# New Orleans
# Community Health Improvement Plan

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# GLOSSARY OF ACRONYMS

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|---|---|
| ART | Antiretroviral Therapy |
| BFS | Blueprint For Safety |
| BRFSS | Behavioral Risk Factor Surveillance System |
| CAN | Community Action Network |
| CCANO | Catholic Charities Archdiocese of New Orleans |
| CEU | Continuing Education Unit |
| CHA | Community Health Assessment |
| CHI | Community Health Improvement |
| CHIP | Community Health Improvement Plan |
| DCSNO | Daughters of Charity Services of New Orleans |
| DVAC | Domestic Violence Advisory Committee |
| FQHC | Federally Qualified Health Center |
| GNO | Greater New Orleans |
| GNOCHC | Greater New Orleans Community Health Connection |
| HiAP | Health in All Policies |
| HIV | Human Immunodeficiency Virus |
| HSNO | Healthy Start New Orleans |
| LA CCYS | Louisiana Caring Communities Youth Survey |
| LGBTQ | Lesbian, Gay, Bisexual, Transgender, Queer or Questioning |
| LLAC | LA Language Access Coalition |
| LPHI | Louisiana Public Health Institute |
| MAPP | Mobilizing for Action through Planning and Partnerships |
| MHSD | Metropolitan Human Services District |
| NACCHO | National Association of County and City Health Officials |

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|---|---|
| NOHD | New Orleans Health Department |
| NOLA | New Orleans, Louisiana |
| NOPD | New Orleans Police Department |
| NPS | National Prevention Strategy |
| OHP | Office of Health Policy |
| PTSD | Posttraumatic Stress Disorder |
| SAAC | Service Area Advisory Committee |
| SART | Sexual Assault Response Team |
| STI | Sexually Transmitted Infections |
| TBD | To Be Determined |
| VAYLA | Vietnamese American Young Leaders Association |

# INTRODUCTION

New Orleans counts over 378,000 residents and is Louisiana's major urban metropolis and largest tax base. Though rich in assets including history, culture, ethnic diversity, and natural resources, New Orleans has many longstanding income and health disparities which must be addressed in order for all residents to live up to their fullest potential.

The New Orleans Community Health Improvement Plan (CHIP) describes the community's shared vision for health in the city and details collaborative action plans across five health priority areas in order to meet this vision. The New Orleans Health Department (NOHD) facilitates the CHIP formation and evaluation process, yet the CHIP is meant to be owned by the community at large and is a product of efforts by a myriad of local organizations and community members concerned with the public's health.

NOHD and the Community Health Improvement (CHI) Steering Committee released the first version of the CHIP in January 2013. In a process facilitated by Centers for Disease Control and Prevention fellow Yvette Wing, and with support from the National Association of County and City Health Officials (NACCHO), NOHD staff, the CHI Steering Committee, and other partners developed action plans with measurable targets to address the following priority areas:

1. Access to Physical and Behavioral Healthcare
2. Social Determinants of Health
3. Violence Prevention
4. Healthy Lifestyles
5. Family Health

> **"We envision a safe, equitable New Orleans whose culture, institutions, and environment support health for all."**
> -Vision for Community Health Improvement in New Orleans, 2012

In June 2014, the NOHD reconvened the CHI Steering Committee to evaluate CHIP efforts and begin the process of revising CHIP Goals, Objectives and Action Plans where relevant. With the above five priority areas as the foundation, NOHD continues its collaborative work with community stakeholders and partner agencies to develop and implement actionable policies and programs. The plans in this revised version of the CHIP reflect a nine month revision process and will serve as our guide as we collectively strive to achieve our vision for community health improvement in New Orleans.*

**The use of "our" and "we" throughout this document refers to collaborations between the NOHD, CHI Steering Committee, and other community partners where relevant*

# COMMUNITY HEALTH IMPROVEMENT PLAN

## What is a Community Health Improvement Plan?

Public health is defined by three core functions: assessment, policy development and assurance. Health departments around the nation are beginning to conduct community health assessments (CHAs) to fulfill this first function. According to NACCHO, CHAs provide data for problem and asset identification and policy formulation, implementation, and evaluation, as well as measure how well a public health system is fulfilling its assurance function.

With CHA data, health departments and partners are then encouraged to conduct a community health improvement process to identify public health priority issues in the area, develop and implement strategies for action, and establish accountability among partners to ensure measurable health improvement. The product of this process is a community health improvement plan, or CHIP. Instead of simply focusing on the efforts of one individual organization or health department, CHIPs should define a shared vision for community health and address the broad range of strengths, weaknesses, challenges, and opportunities that exist within the community to improve health. Through collaboration and technical assistance from national partners, the New Orleans CHIP provides a blueprint for our local public health system to best address population-level health issues for all city residents.

The NOHD houses the CHIP, facilitating its formation, revision, and evaluation. The CHIP, however, is meant to be owned by the community at large as it reflects months of collaborative planning efforts by local organizations and reflects collective community action plans to address priority area health issues. The CHIP is also meant to complement, not supersede, more detailed planning and/or assessment documents produced by coalitions working within CHIP priority areas.

## How Will We Use the Revised CHIP?

The first version of CHIP (January 2013) laid the foundation for five years (2013-2018) of collaborative work across each priority area. This revised version ensures that the NOHD and partners continue on the original path, yet consider new developments in public health and the city when moving forward. The CHIP is a living document, which means that although we have captured specific goals, objectives, performance measures, and targets on paper now, the plan will continue to grow and evolve over the next years as we do. As such, while the NOHD will lead revision efforts each year, we will also update the CHIP intermittently throughout the year as plans need updated and/or change.

## Methods: Developing and Revising the New Orleans CHIP

### *Developing the CHIP*

In 2011 and with the support of the Louisiana Public Health Institute (LPHI), the NOHD brought together a diverse group of community partners to serve as the CHI Steering Committee and engage in the first city-wide health assessment and health improvement planning process since 2000. With funding from NACCHO through the Robert Wood Johnson Foundation, we collaborated with nearly 100 community partners over one and a half year to conduct a CHA and develop a CHIP, using the Mobilizing for Action through Planning and Partnership (MAPP) framework as our guide and ensuring alignment with national priorities such as Healthy People 2020.

Through a comprehensive selection process described in the original CHIP, the CHI Steering Committee selected the following as the most critical issues to address in order to achieve our vision for community health improvement in New Orleans:

1. Access to Physical and Behavioral Healthcare
2. Social Determinants of Health
3. Violence Prevention
4. Healthy Lifestyles
5. Family Health

### *Revising the CHIP*

To revise the CHIP, the NOHD Community Health Improvement Program Lead first worked with CHIP partners to evaluate Action Plan progress since January 2013. NOHD then reconvened the CHI Steering Committee in June 2014 to begin the revision process. The CHI Steering Committee divided itself into five subcommittees – one for each priority area - based on interest and expertise. The NOHD then led each subcommittee in a Health Problem Analysis exercise wherein group members used CHA data to define the overarching problem for the strategic issues and identify related direct and indirect risk factors. Each subcommittee also used the CHIP evaluation to determine which pieces of the CHIP were no longer relevant, and which needed revision.

**Timeline of CHIP Revision**

<table>
<tr><th colspan="7">2014</th><th colspan="2">2015</th></tr>
<tr><th>June</th><th>July</th><th>Aug</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th></tr>
<tr><td colspan="9">Continued implementation of relevant CHIP Action Plans</td></tr>
<tr><td>Reconvene Steering Committee</td><td colspan="2">Subcommittees complete Health Problem Analysis, evaluate CHIP progress</td><td colspan="5">Subcommittees revise goals, objectives, and action plans where relevant</td><td>Steering Committee approval of revised CHIP<br><br>Publish revised document</td></tr>
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Each priority area group went through a slightly different process of revising CHIP goals, objectives, and action plans as the context of each issue area in the city is different.

Access to Physical and Behavioral Healthcare: Using the Health Problem Analysis worksheet, priority area members voted on criteria to use in narrowing down issue areas on which to focus objectives and action plans. The final criteria are as follows:

- *Seriousness*: There will be serious consequences if we do not address this
- *Equity*: Some groups are disproportionately affected more than others
- *Impact*: We are in a position to effectively make a difference; we have some control and knowledge
- *Trends*: This issue is getting worse

Priority area members then used these criteria to anonymously vote on which risk factors to address in the CHIP. Through a number of meetings thereafter, the members formed objectives and work plans for each risk factor.

Social Determinants of Health: Priority area members met multiple times to discuss the best path forward to address Social Determinants as its own priority area. The group decided that the best path is to work with NOHD on a plan to develop a Health in All Policies initiative at the City.

Violence Prevention & Healthy Lifestyles: Both of these priority areas house the work of collective impact initiatives. For Violence Prevention, the initiative is NOLA For Life, Mayor Landrieu's comprehensive murder reduction strategy. For Healthy Lifestyles, the initiative is Fit

NOLA, the city-wide strategy to promote physical activity and healthy eating. The 2013 CHIP reflected the work streams of these initiatives, and the revised CHIP is an update of this work.

Family Health: During the time of CHIP revision, the NOHD began developing its Healthy Start Community Action Network, a collective impact initiative to address child well-being by using a life-course perspective. Steering Committee members in this priority area agreed that the revised CHIP should reflect the work of this initiative as it seeks to involve a wide variety of organizations and participants to address family health and social determinants.

The revised narrative sections for each priority area are meant to provide a context for the relevant action plans. The narratives use data from the CHA and, when available, more recent data. CHI Steering Committee members reviewed these narratives to ensure both their relevance and accuracy.

# ACCESS TO PHYSICAL AND BEHAVIORAL HEALTHCARE

## Background

"Access" to healthcare services is a multi-faceted concept. One part of "access" concerns the adequate supply of healthcare facilities and healthcare professionals available to every segment of a population. However, even though sufficient healthcare facilities and professionals may exist in a community, residents may not be appropriately utilizing them. Utilization depends on 1) how affordable the services actually are, as well as how affordable people perceive or understand these services to be; 2) how physically accessible the services actually are, as well as how physically accessible people perceive them to be; 3) whether or not people feel the services are adequate and respectful of one's culture and language, and; 4) whether or not people believe they actually need the services.[1] Inadequate access on any of these fronts is likely to show up as poor health outcomes.

To ensure true access to healthcare services in relation to the above, the "supply" - or provider - side must demonstrate an adequate amount of services which are physically easily accessible, affordable, of quality, have services in the languages of all local populations, and display cultural competency towards all local populations. On the "demand," or community side, potential healthcare consumers must also understand when and why to seek services, feel that

[1] Gulliford M, Figueroa-Munos, J, et al. What does 'access to healthcare' mean? *Journal of Health Services Research and Policy*. 2002; 7(3): 186-188.

the services are relevant, affordable and effective, have a solid understanding of where they can seek the services they need, as well as feel comfortable that their provider will be culturally competent and speak their language. Much of this "demand" side speaks to the health literacy levels of consumers and availability of information, as well as the cultural competency levels of providers.

## Access to Physical and Behavioral Healthcare in Louisiana and New Orleans

According to America's Health Rankings, Louisiana is one of the unhealthiest states in the nation, ranking at 48 out of 50.[2] The 2014 County Health Rankings and Roadmaps shows that, within Louisiana, Orleans Parish ranks in the lower half of all Parishes in both health factors and health outcomes.[3] The CHA includes many data points reflecting these poor health outcomes, including New Orleans' higher-than state average rates of poor physical health days, poor mental health days, premature deaths, percentage of low birthweight babies, and sexually transmitted infections. The CHA also shows how poor health outcomes are unequally distributed across geographic areas, racial and ethnic, and socioeconomic groups in the city, indicating healthcare access inequities.

### *Service Availability*

The healthcare safety-net in the Greater New Orleans has transitioned from the pre-Katrina centralized model of care delivery, in which Charity Hospital provided the vast majority of indigent care. Instead, the current safety-net is a decentralized system in which people may access care at community clinics and medical homes in their neighborhood, many of which are run by different organizations.

There are arguably a sufficient number of preventive and primary care providers to serve the insured and uninsured in New Orleans, yet the sustainability of the current system remains to be seen. Federally Qualified Health Clinics (FQHCs) serve as an integral part of the New Orleans healthcare safety net and include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid and must serve an underserved area or population, offer a sliding fee scale for services, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.[4] In 2013, the Greater New Orleans area counted six FQHCs which saw a total of 94,466 unique patients that year.[5] In November 2014, four additional local

[2] http://www.americashealthrankings.org/LA
[3] http://www.countyhealthrankings.org/
[4] http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html
[5] http://504healthnet.org/

organizations were granted FQHC status, bringing the total number to 10.[6] Many of these FQHCs offer behavioral health services, and a small handful offer dental services. A number of organizations are also currently working to integrate primary care and mental health services. Despite these advances and the ability of this safety net to serve a large volume of people, however, the sustainability of the current system remains reliant on public funds, especially for care to the uninsured.

In terms of access to behavioral health services, there are a number of challenges in ensuring availability of services for the mentally ill and particularly the uninsured mentally ill. For example, the rate of inpatient psychiatric beds available to the general public in the Greater New Orleans area has still not returned to pre-Katrina numbers, mirroring the national trend of a deficiency in inpatient beds overall. The low number of beds available to the uninsured general adult population and for medically assisted detoxification further deepens this issue.[7] One other glaring gap in the local behavioral health system is the lack of bilingual (English-Vietnamese and English-Spanish) mental health providers available to serve the city's low-income, largely uninsured immigrant populations. While there has been a decrease in inpatient beds, there has, however, been an increase in outpatient programs, including services such as Assertive Community Treatment, Forensic Assertive Community Treatment, and Intensive Case Management.[8] While these services are but one component of a larger continuum of community-wide mental health and substance abuse services, their growth is promising as it helps expand the availability of services to accommodate all New Orleanians with mental health issues.

### *Consumer Barriers to Care*

NOHD and partners successfully advocated for renewal of the Greater New Orleans Community Health Connection (GNOCHC) waiver through December 31, 2016 and have consistently exceeded their goals of Marketplace enrollment since March 2014. Despite these efforts, however, many New Orleanians remain ineligible for any insurance due to income or immigration status, and others, though eligible, cannot afford the premiums of their Marketplace options. For these and other reasons, 16.9% of adults in the city were uninsured in 2013.[9] Additionally, GNOCHC, though critical in providing thousands with primary and behavioral healthcare coverage, leaves many *under*insured as it does not cover prescriptions, specialty care, or hospitalizations. While being under- or uninsured are risk factors for poor health outcomes, underinsurance or lack of insurance status also endangers the sustainability

[6] http://504healthnet.org/
[7] New Orleans Health Department. New Orleans Inpatient Psychiatric Bed Capacity. 2015.
[8] Ibid.
[9] http://www.census.gov/

of the healthcare infrastructure as emergency rooms are often used as the only viable care option, placing a cost burden on the public purse. In regards to behavioral healthcare specifically, the low rate of inpatient beds in the area also limits access as provisions may not be available even if a person in need has the appropriate insurance.

These rates do not affect New Orleanians equally; New Orleans' African American residents disproportionately suffer lower rates of health insurance coverage and subsequent poorer health outcomes than whites in the city. For example, from 2009-2013, African Americans ages 18-64 were close to twice as likely to be uninsured than white adults. A survey conducted by the Kaiser Family Foundation in 2010 found that African Americans in Orleans Parish were significantly more likely than whites to have any chronic condition. For example, they were 1.6 times more likely to have diabetes than whites and almost twice as likely to die as a result of diabetes.[10]

In addition to low-income African Americans in New Orleans, many in the city's Latino and Vietnamese communities also experience barriers to health care access when compared to other groups. For example, a recent survey of Latino immigrants in New Orleans shows an estimated 62% of these immigrants as uninsured with only 14% responding that they had any form of health insurance. Of the respondents, only 45% indicated that they went to the doctor for medical care in the past two years, citing cost, not knowing where to go for care and anxiety over language access and their legal status affecting their decision to seek care.[11] While there is little data to show why or why not many vulnerable groups seek primary or behavioral healthcare services in New Orleans specifically, the poor health outcomes indicate the presence of some barriers between potential healthcare consumers and the healthcare system. These barriers may also result in emergency room use among the uninsured, placing the cost burden on the public purse.

## Work to Address Access

While some pieces of the healthcare infrastructure serving low-income populations in New Orleans continue to strengthen and there are active efforts to register eligible individuals for health insurance, we still have much work to do in order to create equitable access to physical and behavioral healthcare services. This includes ensuring that there is a sufficient supply of providers, as well as ensuring that providers interact with clientele in culturally competent ways

[10] New Orleans Health Department. Health Disparities in New Orleans. 2013. Available at: https://www.nola.gov/nola/media/Health-Department/Publications/Health-Disparities-in-New-Orleans-Community-Health-Data-Profile-final.pdf

[11] Puentes New Orleans, Committee for a Better New Orleans, New Orleans Health Department. I Don't Know Where to Go: Latino Community Health Issues in New Orleans. 2014. Available at: http://www.nola.gov/health-department/data-and-publications/ .

and in a client's own language. It also means structuring systems so that patients who need behavioral health help are able to access it in a seamless manner. From the "demand," or community side, needed work includes ensuring that all who qualify for insurance are enrolled in the correct program, as well as educating the public on why and where they are able to seek quality and relevant services, regardless of insurance status.

NOHD and partners are committed to the continued work of enrolling eligible New Orleanians in health insurance programs through intensive outreach work by Certified Application Counselors. We are also committed to ensuring that everyone, regardless of insurance status, understands where s/he/they can go for physical and behavioral healthcare. To this end, NOHD and partners have planned various educational outreach strategies and will, by summer 2015, devise a collective strategy to increase the health literacy of all New Orleanians. NOHD and partners also plan to work with healthcare providers to increase culturally competency and cultural humility skills through seminars and online trainings, as well as better equip providers to bridge gaps of health illiteracy with patients. To address gaps in the behavioral health system, NOHD and partners, most notably the Metropolitan Human Services District (MHSD) and Louisiana Public Health Institute (LPHI), will continue to implement and evaluate the coordination and integration of primary and behavioral healthcare services, as well as reinvigorate the cross-collaborative Behavioral Health Council to ensure that all have the opportunity to be seen by a provider.

## GOAL: Improve access to equitable, comprehensive and quality physical and behavioral health care services

| **Objective 1: By 2016, decrease the percentage of uninsured New Orleans residents from 16.9% to 16%.** | | | |
|---|---|---|---|
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Health Insurance Marketplace and GNOCHC outreach and enrollment events utilizing over 100 Certified Application Counselors<br><br>**MHSD also actively enrolls eligible clients in Medicaid or the Marketplace when applicable. Numbers not* | 13,000 outreach touches and assists | December 2015 | NOHD<br><br>504HealthNet<br><br>MHSD |

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| *currently available.* | | | |

| **Objective 2: By 2016, increase unique patients to Federally Qualified Health Centers by 5%.** | | | |
|---|---|---|---|
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| 504HealthNet potential funding for message testing and subsequent outreach materials and activities | Funding announcement | Funding announced by May 2015 | 504HealthNet |

| **Objective 3: Ensure accessible HIV/AIDS diagnostic, preventative, primary care and treatment services for 2,600 clients via the Office of Health Policy and AIDS Funding – City of New Orleans Ryan White-funded providers.** | | | |
|---|---|---|---|
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Link clients to medically appropriate client-centered services | # of clients linked to services | December 2015 | OHP |
| Targeted activities to promote an individual's awareness of Part A services to enable them to access care and treatment | # of clients informed of Part A services | December 2015 | OHP |
| Ensure provision of approved ART and non-ART medications | # of clients provided medications | December 2015 | OHP |

| **Objective 4: By June 2015, devise a collective strategy to assess and increase levels of health literacy among New Orleans residents, as well as increase health care providers' ability to address low health literacy and bridge knowledge gaps.** |
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| Evidence Base: http://www.cdc.gov/healthliteracy/learn/ |

| http://www.hrsa.gov/publichealth/healthliteracy/ | | | |
|---|---|---|---|
| Policy: TBD | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Research re: general population capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions | Research notes | May 2015 | NOHD; 504HealthNet; LA Language Access Coalition; Puentes; Committee for a Better New Orleans; VAYLA; MHSD |
| Write and submit proposal to further assess, address and increase levels of health literacy amongst New Orleans residents | Proposal submitted | June 2015 | NOHD<br>Partner organization to contribute to and submit proposal TBD |
| Rework messaging and branding, work with targeted partners to increase understanding of MHSD services | Finalized brochures;<br># of presentations;<br># of people reached | TBD | MHSD |
| Launch NOHD Health Literacy Committee, establish guidelines and Committee structure, redesign NOHD website | List of Committee members, roles and guidelines;<br>Redesigned NOHD website | December 2015 | NOHD |
| Distribute Vietnamese and Spanish-language health care resource guides to relevant community partners and residents | # of community-based organizations committed to dispersing resource guides | Ongoing | NOHD; 504HealthNet; LLAC; VAYLA; Puentes |

| **Objective 5: Continue to explore, implement, and evaluate primary and behavioral health coordination and integration in New Orleans** | | | |
|---|---|---|---|
| Evidence Base: *http://www.integration.samhsa.gov/workforce/Guiding_Principles_for_Workforce_Development.pdf* | | | |
| Policy: TBD | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Administer and evaluate New Orleans Charitable Health Fund grantee projects re: primary care, behavioral health, and linkages to social services | Project evaluations | June 2015 | LPHI |
| Form a 3-year plan to integrate primary and behavioral healthcare for adolescents in the GNO area. | Finalized plan | June 30, 2015 | LPHI |
| Co-location of MHSD and Daughters of Charity Services of New Orleans (DCSNO) New Orleans East to better integrate primary care and behavioral health services to population with serious and persistent mental illness | List of services offered by each provider;<br># clients served each month;<br># referrals made by each provider | April 1, 2015 | MHSD<br>DCSNO |

| **Objective 6: By July 2016, train 300 staff in the New Orleans health care sector in cultural competency and cultural humility.** | | | |
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| Evidence Base: *http://www.hrsa.gov/culturalcompetence/index.html* | | | |
| Policy: TBD | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Identify local institutions | List of potential | July 2015 | LLAC |

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|---|---|---|---|
| with which to partner to offer CEU credits for cultural competency trainings | institutions | | |
| Recruit healthcare sector professionals to attend Louisiana Language Access Coalition's 2016 conference, specifically the cultural competency training | # of healthcare sector professionals recruited to attend cultural competency training | July 2016 | LLAC<br>NOHD<br>CHI Steering Committee Members |
| Work with local experts to establish online cultural competency trainings offered for CEU credit | # of healthcare sector professionals completing online modules;<br>List of institutions partnered with to offer CEUs | July 2016 | 504Healthnet |

| **Objective 7: Establish plans to ensure that all New Orleanians are able to easily access quality and affordable behavioral healthcare resources.** | | | |
|---|---|---|---|
| Evidence Base: N/A | | | |
| Policy: TBD | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Convene the Behavioral Health Council to set two-year priorities | Meeting minutes | July 2015 | NOHD<br>MHSD |
| Develop a work group to address the dearth of bilingual behavioral health professionals in the GNO area | Work group participants and plans | July 2015 | TBD |

## PERFORMANCE MEASURES

| Long-term indicators: | Source: | Frequency: |
|---|---|---|
| Premature death in Orleans Parish, 2008-2010: 11,091 | National Center for Health Statistics | Every three years |
| Low Birthweight in Orleans Parish, 2013: 12.5% | LA Office of Public Health | Annual |
| Poor or fair health in Orleans Parish, 2006-20012: 18% | BRFSS | Annual |
| Poor physical health days in Orleans Parish, 2006-20012: 3.6% | BRFSS | Annual |
| Poor mental health days in Orleans Parish, 2006-20012: 4.4% | BRFSS | Annual |
| **Short-term indicators:** | **Source:** | **Frequency:** |
| Percent of uninsured, unincarcerated population in Orleans Parish, 2013: 16.9% | American Community Survey | Annual |
| Number of unique patients to FQHCs, 2013: 94,466 | 504HealthNet reports | Annual |
| Could not see a doctor in past 12 months because of cost, 2014: Waiting on data | BRFSS | Annual |

## ALIGNMENT WITH NATIONAL PRIORITIES

| Healthy People 2020 | National Prevention Strategy |
|---|---|
| Access to Health Services: | Elimination of Health Disparities: |
| *Objective 1.* Increase the proportion of | *Recommendation 2.* Reduce disparities in access to quality health care. |

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|---|---|
| persons with health insurance<br><br>*Objective 3.* Increase the proportion of persons with a usual primary care provider<br><br>*Objective 5*. Increase the proportion of persons who have a specific source of ongoing care<br><br>*Objective 6.* Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines<br><br><u>Mental Health and Mental Disorders:</u><br><br>*Objective 5.* Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral<br><br>*Objective 9.* Increase the proportion of adults with mental health disorders who receive treatment | *Recommendation 3.* Increase the capacity of the prevention workforce to identify and address disparities.<br><br><u>Reproductive and Sexual Health:</u><br><br>*Recommendation 4.* Enhance early detection of HIV, viral hepatitis, and other STIs and improve linkage to care.<br><br><u>Empowered People:</u><br><br>*Recommendation 1.* Provide people with tools and information to make healthy choices.<br><br><u>Clinical and Community Preventive Services</u>*:*<br><br>*Recommendation 5.* Reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk.<br><br>*Recommendation 6:* Enhance coordination and integration of clinical, behavioral, and complementary health strategies.<br><br><u>Mental and Emotional Well-being:</u><br><br>*Recommendation 4.* Promote early identification of mental health needs and access to quality services. |

# SOCIAL DETERMINANTS OF HEALTH

## Background

If you are poor, less educated or a minority in the United States, your prospects for living a long, healthy life are significantly worse than if you are more affluent, better educated or white.[12]

[12] Overcoming obstacles to health. Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America. 2008. Available at: http://www.rwjf.org/en/research-publications/find-rwjf-research/2008/02/overcoming-obstacles-to-health.html

The reasons behind this fact are nothing inherent to a particular race, ethnicity, or socioeconomic group; instead, these "health inequities" are differences in health "that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity."[13] While personal choice certainly plays a role in our health, the social, physical, environmental, and economic circumstances in which we live greatly affect and in some cases determine our health outcomes.

These non-biological factors contributing to one's health are formally referred to as the "Social Determinants of Health." Social Determinants of Health are: "The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world."[14]

Considering that many health disparities between groups are the result of dysfunctional systems which afford more opportunity to some groups over others, there is potential to affect health outcomes by working to change the way systems operate. In other words, we must work to unravel institutionalized discrimination to ensure that all people have equitable access to employment, healthy foods, a quality education, quality housing, quality transportation, and more.

## Social Determinants in New Orleans

The CHA illuminates the heavy health disparities in New Orleans and also presents statistics on the Social Determinants of Health behind many of these disparities. For one, poverty is not randomly distributed across the New Orleans population. Populations with marginal positions in the social structure (i.e., the young, non-white, less educated, and/or women) are more likely to live below the poverty level and in areas of concentrated poverty than those who occupy higher positions in the social structure (e.g., older, white, more educated, and men).

This uneven distribution often impacts health outcomes in these minority communities, not because they are predominantly Black, Hispanic, and/or women, but because concentrated poverty affects residents' opportunity for a quality education, job, quality housing, and access

[13] Virginia Department of Health. What is health inequity? January, 2012. Available at: http://www.vdh.virginia.gov/healthpolicy/healthequity/unnaturalcauses/healthequity.htm

[14] Commission on Social Determinants of Health (CSDH). Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.

to affordable and healthy foods, among other things. The effects of these conditions can be seen through many health statistics in the CHA, one of the most stark being the fact that there is a 25 year gap in life expectancy between residents of one of the city's most economically depressed and majority Black neighborhoods compared to those in the most affluent, majority white neighborhoods.[15]

## Work to Address the Social Determinants of Health: Health in All Policies

While the NOHD currently addresses Social Determinants of Health through many of its initiatives, the Department seeks to establish a coordinated, formalized response to addressing these determinants in the coming years. With guidance from the CHI Steering Committee and additional outside partners, the NOHD is currently formulating a plan to work with other City departments and ensure that health is considered in decision-making efforts across sectors and policy areas. We have already engaged the following City departments in conversations around health equity: The Network for Economic Opportunity; Office of Place-Based Planning; New Orleans Redevelopment Authority; Housing Authority of New Orleans, and; Office of Housing Policy and Community Development. In the public health world, this type of work is popularly referred to as Health in All Policies. The overall goal of this work is to embed a health equity lens throughout City government which will eventually lead to more equitable policies and systems across the city, improving health outcomes for all.

## GOAL: Create social and physical environments that promote good health for all

| **Objective 1: By April, 2015 the NOHD will adopt a Policy Statement on Health in All Policies (HiAP) in New Orleans City government.** | | | |
|---|---|---|---|
| Evidence Base:<br>*http://www.naccho.org/topics/environmental/HiAP/*<br>*http://www.phi.org/resources/?resource=hiapguide* | | | |
| Policy: Yes. The NOHD will issue an internal policy statement re: HiAP. | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Draft a Policy Statement | Draft statement | March 2015 | NOHD |
| Policy Statement approved by NOHD | Written approval from | April 2015 | NOHD |

[15] Place Matters for Health in Orleans Parish: Ensuring Opportunities for Good Health for All. 2012. Available at: http://www.orleansplacematters.org/wp-content/uploads/2012/06/CHER-Final-text.pdf

| | | | |
|---|---|---|---|
| leadership and CHI Social Determinants of Health priority area group. | NOHD leadership;<br>Verbal approval from Priority Area group | | |
| NOHD formally adopts and publishes the policy statement | Published statement | April 2015 | NOHD |
| Educate NOHD staff re: Social Determinants and Policy Statement | Meeting with NOHD staff | April 2015 | NOHD |

| **Objective 2: By July 2015, NOHD will hold meetings with representatives from at least 5 other City Departments and pursue collaboration on at least one equity-related effort.** | | | |
|---|---|---|---|
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Identify and contact City departments | List of departments contacted | March 2015 | NOHD |
| Hold meetings with representatives from 5 different City departments | Meeting minutes | June 2015 | NOHD |
| Partner with at least one City department on equity-related issue | Description of collaborative work | July 2015 | NOHD |

| **Objective 3: By December 2015, NOHD will begin implementation of a communications plan to inform key stakeholders in City government on Health in All Policies and garner their support for cross-departmental equity work.** | | | |
|---|---|---|---|
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |

| | | | |
|---|---|---|---|
| Research other HiAP communications plans | Research notes | June 2015 | NOHD |
| Complete a draft communications plan and communications materials | Draft plan and materials | August 2015 | NOHD |
| Communications plan and materials approved by NOHD leadership and CHI Social Determinants of Health priority area group. | Written approval from NOHD leadership;<br>Verbal approval from Priority Area group | September 2015 | NOHD |
| Implement communications plan | Meetings with City departments and leaders | December 2015 | NOHD |

## PERFORMANCE MEASURES

| **Short-term indicators:** | **Source:** | **Frequency:** |
|---|---|---|
| TBD<br>(NOHD will populate this section once we decide which departments to initially collaborate with for HiAP work) | | |
| **Long-term indicators:** | **Source:** | **Frequency:** |
| Persons below poverty level in Orleans Parish, 2009-2013: 27.3% | U.S. Census | Every 5 years |
| Unemployment in Orleans Parish, 2014: 7.8% | County Health Rankings and Roadmaps | Annual |
| Children in poverty in Orleans Parish, 2014: 41% | County Health Rankings and Roadmaps | Annual |

### ALIGNMENT WITH NATIONAL PRIORITIES

| Healthy People 2020 | National Prevention Strategy |
|---|---|
| Social Determinant of Health Topic Area<br>Recommended resources to address SDOH | Healthy and Safe Community Environments:<br><br>*Recommendation 4.* Integrate health criteria into decision making, where appropriate, across multiple sectors<br><br>Elimination of Health Disparities:<br><br>*Recommendation 1*. Ensure a strategic focus on communities at greatest risk |

# VIOLENCE PREVENTION

## Background

Violence in any form is a public health issue. Victims of violence themselves may suffer a myriad of issues, including temporary or permanent physical harm, emotional trauma, and even death. Witnessing violence can also have a long-term impact on an individual; witnesses of community violence and those with prolonged exposure to violence during childhood are more likely to be victims of violence and are at elevated risk of post-traumatic stress disorder (PTSD), depression, anxiety, aggression, and problems in school.[16]

In addition to affecting the health of individuals, violence can also affect the health outcomes of entire communities. According to The Prevention Institute, violence and the fear of violence are "major roadblocks to the success of chronic disease prevention strategies."[17] This is because, for one, people who feel unsafe in their neighborhood are understandably less likely to use local parks, walk or let their children play outside, and access public transportation, all of which affect their level of physical activity. Additionally, communities perceived as "unsafe" less often benefit from investments such as healthy food retail and recreation centers. These effects are disproportionately prominent in communities of color and low-income populations across the

[16] Salloum A., Overstreet, S. (2012). Grief and trauma intervention for children after disaster: Exploring coping skills versus trauma narration. *Behavioral Research and Therapy*, 50(3), 169-179.
[17] http://www.preventioninstitute.org/focus-areas/preventing-violence-and-reducing-injury/connecting-safety-to-chronic-disease.html

nation, further widening health and safety inequities between these and more privileged communities.[18]

## Violence in Louisiana and New Orleans

### *Murder*

There were 150 murders in New Orleans in 2014. This was a marginal decrease from the 156 murders in 2013, yet it was a substantial decrease from the 199 murders in 2011 and also marked the city's lowest murder rate in 43 years.[19,20] Despite this change, however, New Orleans still has one of the highest murder rates in the country, and nonfatal shootings increased in 2014 by 23%, demonstrating that violent crime remains a major issue.[21]

In New Orleans, victims and perpetrators of murder were predominately found to be unemployed, African-American males between the ages of 16-25 years, many of whom had previous criminal records and little formal education. For example, according to the Greater New Orleans Drug Demand Reduction Coalition, 47% of murder offenders in the GNO area had a prior arrest for drug offense.[22] When considering these statistics, it is important to also consider that many risk factors for violence, including poor access to quality education, concentrated poverty, racism, and some mental health issues, are results of systemic inequities and do not reflect the innate nature or character of a particular demographic.

### *Domestic Violence and Sexual Assault*

Unlike murder, it is difficult to obtain accurate rates of domestic violence and sexual assault as many of these crimes go un- or underreported for a myriad of reasons, including fear of further violence and potential distrust of the police, amongst others. Louisiana ranked fourth highest out of all 50 states in its rate of females murdered by men in 2012. The vast majority (93%) of these women were murdered by someone they knew.[23] These statistics, however, do not reflect the multifaceted types of domestic violence in the state as not all domestic violence ends in murder, and intimate partner violence also includes women abusing men and abuse in Lesbian, Gay, Bisexual, Transgender, or Queer (LGBTQ) relationships. In New Orleans, New Orleans Police Department (NOPD) records show that in 2014, there were 2,601 arrest and warrant reports issued for incidences of domestic violence. This number, however, only reflects incidents resulting in the arrest of a suspect or a warrant being issued for a suspect and

[18] Ibid.
[19] http://nolaforlife.org/media/20150102-nola-murder-rate-falls/
[20] http://www.nola.gov/mayor/press-releases/2015/20150102-43-year-historic-murder-low/
[21] http://nolaforlife.org/media/20150102-nola-murder-rate-falls/
[22] http://www.citizensfor1.com/GNO_drug-reduction_initiative.html
[23] http://www.vpc.org/studies/wmmw2014.pdf

does not include any information on all other incidents that do not result in probable cause for an arrest or warrant.

In 2013, there were 176 reported rapes in New Orleans, up from 136 reported rapes in 2012, an increase of almost 30%.[24] It is virtually impossible to know, however, if this increase indicates an increase in sexual assault in the city or simply an increase in victims reporting these crimes. Even this number, however, drastically underestimates rates of sexual assault. In forthcoming research, through a survey of 1,000 New Orleans university students, 37% of surveyed students reported an act of sexual coercion in the past year to researchers, and 18% reported an act that would be classified as rape under the law. Less than 4% of the respondents whose experiences met the definition of rape said they reported it to law enforcement or another official body.[25]

## Work to Prevent Violence: NOLA For Life, Blueprint for Safety, DVAC, SART

### *NOLA For Life*

NOLA For Life is Mayor Mitch Landrieu's comprehensive murder reduction strategy which takes a holistic, public health approach to violence reduction by seeking to address the problem of murder on a variety of different levels. The city-wide, collaborative strategy outlines initiatives in the following five categories: Stop the Shooting; Invest in Prevention; Promote Jobs and Opportunity; Get Involved and Rebuild Neighborhoods, and; Improve the NOPD. By employing this holistic approach, the City of New Orleans hopes to overcome long-standing challenges to achieve its vision to have youth and families flourishing in safe and healthy neighborhoods, with access to quality educational, economic and cultural opportunities that allow them to become self-reliant, self-sufficient and creative human beings capable of giving back to the world.

NOHD is taking the lead on several NOLA For Life initiatives. These include leading the NOLA For Life Services Collaborative, working with partners to promote group violence reduction strategies, improving trauma response and promoting the use of restorative approaches in schools, promoting Positive Behavioral Interventions and Supports, and promoting the Realtime Resources mobile website, a web-based resource with up-to-date, detailed listings of all social and community-based services available to residents of New Orleans.

Over the coming months and years, NOHD and partners are committed to strengthening the capacity of organizations working with the NOLA For Life target population through capacity-

[24] http://www.nola.com/crime/index.ssf/2014/02/new_orleans_crime_statistics_2.html

[25] Forthcoming article: Kondkar, M. The Triad of Gender-Based Violence: College Students' Experiences with Stalking, Sexual Coercion, and Partner Violence. Preparation of manuscript for submission to *Violence Against Women.* (Survey of 1,000 college students (500 from Tulane University, 500 from Loyola University) on experiences of sexual assault).

building trainings, data sharing agreements, and the standardization of processes and measurement systems. NOHD and partners are also committed to promoting valuable resources targeted to this population, including the Realtime Resource application and the promotion of restorative approaches in local schools through a partnership with The Center for Restorative Approaches.

### *Blueprint for Safety and the Domestic Violence Advisory Committee (DVAC)*

New Orleans is one of three jurisdictions across the nation chosen by the Office on Violence Against Women to adapt The Blueprint for Safety, a model policy coordinating the criminal justice response to domestic violence, from 911 through probation and parole. The Blueprint is designed to prevent victims of domestic violence from falling through the cracks by working to improve and strengthen institutional response to domestic violence. NOHD's Blueprint mission is to respond more quickly and ably to domestic violence in order to stop the violence and save lives, and it works with the following criminal justice institutions to provide complete agency guidelines prioritizing victim engagement and holding offenders accountable: 911 Communications, NOPD patrol and investigation, Orleans Parish Sheriff's Office, the Orleans Parish District Attorney's Office, Domestic Violence Monitoring Court, Municipal Court and the Louisiana Department of Corrections.

New Orleans was the first of the three demonstration communities to launch the Blueprint for Safety in October 2014. Since the launch, the NOHD has been working with its criminal justice partners to train criminal justice practitioners on the Blueprint policies, and develop plans to implement and track the impact of Blueprint policies. Additionally, the NOHD leads the Domestic Violence Advisory Committee; a body tasked with making recommendations for systems improvement regarding domestic violence, and will be leading DVAC members in a goal and objective setting process this year in order to assure efficient coordination and impact.

### *New Orleans Sexual Assault Response Team (SART)*

The NOHD also co-leads the New Orleans Sexual Assault Response Team (SART), a collaboration of agencies working together to strengthen New Orleans' response to sexual assault. SART members include City agencies such as the New Orleans Police Department and the Orleans Parish District Attorney's Office, as well as academic institutions, advocate and service organizations. The SART currently has a strategic plan which speaks to its efforts to:

- Form strong partnerships between all agencies involved in the sexual assault response to improve and streamline services for survivors
- Provide ongoing training and outreach to agencies and communities
- Expand the scope of services for survivors to reach all communities in New Orleans

- Work with the community to raise awareness and prevent sexual assault
- Hold offenders accountable for sexual assault

Similar to its planned work with DVAC, the NOHD intends to lead SART members in a process wherein the collective will set goals and develop a strategy for its collective work.

## CHIP Notes

There are many organizations across many sectors working to prevent violence and improve response to violence in New Orleans. In lieu of cataloguing all the individual work of these organizations, the CHIP will track the progress of the collective impact initiatives NOLA For Life initiatives, the Blueprint for Safety, DVAC and SART.

## GOAL: Prevent violence and reduce its consequences.

| **Objective 1: By June 2016, increase visits to the Realtime Resources mobile web application by 10%.** | | | |
|---|---|---|---|
| Evidence Base: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70452 | | | |
| Policy: None | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Record baseline visits to Realtime Resources web application | # of visits | June 2015 | NOHD |
| Promote Realtime Resources web application to Nola For Life population through demonstrations to partner organizations, email blasts and social media | # of demonstrations;<br># of email blasts;<br>Development of social media platform | Ongoing | NOHD |

| **Objective 2: Increase the number of NOLA For Life agencies that adopt and agree to share data across a universal/shared client tracking and performance management system from 0 to 5 by April 2015.** | | | |
|---|---|---|---|
| Evidence Base:<br>http://www.hrsa.gov/quality/toolbox/methodology/performancemanagement/index.html | | | |
| Policy*:* Yes. Data sharing MOUs between agencies. | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Form collaborative coalition to share data | List of agencies in collaboration | January 2015 | City of New Orleans<br>Baptist Community Ministries |
| Signing of data sharing MOUs | # of signed MOUs | February 2015 | Data Sharing Council<br>Social Solutions |
| Determine which data to share and which data points to track | Catalogue of data points | March 2015 | Data Sharing Council<br>Efforts To Outcomes Services Collaborative |

| **Objective 3: By March 2015, the NOLA For Life Services Collaborative will have determined operations, performance, and monitoring standards for agencies working with the NOLA For Life target population.** | | | |
|---|---|---|---|
| Evidence Base:<br>Best practices TBD by the Services Collaborative | | | |
| Policy*:* Yes. NOHD will issue a Pilot RFP requiring adherence to the standards compiled by the Services Collaborative. | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Develop common intake and referral components for providers serving NOLA For Life target population | List of components | February 2015 | NOHD |
| Develop program standards and evidence based best practices | List of standards and best practices | February 2015 | NOHD |

| | | | |
|---|---|---|---|
| for providers | | | |
| Develop common performance measures for providers servicing high-risk boys and men of color | List of performance measures | February 2015 | NOHD |
| Update CHIP to reflect the newly developed intake and referral components, program standards and evidence based best practices, and performance measures | Updated Objective | March 2015 | NOHD |
| Complete 4 trainings for NOLA For Life partner agencies | List of completed trainings and agencies trained | December, 2015 | NOHD |
| Offer two funding opportunities to NOLA For Life partner agencies | List of funding opportunities and agencies offered | December, 2015 | NOHD |

| **Objective 4: By December 2015, New Orleans schools will have made 60 referrals to The Center for Restorative Approaches, and The Center for Restorative Approaches will have trained 20 additional volunteers.** | | | |
|---|---|---|---|
| Evidence Base*:* http://www.restorativejustice.org/ | | | |
| Policy: Yes. Contract between The City of New Orleans and Center for Restorative Approaches. Also, schools sign an agreement with the Center when selected for the whole-school approach. | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Work with 3 schools to increase referrals made to the Center for Restorative Approaches | 60 referrals made to The Center for Restorative Approaches | December, 2015 | NOHD |
| Train 20 volunteers in restorative approaches | List of 20 volunteers trained | December 2015 | The Center for Restorative Approaches |

| **Objective 5: By December 2015, have a completed collaborative plan to ensure City agency implementation and tracking of Blueprint for Safety protocol.** | | | |
|---|---|---|---|
| Evidence Base: http://www.praxisinternational.org/blueprintforsafety.aspx | | | |
| Policy: Yes. Six agencies adopted Blueprint For Safety policies. | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Conduct initial meetings with all participating City agencies to determine Blueprint for Safety implementation plans | Meetings conducted with each agency | April 2015 | NOHD – BFS Interagency Coordinator |
| Complete implementation plans for each agency | Completed plans | December 2015 | NOHD – BFS Interagency Coordinator |
| Revise CHIP to incorporate implementation plans | Revised objective | January 2016 | NOHD |

| **Objective 6: By December 2015, have completed a minimum of 13 trainings with the New Orleans criminal justice system.** | | | |
|---|---|---|---|
| Evidence Base*:* http://www.praxisinternational.org/blueprintforsafety.aspx | | | |
| Policy: Yes. Six agencies adapted Blueprint For Safety policies, including participating in trainings. | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Scheduling and conducting trainings | # of trainings completed | December 2015 | NOHD – BFS Interagency Coordinator |

| **OBJECTIVE 7: By May, 2015, DVAC and SART will develop defined goals for the Community Health Improvement Plan.** | | | |
|---|---|---|---|
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Meet with DVAC to introduce process | Meeting minutes | February 2015 | NOHD |
| Meet with SART to | Meeting minutes | February 2015 | NOHD |

| | | | |
|---|---|---|---|
| introduce process | | | |
| Meetings to develop shared goals | Meeting minutes;<br><br>Final documents reflecting plans for both bodies | May 2015 | NOHD |

## PERFORMANCE MEASURES

| **Short-term indicators:** | **Source:** | **Frequency:** |
|---|---|---|
| <u>Objectives 1-4</u><br>Murder rate in New Orleans,<br>2014: approximately 40 per 100,000 | City of New Orleans | Annual |
| <u>Objective 5-6</u><br>TBD through the Blueprint for Safety tracking and implementation planning process | Participating City Agencies | TBD |
| <u>Objective 7</u><br>TBD through DVAC and SART Goal and Objective setting process | TBD | TBD |
| **Long-term indicators:** | **Source:** | **Frequency:** |
| <u>Objectives 1-4</u><br>Percentage of youth who feel safe in their school<br>2012: 6th grade: 80.6%, 8th grade: 77%, 10th grade: 78.8%, 12th grade, 69.2% | Louisiana Caring Communities Youth Survey* (LA CCYS) | Every two years |
| Percentage of youth who feel safe in their neighborhood<br>2012: 6th grade: 68.4%, 8th grade: 78.1%, 10th grade: 72.2%, 12th grade: 68.1% | Louisiana Caring Communities Youth Survey | Every two years |
| <u>Objectives 5-7</u><br>Improved victim experiences with the New Orleans Criminal Justice System | Focus groups (beginning 2016) | Annual |

| | | |
|---|---|---|
| Improved sense of ability to respond to domestic violence cases among practitioners | TBD | TBD |
| Objective 7<br>TBD through DVAC and SART Goal and Objective setting process | TBD | TBD |

**The LA CCYS is currently experiencing sampling limitations. Other data sources will be explored for these or similar measures if sample size does not improve.*

### ALIGNMENT WITH NATIONAL PRIORITIES

| Healthy People 2020 | National Prevention Strategy |
|---|---|
| Adolescent Health:<br><br>*Objective 11.1.* Reduce the rate of minor and young adult perpetration of violent crimes.<br><br>Injury and Violence Prevention:<br><br>*Objective 39.* Reduce violence by current or former intimate partners<br><br>*Objective 40* (Developmental). Reduce sexual violence*<br><br>Social Determinants of Health:<br>Objectives included in the following five key areas: Economic Stability; Education; Health and Health Care; Neighborhood and Built Environment; Social and Community Context | Injury and Violence Free Living:<br><br>*Recommendation 5:* Strengthen policies and programs to prevent violence<br><br>*Recommendation 6:* Provide individuals and families with the knowledge, skills, and tools to make safe choices that prevent violence and injuries |

**this includes rape, attempted rape, other abusive sexual contact, and non-contact sexual abuse*

# HEALTHY LIFESTYLES

## Background

Engaging in healthy behaviors including proper nutrition and physical fitness throughout the life course can help reduce the risk of obesity-related conditions like diabetes, stroke, heart disease and hypertension. Healthy eating and physical activity can also help with management of chronic disease symptoms.

### *Health in Louisiana and New Orleans*

Louisiana is among the unhealthiest states in the nation, currently ranking 48th in the United Health Foundation's annual America's Health Rankings.[26] According to the 2013 Behavioral Risk Factor Surveillance Survey (BRFSS) results, Louisiana also has the sixth highest obesity rate in the nation at 33.1%.[27] In Orleans Parish, 31% of adults are obese, contributing to high rates of death from preventable diseases such as heart disease, stroke, type 2 diabetes and cancer.[28] Some 29% of adults in New Orleans report being physically inactive, despite the fact that 95% of New Orleanians are estimated to have access to exercise opportunities.[29] While there is not current data regarding youth obesity in New Orleans, 2007 data shows that only 36% of high school students meet recommended levels of physical activity and only 22% report eating 5 or more servings of fruits and vegetables per day.[30]

These statistics do not affect New Orleans residents equally. Approximately 41% of African Americans in the city are obese compared to 30% of whites and 27% of Latinos.[31] A 2010 survey of adults in New Orleans found that African Americans were significantly more likely than whites to have any chronic condition and more likely than whites to die from that condition; African Americans in New Orleans are 33% more likely to die of heart disease and three times more likely to die of diabetes than whites.[32]

There are many factors driving these disparities. One's neighborhood, income, and race are interrelated in New Orleans and directly affect one's health. An examination of life expectancy by zip code revealed differences in life expectancy of as much as 25 years between the highest (majority high income white) and lowest life expectancies (majority low income black) in the city.[33] While personal choice drives some of the statistics, one's environment has an immense impact on one's ability to make and follow through on healthy choices. For example, while some neighborhoods have healthy and affordable food retail options, 12.5% of the New

[26] http://www.americashealthrankings.org/
[27] http://www.cdc.gov/obesity/data/adult.html
[28] http://www.countyhealthrankings.org/rankings/data/LA
[29] Ibid.
[30] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance – Selected Steps Communities, United States, 2007 and Youth Risk Behavior Surveillance – Pacific Island United States Territories, 2007. Surveillance Summaries, November 21, 2008. MMWR 2008;57 (No. SS-12).
[31] http://www.cdc.gov/obesity/data/adult.html
[32] New Orleans Health Department. Health Disparities in New Orleans. 2013. http://nola.gov/nola/media/Health-Department/Publications/Health-Disparities-in-New-Orleans-Community-Health-Data-Profile-final.pdf
[33] http://www.orleansplacematters.org/wp-content/uploads/2012/06/CHER-Final-text.pdf

Orleans population lives in food "swamps" where unhealthy, cheap food options are far more prominent than fresh, healthy food options.[34]

## Work to Enable Healthy Lifestyles: Fit NOLA

To promote healthy lifestyles, the City of New Orleans took action to become a *Let's Move!* city in February 2011 as part of First Lady Michelle Obama's childhood obesity elimination initiative. As part of this effort, Mayor Mitch Landrieu launched Fit NOLA, a collective impact initiative, in 2012. With funding and support from the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity and the Arkansas Center for Health Improvement, the City convened key partners to help develop the Fit NOLA Partnership Shared Action Blueprint to guide Fit NOLA.

The New Orleans Health Department serves as the backbone organization for Fit NOLA, and the initiative counts approximately 200 organizational partners. Fit NOLA uses a multi-sector approach to achieve shared goals of building capacity, increasing awareness, and setting institutional policy and standards to improve the health and fitness of all New Orleanians, with the goal of becoming one of the nation's top ten fittest cities by 2018.[35] The initiative is guided by a Coordinating Group and features the following six sector groups with their respective goals:

1. Active Community Design: To create access to nutritional and physical activity by way of community design/built environment
2. Business Sector: To connect NOLA businesses to workplace wellness initiatives and policies
3. Community Sector: To create opportunities for the entire community, down to the individuals, to connect with wellness programming.
4. Early Childhood Sector: Create access to nutritional and physical activity for children younger than school age.
5. School and Out-of-School Sector: Create access to nutritional and physical activity in and out of school
6. Healthcare Sector: Goal to be determined

Equity is a core value of Fit NOLA. The Blueprint states that "every child and family should have access to a variety of safe outdoor places to exercise and play and nutritious food regardless of geography, gender, race, ethnicity and income."

[34] http://nola.gov/nola/media/Health-Department/Publications/Healthy-Lifestyles-in-New-Orleans-Community-Health-Data-Profile-final.pdf

[35] New Orleans Health Department: Fit NOLA Partnership Shared Action Blueprint. Summer 2012. Available at: http://nola.gov/nola/media/Health-Department/Healthy%20Lifestyles/Fit-NOLA_Book.pdf

### *Fit NOLA Plans*

Over the past two years, Fit NOLA has successfully convened sector groups and other partners to complete projects and create a vision for future efforts. As Fit NOLA continues to grow, the New Orleans Health Department and Coordinating Group will work to refresh the original Fit NOLA Blueprint beginning in January 2015. With the refreshed Blueprint, the Fit NOLA team will determine an initiative-wide measurement and evaluation protocol, create tangible opportunities for individuals to connect with Fit NOLA, and ensure maximum impact of Fit NOLA projects. The New Orleans Health Department will facilitate this planning process with monthly meetings until the document is completed in Spring 2015. Once completed, the CHIP will be updated to reflect the refreshed Fit NOLA Blueprint.
For more information on Fit NOLA and to sign up for the Fit NOLA newsletter, please visit: http://www.nola.gov/health-department/fit-nola/

## GOAL: New Orleans will be a top ten fittest city in the United States by 2018.

| **Objective 1: By May 2015, Fit NOLA will have a refreshed strategic plan, complete with a refreshed monitoring and evaluation plan, descriptions of strategies and activity plans, and designated roles for the New Orleans Health Department and partner organizations.** | | | |
|---|---|---|---|
| Evidence Base*:* TBD | | | |
| Policy*:* TBD | | | |
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Perform literature review re: design, implementation, and monitoring and evaluation of successful obesity prevention programs and initiatives | Completed literature review | January 29, 2015 | NOHD |
| Complete progress report of Action Strategies outlined in original Fit NOLA Blueprint | Completed progress report | January 29, 2015 | NOHD |

| | | | |
|---|---|---|---|
| Host monthly strategic planning sessions with Fit NOLA Coordinating Committee | Completed sessions | Session #1, January 2015; Session #2, February 2015; Session #3, March 2015 | NOHD |
| Unveiling of refreshed Fit NOLA Strategic Plan | Strategic Plan distributed to attendees at Fit NOLA's Spring Forum | May, 2015 | NOHD |
| Update CHIP to reflect refreshed Fit NOLA Strategic Plan | Updated CHIP | May, 2015 | NOHD |

## PERFORMANCE MEASURES

| **Short-term indicators:** | **Source:** | **Frequency:** |
|---|---|---|
| TBD | | |
| **Long-term indicators:** | **Source:** | **Frequency:** |
| New Orleans overall state of health and fitness ranking among the 50 most populous metropolitan areas in the United States, 2014: 39th | American College of Sports Medicine's American Fitness Index Report | Annual |

## ALIGNMENT WITH NATIONAL PRIORITIES*

| **American College of Sports Medicine's American Fitness Index Indicators** |
|---|
| Decrease the percentage of persons that are overweight and/or obese. |
| Increase the proportion of persons that are physically active at least moderately |
| Increase the proportion of persons that eat 5+ servings of fruits and vegetables per day |

**These are subject to change as the Fit NOLA partnership reexamines which national body to which it will align its goals and objectives*

# FAMILY HEALTH

## Background

According to the Life Course Perspective, an individual's health is dependent on her/his/their health, psychological, economic, education, social, and community environments from the point of conception through the grave. In other words, where you live, learn, work and play heavily influence your health for the entirety of your life. In New Orleans, the majority of adverse birth outcomes are the direct result of the mother's health status when she became pregnant, which, according to this Life Course Perspective, reflect the poor conditions of her surroundings.[36] As such, low birth weight (babies weighing less than 5.5 pounds at birth) is one of the strongest predictive indicators of a community's overall health. In their own right, adverse birth outcomes are also linked to challenges throughout the life course, including decreased educational attainment, asthma, cardiovascular disease, and diabetes.
This perspective emphasizes that risk factors undermine an individual's ability to achieve and maintain optimal immediate and future health, while protective factors support an individual's health and can help make an individual more resilient in the face of challenges. Thus, for a person or a community to experience optimal health, s/he/it must experience reduced risk factors and enhanced protective factors across the health, psychological, economic, education, social and community sectors.[37]

## Family Health in Louisiana and New Orleans

In 2012, 8% of babies in the United States and 10.8% of babies in Louisiana were born at a low birth weight.[38] New Orleans fared even worse, with 12% of babies born at less than 5.5 pounds.[39] As risk and protective factors vary by neighborhood, there are understandably more low birth weight babies being born to residents of some neighborhoods than others. Table 1 shows demographic information for four New Orleans neighborhoods with unusually high rates of low weight births.

As seen in Table 1, in addition to exceptionally high rates of low birth weight babies, these hotspots exceed (sometimes vastly) citywide rates in terms of risk factors including percentage of unemployed adults, percentage of children living in poverty, percentage of population experiencing housing cost burden, and homicides per 1,000 people. Further elucidating the fact

[36] Louisiana Office of Public Health (per a private data request)
[37] New Orleans Health Department. Child and Family Health in New Orleans Report. 2013. Available at: www.nola.gov/health
[38] Kids Count Data Center. 2015. Available at: http://datacenter.kidscount.org/
[39] New Orleans Health Department. Child and Family Health in New Orleans Report. 2013. Available at: www.nola.gov/health

that health and other inequities locally and nationally typically fall across racial and ethnic lines, these neighborhoods are almost all homogenously Black.

***Table 1:*** *New Orleans Low Birth Weight Hotspot Neighborhood Clusters, 2013*[40]

| | Hotspot #1 (Hollygrove, BW Cooper, Dixon, Gert Town) | Hotspot #2 (Behrman) | Hotspot #3 (Little Woods, Read East, Read West) | Hotspot #4 (Plum Orchard, Pines Village) | New Orleans |
|---|---|---|---|---|---|
| **Population** | 10,067 | 8,064 | 43,194 | 3,951 | 343,829 |
| **Low Birth Weight**[41] | 22.5 | 18.4 | 19.8 | 18.9 | 12.0 |
| **Black (%)** | 90.9 | 81.5 | 90.7 | 95.7 | 60.0 |
| **Unemployed (%)** | 22.0 | 13.1 | 13.7 | 11.4 | 11.4 |
| **Children < 18 living in poverty (%)** | 51.7 | 41.9 | 40.8 | 26.1 | 34.4 |
| **Experiencing Housing Cost Burden (%)** | 73.3 | 64.8 | 75.3 | 67.4 | 63.0 |
| **Homicides per 100,000** | 93 | 54 | 23 | 55 | 40 |

## Work to Address Family Health: Healthy Start New Orleans Community Action Network (CAN)

### *The Child and Family Health Report*

In February 2013, the New Orleans Health Department (NOHD) and Healthy Start New Orleans (HSNO) invited leaders from 18 local and state agencies that work with New Orleans families to join the newly developed Children and Families Coalition. The aim of this coalition was to determine gaps in services available to New Orleans families and how to address those gaps employing the Life Course Perspective.

To ensure data-driven decision making, the NOHD and HSNO developed the Child and Family Health Report with the help of organizational partners and community members. The report

[40] Ibid.
[41] Louisiana Office of Public Health (per a private data request)

includes an in-depth analysis of New Orleans neighborhoods based on 12 risk factors and six protective factors as methods to indicate the wellbeing of a family and/or a young child in the neighborhood. These 18 indicators span across the health, economic, education, social and community domains.

### *Collective Impact: The Community Action Network*

Using this report as a foundation, NOHD and HSNO will reconvene the Children and Families Coalition in late February 2015 as the Community Action Network (CAN). The CAN will be a collective impact initiative with NOHD and HSNO as the backbone organization. Considering the Life Course Perspective and importance of addressing social determinants of health, the CAN will engage participants and partners from a wide variety of sectors, including health, economic, education, social and community agencies to develop a common agenda with shared outcomes to minimize risk factors and maximize protective factors. The CAN will use a place-based approach to improve community wellness and will focus initial work on the four "hotspot" neighborhood clusters in Table 1.

To ensure community participation and integrity of the work, select HSNO participants will be involved in the CAN via an active role on the Service Area Advisory Committee (SAAC) where they will not only assist with outreach, but will provide their perspectives on proposed goals and activities.

## CHIP Notes

There are many organizations across many sectors working to improve family and neighborhood health in New Orleans. In lieu of cataloguing all the individual work of these organizations, the CHIP will track the progress of the CAN, the collective impact initiative working to unite these efforts under overarching goals, objectives and action plans. Additionally, as the CAN progresses in defining its goals, objectives and work plan, the CHIP will be updated to reflect these changes.

## GOAL: Assure that each young child and his/her family may achieve and maintain their optimal well-being (CAN Goal)

| **Objective 1: By July, 2015, the Community Action Network will implement its action plans to improve family health in four pre-determined "hot spot" areas of New Orleans.** |
|---|
| Evidence Base: http://www.wkkf.org/resource-directory/resource/2009/07/health-matters-the-role-of-health-and-the-health-sector-in-place-based-initiatives-for-young |
| Policy: TBD by CAN |

| Activity | Performance Indicator | Target Date | Lead Organization |
|---|---|---|---|
| Identify and invite potential CAN members to join the CAN. Ensure members represent a wide variety of agencies in health, economic, education, and social sectors | List of CAN members invited to first meeting | February 2015 | HSNO CAN Coordinator<br><br>CHI Steering Committee |
| Establish regular quarterly CAN meeting times and monthly neighborhood-level meeting times | List of established meeting times and attendance records | February 2015 | HSNO CAN Coordinator |
| Develop a shared vision, performance and action plan for CAN work in each hotspot | Documented overall vision and performance plans for each hotspot | May 2015 | HSNO CAN Coordinator<br><br>CAN members |
| Develop core CAN leaders and subgroups for each hot spot with identified point people | List of core CAN leaders, subgroup membership, and point people for each subgroup | May 2015 | HSNO CAN Coordinator<br><br>CAN Members |
| Update CHIP to reflect CAN action plans | Updated CHIP | June 2015 | NOHD CHI Program Lead<br><br>HSNO CAN Coordinator |
| Build relationships with relevant community leaders, service-providers and agencies in each of the target areas | List of leaders, providers, and agencies | July 2015 | CAN Members |
| Begin implementing action plans | | September 2015 | CAN Members |

| Objective 2: By December 31, 2018, build the percentage of Healthy Start New Orleans SAAC participants on the CAN to 20% and continue to build SAAC members' capacity. | | | |
|---|---|---|---|
| **Activity** | **Performance Indicator** | **Target Date** | **Lead Organization** |
| Identify and invite HSNO participants to serve on the SAAC | # of invitations | Ongoing | HSNO CAN Coordinator |
| Host regular SAAC-sponsored meetings to encourage participation in the SAAC | HSNO Health Education classes incorporate SAAC topics | Ongoing | HSNO CAN Coordinator<br>HSNO Health Education Coordinator |
| Host forums and plan training opportunities for SAAC members in leadership, life skills, self-advocacy, and organizational skills. | Attendance records from forums and training opportunities | December 2015 | HSNO CAN Coordinator<br>CAN members<br>SAAC members |
| Invite SAAC members to attend CAN and subgroup meetings | List of SAAC participant representation at CAN meetings and in subgroups | Ongoing | HSNO CAN Coordinator |

## PERFORMANCE MEASURES

| **Short-term indicators:** | **Source:** | **Frequency:** |
|---|---|---|
| TBD by CAN members | | |
| **Long-term indicators:** | **Source:** | **Frequency:** |
| Low birth weight in Orleans Parish, 2013: 12.5%<br><br>Others TBD by CAN members | LA Office of Public Health | Annual |

### ALIGNMENT WITH NATIONAL PRIORITIES

| Healthy People 2020 | National Prevention Strategy |
|---|---|
| Adolescent Health Goal: Improve the healthy development, health, safety, and well-being of adolescents and young adults.<br><br>Early and Middle Childhood Goal: Document and track population-based measures of health and well-being for early and middle childhood populations over time in the United States.<br><br>Family Planning Goal: Improve pregnancy planning and spacing, and prevent unintended pregnancy.<br><br>Maternal, Infant and Child Health Goal: Improve the health and well-being of women, infants, children, and families.<br><br>Sexually Transmitted Diseases Goal: Promote healthy sexual behaviors, strengthen community capacity, and increase access to quality services to prevent sexually transmitted diseases (STDs) and their complications | Reproductive and Sexual Health<br><br>*Recommendation 1*. Increase use of preconception and prenatal care.<br><br>*Recommendation 2.* Support reproductive and sexual health services and support services for pregnant and parenting women.<br><br>*Recommendation 3.* Provide effective sexual health education, especially for adolescents.<br><br>*Recommendation 4*. Enhance early detection of HIV, viral hepatitis, and other STIs and improve linkage to care.<br><br>Mental and Emotional Well-being Recommendations:<br><br>*Recommendation 1.* Promote positive early childhood development, including positive parenting and violence-free homes.<br><br>*Recommendation 2.* Facilitate social connectedness and community engagement across the lifespan.<br><br>*Recommendation 3.* Provide individuals and families with the support necessary to maintain positive mental well-being. |

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