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

Produced by the Extension Committee on Organization and Policy
Health Innovation Task Force

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COOPERATIVE EXTENSION

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Introduction

Every day, people make choices that impact their health. Those choices have been the focus of health professionals for years. Generations of time, energy, and resources have been dedicated to informing and influencing these choices through education, social marketing, and scores of other methods. As a result, our public discourse around health has been framed as a personal responsibility where good health is seen as a personal success, ill health a personal failing.

Without question, there is much that we can do as individuals to improve our 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).

We now know that linking a person's health outcomes to their individual choices alone tells an incomplete story. Those choices exist within a system of contextual factors that together have a far greater influence on health than their individual behaviors. Collectively, these factors are referred to as the **social determinants of health**.

When an individual or community is negatively impacted by the social determinants of health, they are said to be experiencing **health inequities.** Among the groups experiencing the greatest inequities are people of color and those who live in rural areas. 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 prevent all of us being as healthy as we can be.

In this context, the need for a refreshed framework to guide Cooperative Extension's health-related work has never been greater. This document is designed to serve as that framework.

Methods

In 2012, the Extension Committee on Organization and Policy ECOP appointed a National Task Force on Health to identify systemwide priorities for guiding Cooperative Extension's work in the area of health for the next three to five years. Approved by ECOP in 2014, [Cooperative Extension's National Framework for Health and Wellness](#), was instrumental in establishing work in the area of health as a priority for the Cooperative Extension System. It also served to raise the visibility of Cooperative Extension's health-related work and catalyzed the establishment of new programs, partnerships, and professional development opportunities for staff.

Recognizing the need for updated guidance for its work in this area, ECOP appointed a Health Innovation Task Force in 2020 to provide recommendations for system level change that would further advance Cooperative Extension's work in the area of heath. Those recommendations are included in this document.

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." Well-being also aligns more closely with the construct of health-related quality of life (CDC, 2018).

The term wellness is typically "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). 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). Well-being also 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). Moreover, well-being focuses on creating equitable opportunities for people to thrive in every aspect of life and to create meaningful futures.

This updated Framework is grounded in an examination of (1) major health-related events which have occurred since 2014, (2) changes which have occurred within Cooperative Extension over time, and (3) a review of current literature and best practices in relevant fields. Summaries of these in-depth examinations can be found in the sections which follow.

The Changing Health Landscape

Since 2014, numerous societal and environmental influences have produced significant changes to the landscape in which people live their lives. This section highlights some of the those influences and their impact on the health of various groups. These influences include the opioid crisis, mental health, coronavirus pandemic, climate change, food insecurity, and the increasing costs of health insurance and healthcare.

America's Opioid Misuse 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 were 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). A recent survey suggests that mental issues may be even more prevalent in young people with 81% of teens indicating that they believe mental health is a major issue among their peers and 71% reporting that they were experiencing mental health struggles of their own (Harris Poll, 2020). SAMHSA warns that the effects of mental health issues experienced during the pandemic are potentially long-lasting and very consequential for individuals and their families.

COVID-19

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 200 million people being infected by the virus and over 4 million deaths worldwide. Individuals 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 the impact of social and economic factors" that are already contributing to poor health outcomes (SAMHSA, 2020). Most disadvantaged by these social and economic conditions were Black and Latinx individuals (Kaiser Family Foundation, 2020).

Consequently, it is not surprising that while life expectancy in the United States decreased by a full year 2020 due to the impact of the COVID-19 pandemic, the decrease for Black and Latino populations was far greater.

Climate Change

The National Academy of Medicine (2020) has suggested that climate change will be one the most significant threats to human health in the 21st century and the negative impacts of the change will "disproportionately affect the very young, the very old, people who are ill, those 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 warned 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. Moreover, food insecurity does not exist in a vacuum, rather is it shaped by the unequal distribution of material, social, and cultural resources and is exacerbated 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). Additionally, the rate of uninsured individuals has increased each year since 2016 due to the elimination of the ACA's individual mandate for coverage.

Cooperative Extension Evolves

Cooperative Extension has been working to advance personal health since its inception. The foci of 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.

Nutrition Education

Over time, the scope of health-related programming by Cooperative Extension diversified, and its audience expanded. For example, Cooperative 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. More recently, Cooperative Extension has become the nation's largest provider of nutrition education for individuals and families eligible to receive food assistance benefits by serving as an implementing agency for a program called the Supplemental Nutrition Assistance Program - Education (SNAP-Ed) (Yetter and Tripp, 2020).

Expansion of Health Programming

Beyond nutrition education, Cooperative 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, water quality, skin cancer prevention, radon education, immunization education, and healthy aging. Today, Cooperative Extension is actively engaged in addressing issues related to environmental health, antibiotic resistant bacteria, and the 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 Cooperative Extension's work in health is often understated, undervalued, or unnoticed.

Health Extension Comes of Age

Cooperative Extension's National Framework for Health and Wellness (2014) greatly accelerated health's rise to prominence as a priority for Cooperative Extension. More specifically, a review of literature revealed numerous examples of how the framework has raised awareness of key concepts of public health practice and healthcare within the organization 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). Particularly noteworthy was a special issue of the *Journal of Health Sciences and Extension* published in 2018 devoted exclusively to programming and scholarship emanating from implementation of the framework. The framework also sparked an increased focus on six programmatic priorities identified in the original document.

Extension Engagement with the Health Care Community

Several published works also emphasized the importance of Cooperative Extension 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 Extension to partner 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 suggested a 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 engagement, Cooperative Extension can leverage existing connections with academic health centers 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). But Koukel et al., (2018) suggested that professional development and training for Cooperative Extension staff on clinical and translational science might be needed before the benefit of these partnerships can be realized.

Capacity Building and Professional Development

Perhaps most indicative of the emergence of health as a priority for Cooperative Extension has been an increase in the use of the word "health" in the lexicon of Cooperative Extension. Many state Extension services now include health as a named priority in their strategic plans. In some states, units that were previously referred to by historic program area names are reframing their work and adopting unit names that better reflect the inclusion of health-related work.

Cooperative Extension has also turned to hiring many more individuals with formal training in health-related fields, including campus-based Extension specialists with advanced degrees in public health.

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.

Transition from Expert to Partner

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).

The need for Cooperative Extension to engage in policy issues which influence health has also been identified (Andress & Fitch, 2016). Walsh et al, (2018) recommended that an updated framework should promote health-related work across program areas and emphasized that Cooperative Extension can play an important role in informing policy decisions at every level.

New Partnerships, New Investments

Cooperative Extension is also 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 Cooperative Extension to obtain needed expertise and the partner colleges 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 related to 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 funded fellowships for two Extension professionals to work with the health director to further advance capacity-building efforts across Cooperative Extension.

Health Equity as a Core Theme

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.

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."

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).

Extension is well positioned to serve as a catalyst for community-based efforts to address inequities. Doing so, however, will require a 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 Cooperative Extension model, with greater ability to see and do our work differently than in the past.

The 2014 Framework acknowledged the importance of equity in shaping the health and well-being 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, Cooperative Extension moves from treating equity issues as an unfortunate contextual given to actively addressing the conditions that create them.

Definitions of Health Equity

Numerous definitions of health equity exist in the literature. For example, the Robert Wood Johnson Foundation argues that that health equity exists only when "everyone has a fair and just opportunity to be as healthy as possible." The Centers for Disease Control and Prevention operate from the premise that health equity is a state in which "everyone has the opportunity to attain their full health potential, and no one is disadvantaged in achieving this potential because of social or any other socially-defined circumstances." The World Health Organization expands upon these definitions characterizing health equity as the "absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification."

Any individual is an amalgamation of a multitude of individual identities that include race, class, ethnicity, ability, gender identity and expression, sex, weight, veteran, marital, and documentation status. Society has enacted a system of laws, policies, norms, and expectations that intentionally or unintentionally allow differing access to resources and opportunities based on these identities. In this context, Extension's work to advance health in communities through education and behavior change is incomplete when not coupled with a commitment to eliminating barriers to health that these laws, policies, norms, and expectations present.

Rurality and its Relationship to Inequities

Health trends are showing that non-Hispanic white people living in rural areas are 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 at an even slower rate than

their white peers (Monnat, 2020). Many people who live in rural areas still lack many of the assets and 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

More recently, racism is increasingly being elevated as a dimension of social identity that deserves increased attention at 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 establishment of norms, policies, and practices that influence 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 which 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."

Recognizing Inequities

Unfortunately, many community health assessments are done at the county level and lack the granularity needed to identify those communities experiencing the poorest health outcomes. In a sense, these assessments actually mask health inequities that may exist within a county. To ensure that interventions are tailored to unique needs of communities bearing the greatest health burdens, is necessary to examine health by census tract or zip code. CDC's [Places: Local Data for Public Health](#) allows local Extension faculty and staff to access health outcome data at the census tract level and actually visualize disparities. Using such information to drive resources to specific such communities are called precision approaches.

Targeted Universalism

Addressing inequities will require that Cooperative Extension help communities identify measurable health goals that everyone should be able to achieve. A community can then work with a disciplined focus on identifying obstacles to achieving those goals, calling attention to the inequities, and committing resources toward closing the gaps which exist. This approach is more commonly referred to as targeted universalism (Powell, et al, 2019). The goal of this approach is to ensure that no one is disadvantaged in achieving their full health potential.

Social Determinants of Health as a Core Theme

This updated framework continues to reinforce the notion that individuals live, learn, work, and play within a social system. The relationship between an individual and the social system in which they live is frequently depicted through a social-ecological model. In general, such models

show how the daily lives of individuals are nested within and influenced by interpersonal relationships, families, schools, workplaces, communities, and societal norms and values. Factors outside of the individual that have an influence on an individual's health are known as the social determinants of health (SDoH).

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 also 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.

As mentioned earlier, the 2014 Framework recognized the powerful influence of the social determinants of health but stopped short of 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 precision interventions to address barriers and challenges implemented through oppressive and discriminatory policies, systems, and environments.

It is important to note that some individuals may view efforts to address barriers to health as being outside of Cooperative Extension's core work and mission. Others may see efforts to drive resources toward groups that have been historically underserved as taking resources away from those who currently benefit from the work of Cooperative Extension. Not only are these beliefs historically inaccurate, as evidenced by the work by the chronically under-resourced 1890 and 1994 land grant universities, they also jeopardize the future of Cooperative Extension.

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

Coalitions and Community Health Assets as a Core Theme

Extension has a long and rich history of engaging in partnerships with schools, government agencies, and various community-based organizations to support the delivery of programs. The 2014 framework identified partnership development as a key component in advancing Cooperative Extension's health-related work and suggested a number of potential partners with whom Cooperative Extension might engage. However, it stopped short of defining Extension's

role in promoting, establishing, and providing support for community coalitions that provide access to a broader spectrum of community assets. It is through these coalitions that Cooperative Extension and the community together can identify key inequities, and the social determinants of health that underlie them.

Community coalitions that focus on health equity are typically made up of representatives of health and human service providers who engage with racially and ethnically diverse communities in meaningful and significant ways (Anderson et al., 2015). They can be venues for power sharing, collaboration, and group decision-making, and advance Cooperative Extension's commitment to improving health equity. 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 also include active participation from individuals with lived experience in that community.

Extension has extensive experience in mobilizing community action around a wide array of community issues including health equity (Buys & Koukel, 2018). Cooperative Extension can play many different roles within community coalitions, moving in and out of these roles as appropriate. These roles include convening, facilitating, managing, supporting, resourcing, and leading. Perhaps Cooperative Extension's most significant role in a coalition is to connect the community to the knowledge and resources of the broader university. 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.

For Extension, being an effective coalition member involves 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.

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, authentic efforts to build coalitions must be coupled with ownership of harms inflicted and a demonstrated commitment to change. Only then can Cooperative 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.

Because of the ability of community coalitions to produce profound and lasting change, increasing Cooperative Extension's role in coalition development and management s advanced 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 found immediately below illustrates how a focus on the core themes can advance Cooperative Extension's portfolio of work focused on achieving health equity and promoting the well-being of all people. Some readers will notice the visual similarities to the 2014 model, particularly in the utilization of a multi-layered, social-ecological model to show the relationships between the individual and the environments in which they live.
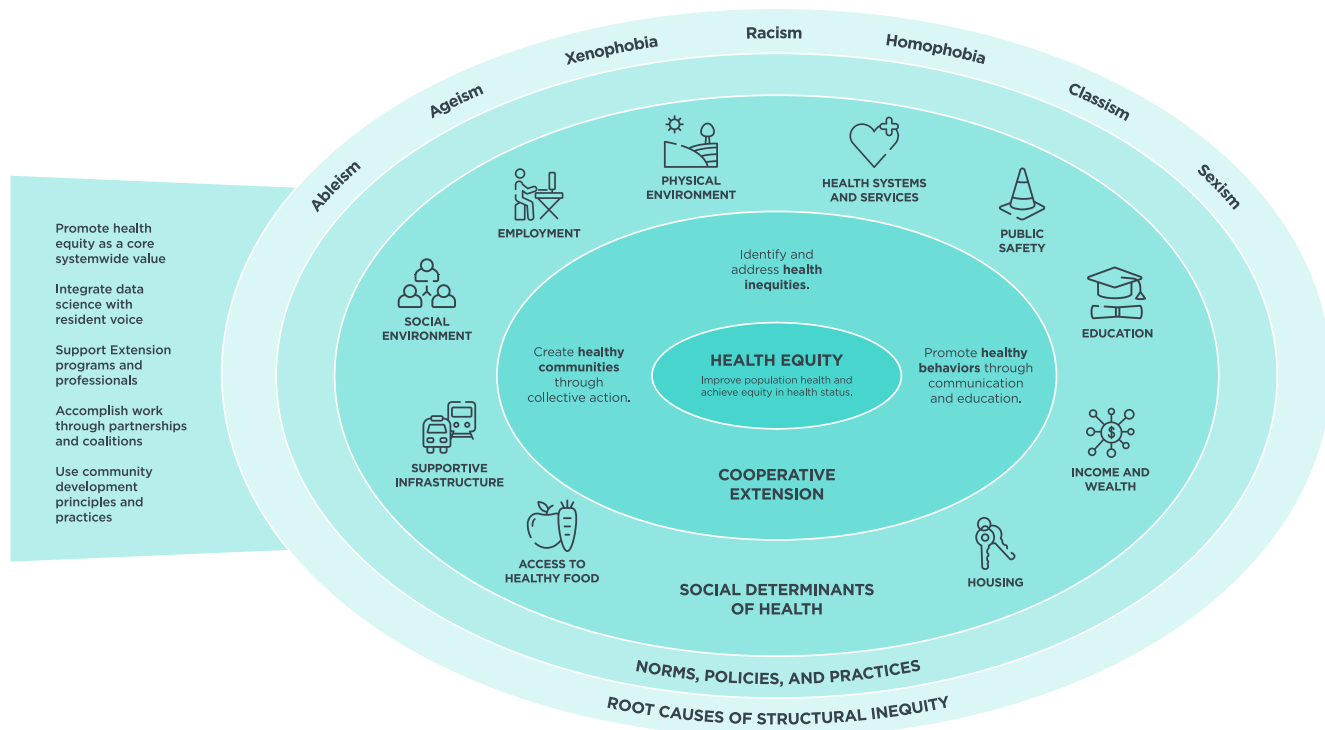
The outer ring of the diagram lists many of the **root causes of structural inequity**. The list, however, should not be viewed as exhaustive of all of the root causes of inequity. But when decision makers use their **power** to establish **norms, policies, and practices** through the lens of racism, for example, people of color may systematically be denied access to the resources and services which support lifelong health and well-being. These resources and services are more commonly referred to as the **social determinants of health.** This framework incorporates the nine social determinants of health identified by the National Academies of Science, Engineering, and Medicine (NASEM, 2017). Access to healthy food was added as a tenth determinant because of its centrality to the work of Cooperative Extension.

The work of **Cooperative Extension** focuses first on **identifying the health inequities** which may exist in a given community. Cooperative Extension then works through two major streams of activity in its efforts to improve health. The first stream is through **promoting healthy behaviors** though communication and education. This work can be focused on either the general population or on groups experiencing inequities in health outcomes. The second stream involves working with and through coalitions **to create healthy communities.** The work of these coalitions frequently focuses on addressing the social determinants of health which are barriers to achieving optimal health.

Together this work focuses on the dual goals **of improving population health** and **achieving equity in health status.** The "fin" attached to the left of the ovals lists the five high-level recommendations that Cooperative Extension System must implement if it to be effective in achieving the dual goals.

Recommendations

Cooperative Extension's Framework for Health Equity and Well-Being 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 healthy as they can be.
2. **Utilize community assessment processes** that integrate data science and resident voice to identify and address health inequities with greater precision.
3. **Invest in the success and visibility** of Extension's health-related professionals, programs, and initiatives.
4. **Establish partnerships** with academic units, universities, government agencies, corporations, nonprofit organizations, and foundations that share a commitment to reducing or eliminating health inequities.
5. **Utilize a community development approach** to advance the work of coalitions focused on influencing the social determinants of health.

These high-level recommendations may be implemented through the following **detailed recommendations.**

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

    1.1   Identify examples of current work explicitly focused on health equity and share those examples across Cooperative Extension.

    1.2   Adopt an organizational perspective that frames racism as a public health issue in a manner similar to other threats to public health.

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

        1.3.1   Evaluate recruitment and retention data at the institution level and implement clear and transparent plans for addressing obstacles to achieving a diverse workforce.

        1.3.2   Create opportunities for individuals who do not possess advanced degrees and professional credentials but have valuable lived experience and community knowledge to participate in the Extension workforce.

        1.3.3   Address embedded issues within tenure track processes that disincentivize the creation of a diverse tenured faculty pool.

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

    1.5   Appoint and resource a national Cooperative Extension health equity task force with diverse representation (including 4-H) to identify nationally applicable goals for advancing health equity.

1.5.1 Conduct a national audit of Cooperative Extension's professional capacities in health equity.

1.5.2 Encourage the creation of local and institutional equity action plans (informed by frameworks such as R4P) which communicate strategies and tactics for achieving equity goals.

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

1.6 Reinforce a system-wide commitment to equity from the top down through accessibility statements, land acknowledgments, and statements acknowledging Cooperative Extension's current and historical harms and the steps taken to address them.

1.7 Establish and strengthen relationships between Extension program areas to advance health as an Extension-wide priority

Recommendation 2: Utilize community assessment processes that integrate data science and resident voice to identify and address health inequities with greater precision.

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

2.2 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.

2.3 Include a discussion of the social determinants of health in Cooperative Extension publications and programs historically focused on individual behavior change.

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

3.1 Increase the number of Extension positions explicitly focused on health and well-being in as many states as possible.

3.2 Develop strategies for increasing funding for Cooperative Extension's health-related work at the local, state, tribal, and federal level.

3.3 Provide professional development on core concepts of health Extension including appropriate and responsible use of data, strategies for engaging resident voice, equity and justice, intersecting identities, the power of bias, social determinants of health and Extension's role in addressing them, coalition building, and translational science tools and proficiencies.

3.4   Encourage and reward the work of Extension professionals who engage in focused activities to address health inequities experienced by specific communities and groups.

3.4   Provide support for the National Health Outreach Conference.

Recommendation 4: Establish partnerships with academic units, government agencies, corporations, nonprofit organizations, and foundations that share a commitment to reducing or eliminating health inequities.

4.1   Establish and strengthen partnerships with academic medical centers and various health science colleges such as public health, nursing, pharmacy, veterinary medicine, dentistry, and social work.

4.2   Establish and strengthen relationships between 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.

4.3   Establish and strengthen relationships with external partners to foster interdisciplinary and collaborative health-related research, teaching and community engagement.

Recommendation 5: Utilize a community development approach to advance the work of coalitions focused on influencing the social determinants of health.

5.1   Capitalize on the experience of Extension professionals and land grant institutions that have historically accomplished work through community coalitions.

5.2   Build an Extension workforce that is comfortable stepping away from an expert-model of program delivery to one where Extension professionals are also comfortable engaging with the community as equal partners.

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

    5.2.2   Revise annual review processes to give value to Extension work that goes beyond the delivery of discreet educational products.

    5.2.3   Update and improve Extension onboarding activities and materials to demonstrate leadership's valuation of community development competency.

5.3   Build the capacity of local residents to lead community-based work through the establishment of health-focused volunteer credentialing programs.

5.4   Support the creation and development of community coalitions explicitly focused on addressing the social determinants of health.

5.5   Compensate community members for partnering with Extension as peer champions and community guides.

5.6   Create an expectation 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, tribal, and local governments both before and throughout the process of launching health initiatives.

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