with the construct of health-related quality of life (CDC, 2018).

Granted some definitions of wellness are broader than others, but few go so far as to include notions of resilience, outlook for the future, realization of personal potential, satisfaction with life, personal agency, and happiness. More typically, the term wellness is “used to refer to services aimed at an individual. For these and probably other reasons, practitioners and researchers working with systems and communities use the term well-being” (Roulier, 2020, page #). As compared to wellness, the concept of well-being also includes such things as how satisfied people are with their lives as a whole, the sense of control they have over their lives, and their sense of purpose in life (New Economics Foundation, 2012). Moreover, well-being focuses on creating equitable opportunities for people to thrive in every aspect of life and to create meaningful futures.