New Orleans

Community Health Improvement Plan

Second Revision November 2016

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new orleans health department

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Glossary of Acronyms

ACA	Affordable Care Act
ACSM	American College of Sports Medicine
ALICE	Asset Limited, Income Constrained, Employed
BCM	Baptist Community Ministries
BFH	Bureau of Family Health
BFS	Blueprint for Safety
BHC	Behavioral Health Council
BI/P	Batterer's Intervention/Program
BRACE	Building Resilience Against Climate Effects
BRFSS	Behavioral Risk Factor Surveillance System
CAC	Certified Application Counselor
CAP	Community Alternatives Program
CBNOLA	Children's Bureau of New Orleans
CCANO	Catholic Charities Archdiocese of New Orleans
CCHC	Child Care Health Consultant Program
CCMG	Crescent City Media Group
CDC	Centers for Disease Control and Prevention
CHA	Community Health Assessment
CHI	Community Health Improvement
CHIP	Community Health Improvement Plan
CLC	Certified Lactation Consultant
CNO	City of New Orleans
CRA	Center for Restorative Approaches
DAIP	Domestic Abuse Intervention Programs
DPW	Department of Public Works
DV	Domestic Violence
DVAC	Domestic Violence Advisory Committee
ED	Emergency Department
EMS	Emergency Medical Services
ERS	Economic Research Service
FBN	Fussy Baby Network
FQHC	Federally Qualified Health Center
FPAC	Food Policy Advisory Committee
FPL	Federal Poverty Limit
GNO	Greater New Orleans
GNOCHC	Greater New Orleans Community Health Connection
HA	Health Ambassadors
HCH	Healthcare for the Homeless
HEAT	Health Equity Action Team
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
HSNO	Healthy Start New Orleans
IWES	Institute of Women and Ethnic Studies
KFF	Henry J. Kaiser Family Foundation
LACCYS	Louisiana Caring Communities Youth Survey
LAFASA	Louisiana Foundation Against Sexual Assault
LAUS	Local Area Unemployment Statistics
LBW	Low Birth Weight
LCCR	Louisiana Center for Children's Rights
LDH	Louisiana Department of Health
LLAC	Louisiana Language Access Coalition
LPHI	Louisiana Public Health Institute
MHSD	Metropolitan Human Services District
MOU	Memorandum of Understanding
NCHS	National Center for Health Statistics
NFP	Nurse Family Partnership
NSCH	National Survey on Children's Health
NOCAC	New Orleans Children's Advocacy Center
NOFJC	New Orleans Family Justice Center

NOHD	New Orleans Health Department
NOLA	New Orleans, Louisiana
NOMTC	New Orleans Mosquito Termite & Rodent Control Board
NOPD	New Orleans Police Department
NORA	New Orleans Redevelopment Authority
NORDC	New Orleans Recreation Development Commission
NVSS	National Vital Statistics System
NWS	National Weather Service
OHP	Office of Health Policy
OPH	Office of Public Health
ONE	Mayor's Office of Neighborhood Engagement
OPA	Mayor's Office of Performance and Accountability
OPEN	Orleans Public Education Network
OPSB	Orleans Parish School Board
PBIS	Positive Behavioral Interventions and Supports
PFDL	Project Fleur-de-lis
PPW	Parks and Parkways
PTSD	Posttraumatic Stress Disorder
PRC	Prevention Research Center at Tulane University
RSD	Recovery School District
RWJF	Robert Wood Johnson Foundation
SA	Sexual Assault
SAHIE	Small Area Health Insurance Estimates
SANE	Sexual Assault Nurse Examiner
SART	Sexual Assault Response Team
SDOH	Social Determinants of Health
SFYD	Strategies for Youth Development
SIDS	Sudden Infant Death Syndrome
STD	Sexually Transmitted Diseases
STDSS	Sexually Transmitted Disease Surveillance System
STI	Sexually Transmitted Infections
SWB	Sewer and Water Board
TBD	To Be Determined
TIPPS	Tulane Innovations in Positive Parenting Study
TPL	Trust for Public Land
TU	Tulane University
UCR	Uniform Crime Reports
UMC	University Medical Center
USDA	United States Department of Agriculture
UWSELA	United Way of Southeast Louisiana
WHO	World Health Organization
WIC	Women Infants and Children

Introduction

New Orleans is a mid-sized city with nearly 390,000 residents, serving as Louisiana's major urban metropolis and largest tax base.[1] Rich in history, culture, ethnic diversity, and natural resources, New Orleans has many assets to be leveraged. Although many opportunities exist for residents of New Orleans, longstanding income and health disparities, exacerbated by Hurricane Katrina in 2005, must be addressed so that all citizens are positioned to reach their fullest potential.

The transformation of the New Orleans Health Department (NOHD) from 2010-2012—moving from clinical care and direct service to population-based policy and program implementation—increased the department's ability to assess community health broadly, while also building internal capacity to address health issues of immediate concern. Together, NOHD and a dedicated group of Community Health Improvement partners defined a shared vision of health for the city and a Community Health Improvement Plan, which they feel will help bring us closer to that vision. The plan outlines actionable objectives with measurable targets to address the following five priority areas:

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

While it is true that there are many challenges that must be addressed to improve health and quality of life for residents, it is also true that New Orleans is a city on the mend, experiencing a period of astounding growth, innovation, and cultural renaissance. Decision-makers and citizens alike are finding newer, more modern, and efficient ways to engage collaboratively to create a future that is brighter than our past through increased opportunities for civic engagement, more governmental accountability, rebuilding of public infrastructure, and advocating for a Health in All Things policy and programmatic agenda for all who live, learn, work and play in New Orleans.

WHAT IS COMMUNITY HEALTH IMPROVEMENT?

Community Health Improvement (CHI) is a process used in Public Health to identify and address the health needs of communities.[2] According to the National Association of County and City Health Officials (NACCHO), the CHI process looks outside of the performance of individual organizations, which often serve a specific segment of a community, to the way in which the activities of many organizations can contribute to health improvement of the community as a whole.[3] Using a collaborative approach, CHI brings partners from all sectors and backgrounds to work together and recognizes the interconnectedness of various sectors and their ability to shape the health of a population. This process marks a shift in health improvement efforts, moving from an individualized healthcare and medical model, to a more comprehensive framework that focuses on whole communities and populations, and incorporates the broader environment in which people exist.

For local public health systems engaging in a CHI process, Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) help to ensure that the process is one defined by data-driven decision making, community-wide collaboration, and accountability. A CHA may be conducted in order to gain a comprehensive view of a community's current health status, needs, and issues and is done by collecting health-related data from a variety of sources.[4] Once data is collected, it is analyzed by CHI partners and used to make informed decisions about the city's priority health issues, strategies for action, and accountability measures to ensure health

improvement, all of which are clearly outlined in a CHIP. A CHIP is a long term, systemic effort to address public health problems and help to provide support for developing new policies and determining health improvement strategies. It should define a shared vision for community health through collaboration with diverse partners 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 so that it is capable of addressing modern, population-level health issues for all citizens.

NEW ORLEANS' COMMUNITY HEALTH IMPROVEMENT PROCESS

Louisiana and Orleans Parish* often fare poorly in national and state level rankings of population health measures. According to United Health Care Foundation's report, *America's Health Rankings 2015*, Louisiana is ranked 50th of 50 states in overall health.[5] Similarly, the Commonwealth Fund Rankings of state health system performance ranks Louisiana 48th of 51 (including DC) between 2009 and 2015. At the county level, Orleans parish ranks in the bottom half for both health outcomes (47th of 64) and health factors (34th of 64) when compared to the other 63 parishes in Louisiana. As data suggests, CHI Partners face many steep challenges ahead in their work to achieve the community's shared vision for "a safe, equitable New Orleans whose culture, institutions and environment support health for all"; however, it is through the cross-sector collaborations, community partnerships, and system-wide interventions facilitated by the CHI process that partners believe this vision can be achieved.

In 2011, with the support of Louisiana Public Health Institute (LPHI), NOHD convened a diverse group of community leaders to serve on the CHI Steering Committee and engage in the first city-wide health assessment and health improvement process since 2000. Due to it's community centered approach, New Orleans chose to use the nationally-recognized Mobilizing for Action through Planning and Partnerships framework as a guide; over the course of 18 months, more than 100 agency partners and community stakeholders contributed to the process. By January 2013, NOHD and the CHI Steering Committee released the New Orleans Community Health Improvement Report[6]; a two part document which includes 1) a Community Health Profile, outlining findings from the CHA, and 2) the original version of the CHIP, which details the city's top priority health concerns, initial action plans, and measurable targets from 2013-2018. Both the CHA and the CHIP are meant to complement, not supersede, any assessments or planning documents outside of this collaborative effort. The aim of CHI partners is to align with local, state, and national efforts so as to maximize the impact of interventions.

The first version of CHIP laid the foundation for 5 years of collaborative work across each priority area. Every year, NOHD and the CHI Steering Committee must evaluate progress and revise the CHIP to ensure that the plan is as effective and relevant as possible. Each revision ensures that NOHD and community partners continue on the original path, yet also consider things such as the release of new data, changes in policy, or reallocation of resources before moving forward. The CHIP is a living document, which means that although a plan has been developed, it will continue to grow and evolve over the next years as the city and its population does. The first CHIP revision was published in June 2014. This document, published in 2016, serves as the second CHIP revision and will guide CHI partner efforts for the next year.

The New Orleans CHIP is owned by the community at large and is a product of efforts put forth by a myriad of local organizations and community members committed to our shared vision of health. NOHD serves as the backbone organization within this partnership and facilitates the formation, evaluation and revision of the CHIP; yet, looks to the expertise and experience of the community to inform processes, define priorities and assist in the development and implementation of action plans. In order to view any CHI documents or for more information on how to can contribute to CHI efforts, please refer to the City of New Orleans Health Department website, www.nola.gov/health.

* Orleans Parish is interchangeable with the city of New Orleans. They have the same boundaries and contain the same population.

CHIP Overview

VISION: *"We envision a safe, equitable New Orleans whose culture, institutions and environment supports health for all"*

GOAL 1: IMPROVE ACCESS TO EQUITABLE, COMPREHENSIVE AND QUALITY PHYSICAL AND BEHAVIORAL HEALTH CARE SERVICES FOR ALL

O1: Decrease the percentage of uninsured New Orleans residents from 16% to 13%

O2: Increase the number unique patients to FQHCs by 5%

O3: Ensure provision of necessary medical, dental, and behavioral health services to vulnerable populations who face increased barriers to obtaining care

O4: Increase levels of health literacy among New Orleans residents and providers ability to address low health literacy and bridge knowledge gaps

O5: Increase cultural competency and cultural humility among health care sector providers

O6: Ensure a comprehensive and cohesive system of behavioral health care through the New Orleans Behavioral Health Council and its partners

O7: Explore, implement and evaluate primary, secondary, and behavioral health coordination and integration with all sectors of healthcare in New Orleans

GOAL 2: CREATE SOCIAL AND PHYSICAL ENVIRONMENTS THAT PROMOTE GOOD HEALTH FOR ALL

O1: Promote the incorporation of health and equity in City-wide initiatives

O2: Promote the development and use of an equity framework across New Orleans Health Department programs

O3: Engage the community in making health a shared value and addressing the social determinants of health through education and awareness

O4: Reduce the impact of climate change on the health of New Orleans communities and vulnerable populations

O5: Reduce poverty through collective impact using United Way of Southeast Louisiana's Blueprint for Prosperity framework

GOAL 3: PREVENT VIOLENCE AND REDUCE ITS CONSEQUENCES

O1: Enhance the capacity of New Orleans public schools to address the effects of violence on school-aged youth

O2: Increase access to violence prevention services for parents and families

O3: Increase community capacity to address violence through a public health approach

O4: Increase coordination of City response to domestic violence through the ongoing implementation and monitoring of the Blueprint for Safety protocol

O5: Reduce disparate impact in criminal justice system response to domestic violence

O6: Improve the quality and cohesion of the community's response to domestic violence through Domestic Violence Advisory Council and its partners

O7: Improve the quality and cohesion of the community's response to sexual assault through the Sexual Assault Response Team and its partners

GOAL 4: IMPROVE PHYSICAL ACTIVITY, NUTRITION, AND QUALITY OF LIFE FOR ALL RESIDENTS

O1: Increase access to physical activity and healthy eating opportunities for youth in New Orleans

O2: Increase awareness and opportunities for physical and nutritional activities and resources in Orleans Parish

O3: Implement early childhood obesity prevention strategies by developing new and supporting existing initiatives designed to: increase physical activity, promote healthy eating, and encourage and support breastfeeding for children in New Orleans

O4: Provide health practitioners with the tools to service the community, with a focus on fitness and nutrition

O5: Facilitate access to nutritional and physical activity by way of community design and environment

O6: Inform, educate & support businesses to become health conscious workplaces

GOAL 5: ENSURE THAT EACH CHILD AND HIS/HER FAMILY MAY ACHIEVE AND MAINTAIN THEIR OPTIMAL WELL-BEING

O1: Improve preconception health among men and women of reproductive age

O2: Increase the proportion of pregnant women who receive early and adequate prenatal care

O3: Increase the proportion of infants who are breastfed

O4: Increase access to services and resources for parents and caregivers

O5: Increase the proportion of fathers who are engaged in activities related to pregnancy and child development

O6: Increase awareness of how social and physical environments can affect the health outcomes of children and families

1 Access to Physical & Behavioral Healthcare

BACKGROUND

Healthy People 2020—the Department of Health and Human Services' (HHS) ten year plan to drive health improvement for the country—views access to comprehensive, quality health care services as a critical component needed to improve health and quality of life for all.[7] The national plan defines access to care as "the timely use of personal health services to achieve the best health outcomes" and requires that individuals are able to: 1) gain entry into the health care system, 2) access a location where services are provided, and 3) find a provider that they can communicate with and trust. One of the strongest predictors of meeting these three components is an individual's health insurance status; those who are uninsured have more difficulty entering the health care system, are less likely to receive medical care, more likely to have poor health status, and more likely to die early. In addition to lack of insurance coverage, other common barriers to care include the lack of availability of services and high cost of services; all of which may lead to diminished quality of care, delays in receiving appropriate care, the inability to get preventive services, and hospitalizations that could have been prevented. Access to care has been shown to have a significant impact on health including improved overall physical, social and mental health status, prevention of disease and disability, and better quality of life.[8]

Disparities in Access to Healthcare

The U.S. has a long history of disparities in access to care that endure today. The implementation of the Affordable Care Act (ACA) has made a noteworthy impact in states that have chosen to utilize funding for expansion programs and community health centers; however, despite the progress made in recent years, people of color are consistently faring worse on all measures of access to care and health outcomes than Whites. According to a recent Henry J. Kaiser Family Foundation (KFF) Survey, "people of color account for more than half (55%) of the total 32.3 million nonelderly uninsured, are more likely than Whites to delay or forgo needed care due to costs…and are less likely than their White counterparts to report having a usual source of care."[9] Subsequently, when compared to Whites, people of color were found to have higher rates of obesity, higher mortality rates related to diabetes, heart disease and cancer, and report more physically and mentally unhealthy days.[10]

In New Orleans, access to care mirrors that of the nation, wherein people of color are particularly vulnerable to experiencing disparities and have poorer outcomes than Whites; however, people of color account for close to 70% of the population in New Orleans compared to an estimated 40% nation-wide.[11] African Americans, in particular, disproportionately suffer lower rates of health insurance coverage and poor health outcomes than any other racial or ethnic group. From 2009-2013, African Americans ages 18-64 were nearly twice as likely to be uninsured than White adults; children under 18 were about three and a half times more likely to be uninsured than Whites of the same age.[12] In 2010, African Americans were found to be significantly more likely than Whites to have *any* chronic condition; an unsettling fact for a city where African Americans account for nearly 60% of the population.[13]

Furthermore, the city's Latino population also experiences significant disparities in access to care. What can be gleaned from the limited data available for this growing population is a severe underutilization of the health care system due to the presence of significant barriers. A survey of Latino immigrants in New Orleans revealed that the rate of uninsured, particularly among recent immigrants to the city, could be nearly double the rate of uninsured African Americans; despite a small sample size, over 60% of those surveyed reported being uninsured and only 14% indicated that they had any form of health insurance.[14] In addition, nearly 25% reported having never been to a doctor in New Orleans and only 45% said that they've seen a doctor for medical care in the past two years. Issues

such as cost of care, not knowing where to go for care, and anxiety over language access and their legal status were all cited as factors affecting the decision to seek care.[15] Reports from the community on Latino health indicate the presence of serious health conditions and an increased risk for chronic disease and substance abuse.

AVAILABILITY OF SERVICES

Development of a Community-Based Healthcare System

Prior to Hurricane Katrina in 2005, the safety-net in New Orleans was a centralized model of service delivery in which Charity Hospital provided the vast majority of indigent care, accounting for between 80-90% of all uncompensated care costs in the area before the storm.[16] This centralized model effectively limited access to primary care and prevention for the uninsured and resulted in a population who relied heavily on emergency rooms in lieu of primary care; a trend seen across Louisiana, which at the time had the 4th highest emergency room visit rate per capita in the U.S.[17] Charity was also the "dominant provider of substance abuse, psychiatric, and HIV/AIDS care in the area and the only Level 1 trauma center on the Gulf Coast"[18]; it's closing devastated the safety net and left a significant gap in services for the city's most vulnerable patients. By 2015, Charity was replaced with University Medical Center (UMC). UMC offers financial assistance for emergency care and other medically necessary care to uninsured and underinsured patients with an annual household income of 400% Federal Poverty Level (FPL) or lower; however, marginalized sectors of the community such as immigrants or others with challenges obtaining proper identification may face barriers obtaining financial assistance.[19]

Post-Katrina, the safety-net in New Orleans moved to a decentralized model of service delivery by increasing the capacity for community-based health care and reducing reliance on hospitals and emergency departments. Through the development of a community- based provider network, efforts to decentralize health service delivery have been largely successful; however, the permanence of this network rests on the ability of providers to secure long-term funding, as many struggle with financial sustainability. Several have looked to HRSA to gain Federally Qualified Health Center (FQHC) status as a method for securing additional funding and to better meet the needs of underserved communities. FQHCs include all public and private non-profit healthcare organizations receiving grants under Section 330 of the Public Health Service Act and qualify for enhanced reimbursement from Medicare and Medicaid. They are required to be located in high need communities, provide comprehensive care regardless of a patient's ability to pay, offer a sliding fee scale for services, have an ongoing quality assurance program, and be governed by a community board of directors.[20] There is a strong body of evidence showing that FQHCs reduce health disparities experienced by underserved populations through increased access to primary care, coordination of primary and preventive care, high performance on quality measures, and ultimately, facilitate improved health outcomes for their patients.[21] In a city with historically high rates of uninsured and substantial health disparities, FQHCs play a vital role in ensuring access to care and equitable health outcomes for all New Orleanians.

Behavioral Health System Limitations

New Orleanians are consistently exposed to traumatic events —from natural disasters to increased rates of violent crime—making the investment in and maintenance of a comprehensive behavioral health system necessary for a healthy population. Shortly after Katrina, the Substance Abuse and Mental Health Services Administration (SAMHSA) predicted that "up to 30% of residents would experience clinically significant mental health problems and that more than 30% would experience mild to moderate depression, post-traumatic stress disorder (PTSD), or both"[22]; in the years since, New Orleanians have exhibited higher than average levels of stress, depression and suicide.[23] Although there is an increased need, the behavioral health system is limited in its capacity to provide services to the area, leaving many at a higher risk of developing a mental illness or a substance use disorder, being victimized by crime, increased contact with the criminal justice system, and poor health outcomes.[24]

After the storm, many inpatient mental health facilities in the Greater New Orleans (GNO) area closed, reducing the availability of inpatient psychiatric beds for the severely mentally ill. Since Katrina, there have been severe decreases in adult psychiatric beds (39%), child/adolescent beds (25%), and detox beds (31%), making access for

the uninsured extremely difficult.[25] The consequences of these closures and cutbacks have led to mentally ill individuals in crisis being treated in the emergency department, police acting as frontline mental health workers, and a high prevalence of mental illness in jails and prisons and among homeless individuals.[26] On a typical day in New Orleans in 2016, 22 persons on average are being held in a mental health crisis in hospital emergency rooms because there is no available in-patient hospital bed; a 16% increase from 2015.

Although the number of inpatient beds has yet to return to pre-Katrina numbers, so does the overall population of New Orleans.[27] It is important to note that although the city has fewer inpatient beds than before Katrina, the gap between the number of inpatient beds and the population of New Orleans has been reduced over time. In addition to an improving inpatient bed to population ratio, there has also been an increase in outpatient programs; these include services such as Assertive Community Treatment and Intensive Case Management, which are critical in stabilizing those with mental illness, substance use disorders, and co-occurring disorders when inpatient beds are difficult to access.[28] Although these services are but one component of a larger continuum of services, their growth is promising, as they increase the capacity of the system to accommodate all individuals with mental health issues.

Efforts to Improve Availability of Services

CHI partners have worked to support and enhance the local network of community health centers, which has become an essential component of the city's healthcare safety-net. As the number of health centers increases every year, so does the number of patients with access to care in underserved communities. In 2013, the GNO area had six FQHCs serving nearly 95,000 patients; by 2014, there were ten FQHCs serving close to 118,000 patients, 94% of which were below 200% FPL, 38% of which were uninsured, and 69% of which people of color.[29] As of June 2016, there were twelve FQHC organizations with over forty health center locations.[30] This growth demonstrates an undeniable need; however, in order to survive, FQHCs must be adaptable and adjust business practices and models to meet long-term financing needs. Partners such as 504HealthNet, Louisiana Language Access Coalition (LLAC), LPHI, and Baptist Community Ministries (BCM) are in varying stages of exploring, piloting and implementing methods known to increase financial stability which may include the integration of primary and behavioral health services, new uses for health information technologies, workforce development in cultural competency, and marketing to new patient groups to increase payer mix.

In 2012, CHI partners formed the New Orleans Behavioral Health Council to improve behavioral health system coordination, address disparities, and connect individuals to appropriate mental health services. Products of the Council's early work include NOHD's Mental Health Dashboard, which tracks behavioral health indicators, and the Community Alternatives Program (CAP), a mental health diversion program housed within Municipal Court. After a year's hiatus, the Council reconvened in 2016, co-chaired by the City Health Director, Charlotte Parent, and Metropolitan Human Services District's (MHSD) Executive Director, Dr. Rochelle Head-Dunham. Partners seek to further address widening gaps in the system of care, in addition to improving service provision and data reporting.

ACCESS TO INSURANCE COVERAGE

Louisiana's Coverage Gap

In the years prior to the full implementation of the ACA and Louisiana's Medicaid Expansion, over 20% of the nonelderly population in the state and the GNO region were consistently uninsured.[31] Unlike the rest of the country, which saw significant decreases in the percentage of uninsured from the ACA, Louisiana's uninsured rate for the nonelderly did not change drastically. For years, Louisiana did not expand Medicaid to cover residents up to 138% FPL ($16,404 for a single adult; $33,540 for a family of four), causing a large portion of low income residents in New Orleans to fall into the "coverage gap"— where one's income is too high to qualify for Medicaid, yet too low to receive subsidies in the Marketplace. As a temporary safety-net, GNO area residents were provided limited coverage through a Section 1115 demonstration waiver, the Greater New Orleans Community Health Connection (GNOCHC). GNOCHC provided coverage for primary care and behavioral health services to uninsured, non-elderly, low-income adults who were not eligible for other public coverage. Though critical in providing thousands with

basic healthcare coverage, GNOCHC left many *under*insured as it did not cover prescriptions, specialty care, or hospitalizations, which would traditionally be covered under a state Medicaid Expansion.

Medicaid Expansion in Louisiana

In January 2016, Gov. John Bel Edwards signed an executive order expanding Medicaid in the state of Louisiana, effective July 1st.[32] Expanding Medicaid greatly increases access to primary care and behavioral health services to an estimated 300,000 low income residents, specifically, those making less than 138% of the FPL who were not eligible for Medicaid prior to expansion. With this drastic increase in coverage it is estimated that: 47,300 Louisiana residents will receive preventative care; 46,000 more will have a usual place to go for care; and 22,000 will receive all the care they need.[33] From which, a significant impact on common health issues is expected: approximately 26,000 additional people will report good, very good, or excellent health; 18,000 will avoid symptoms of depression; and 230 lives will be saved. Those most affected by expansion are low-income parents, childless adults, and low-wage workers employed in industries critical to the state economy such as tourism and construction.[34] Now that Medicaid expansion has been implemented, approximately 35,000 fewer residents are expected to have catastrophic out-of-pocket costs and trouble paying bills due to cost of health care[35].

Efforts to Improve Access to Insurance Coverage

Until Medicaid Expansion, CHI partners and other advocates worked to successfully lobby for the extension of GNOCHC funds twice since the program's original implementation. With Medicaid expanded, partners are now faced with communicating the effects of Medicaid Expansion and enrolling those who are uninsured, but who are now eligible for coverage. To do so, partners such as 504HealthNet and NOHD, will continue to employ marketing techniques such as placing ads (radio, print, bus) in high-traffic or popular neighborhood access points for target communities; build capacity within their organizations by training staff to offer health insurance enrollment assistance; conduct outreach and host enrollment events in communities with high rates of uninsured; and develop educational materials for dissemination—all while ensuring that health literate and culturally and linguistically competent methods and best practices are reflected in communication with the public.

PARTNER IMPLEMENTATION PLAN

GOAL: Improve access to equitable, comprehensive, and quality physical and behavioral health care services for all (HP2020-AHS)[36]

Objective 1: By July 2017, decrease the percentage of uninsured New Orleans residents from 16% to 13%			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Utilize innovative methods to communicate the transition to Medicaid expansion	39,000 reminder text messages sent to GNOCHC enrollees	July 2016	504HealthNet, OPA*
Train outreach staff and case workers to be Certified Application Counselors (CAC)	20 staff trained and registered as CACs	Nov 2016	504HealthNet, NOHD-HCH, NOHD-HSNO
Coordinate outreach and enrollment events across programs and organizations	# of events	July 2017	504HealthNet, NOHD-HCH, NOHD-HSNO
Provide health insurance enrollment assistance and education	# of residents assisted # of residents enrolled	July 2017	504HealthNet, NOHD-HCH, NOHD-HSNO

*For a definition of all acronyms listed in CHI Partner Implementation tables, please refer to the Glossary located on page 5

Objective 2: By July 2017, increase the number of unique patients to FQHCs by 5%			
Evidence Base: County Health Rankings Evidence Rating for FQHCs[37]			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Engage in targeted outreach to specific age groups and income levels promoting FQHCs and primary care	8,000 postcards mailed to Medicaid population ages 55-64 35,000 text messages sent to Medicaid population	Aug 2016	504HealthNet, NOHD, OPA
Engage in marketing campaign to promote FQHCs and primary care including advertising at major access points in the community, on social media, and local radio	# of radio promotions # of social media posts # of bus ads	July 2017	504HealthNet, NOHD, OPA
Provide patient navigation services to high-risk, high-need FQHC and UMC Emergency Department (ED) patients to support strong connections with a primary care home and prevent unnecessary ED utilization	Serve 100 patients on a rolling basis	June 2017	CCANO Health Guardians, LPHI
Provide referral services to individuals calling the Second Harvest Food Bank assistance line	# of referrals made to FQHCs	July 2017	504HealthNet, Second Harvest Food Bank

Objective 3: Ensure provision of necessary medical, dental, and behavioral health services to vulnerable populations who face increased barriers to obtaining care			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Link those in need of Ryan White HIV/AIDS assistance to medically-appropriate client-centered services	4,100 unduplicated clients served	Dec 2016	OHP
Divert defendants with mental illness to treatment in lieu of incarceration	35 CAP program participants served	Dec 2016	NOHD-CAP, Municipal Court
Provide primary care, dental care, and behavioral healthcare services to clients who may be experiencing homelessness	6,500 patient visits to NOHD-HCH program sites 3,000 unduplicated clients receiving NOHD-HCH services	Dec 2016	NOHD-HCH
Prevent individuals with serious mental illness or other behavioral health conditions from being put into jail or the emergency room, instead of into appropriate behavioral health care	Community Action Plan for cross-sector information sharing developed	June 2017	Lead: LPHI Partners: EMS, UMC ED, NOHD, NOPD
Ensure that residents with special medical needs have access to care in the event of an emergency	# of residents with medical needs registered for sheltering and evacuation	July 2017	NOHD Emergency Preparedness

Objective 4: Increase levels of health literacy among New Orleans residents and providers ability to address low health literacy and bridge knowledge gaps			
Evidence Base: Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare[38]; Centers for Disease Control and Prevention (CDC) Health Literacy Overview and Recommendations[39]			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Engage in series of message tests to GNOCHC populations to better understand how to communicate complex information about health	# of tests conducted Best practices in messaging to consumers gained	Sept 2016	504HealthNet, OPA, NOHD
Empower local residents to serve as Health Ambassadors (HA) within their communities and assist others in navigating healthcare in New Orleans	10 HA's complete training and show increased understanding 100 residents attend HA hosted events	Sept 2016	504HealthNet, NOHD, OPA
Ensure that vulnerable populations have an awareness of potential risks faced, prevention methods, and how to access care through outreach and health education using health literate materials	Hurricane preparedness outreach to older adults conducted Climate change vulnerability outreach conducted Zika outreach to pregnant mothers conducted	July 2017	NOHD Emergency Preparedness

Objective 5: By July 2017, increase cultural competency and cultural humility among health care sector providers			
Evidence Base: HRSA Cultural Competence and Health Literacy Practices[40]; County Health Rankings Evidence Rating for cultural competence training to health care professionals[41]			
Activities	**Performance Measures**	**Target Date**	**CHI Partners**
Recruit healthcare sector professionals to attend LLAC's 2016 conference	200 healthcare professionals recruited to attend cultural competency training	July 2016	CHI Steering Committee, LLAC, NOHD
Work with local experts to establish online cultural competency trainings	# of healthcare professionals completing trainings # of modules offered	Dec 2017	504HealthNet

Objective 6: Ensure a comprehensive and cohesive system of behavioral health care through the New Orleans Behavioral Health Council (BHC) and its partners			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Host Public Forum to share BHC priority areas and projects and allow for public feedback	Forum hosted # of community members in attendance	Dec 2016	NOHD
Develop a behavioral health systems map for school staff to utilize for referrals	Comprehensive systems map developed and distributed to all public schools	July 2017	BHC Education Work Group, RSD, NOHD
Develop protocol, guidance, and pertinent contacts for municipal, civil, and criminal judges to utilize in cases involving mental illness or substance use disorders	Decision Tree tool developed and distributed to judges and criminal justice system partners	July 2017	BHC Criminal Justice Work Group, Orleans Public Defenders,NOHD

Objective 6 (cont.): Ensure a comprehensive and cohesive system of behavioral health care through the New Orleans Behavioral Health Council (BHC) and its partners			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Convene stakeholders and pursue funding for a pre-booking jail diversion program for individuals with low-level offenses	Protocol developed Funding Secured	July 2017	BHC Criminal Justice Work Group*, Mayor's Office, Vera Institute
Explore new data sources for NOHD's Behavioral Health Dashboard to better analyze causes of ED boarding and other times of psychiatric saturation	New data sources explored	July 2017	BHC Health & Hospitals Work Group, NOHD
Convene discharge and intake coordinators of outpatient and inpatient service providers to identify ways to coordinate referrals between providers	# of meetings # of attendees	July 2017	BHC Health & Hospitals Work Group, LPHI, MHSD

*For a full list of BHC work group members please refer to the Planning Initiative Partners section in the back of this report

Objective 7: Explore, implement and evaluate primary, secondary, and behavioral health coordination and integration with all sectors of healthcare in New Orleans			
Evidence Base: SAMHSA-HRSA Center for Integrated Health Solutions Guiding Principles for Workplace Integration			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Facilitate learning collaborative sessions with local FQHCs to support financial sustainability of primary care and behavioral health integration	3 learning collaborative sessions held	Sept 2016	BCM, LPHI

Access to Care Health Improvement Indicators:		
Indicators	**Sources**	**Frequency**
Premature death in Orleans Parish (Rate per 100,000 of years of potential life lost before 75) **2009-2011:** 6,703.7; **2010-2012:** 6,621.6; **2011-2013:** 6,605.3; **2012-2014:** 6,601.2	CDC, NCHS, NVSS-M[42]	Every 3 yrs
Fair or poor health in Orleans Parish (Percent of adults reporting fair or poor health) **2006-2010**: 18.3%; **2008-2010:** 18.5%; **2005-2011:** 19.4%; **2006-2012:** 19.5%	CDC, NCHS, BRFSS[43]	Annually
Rate of uninsured in Orleans Parish (Percent of persons under 65 years of age without health insurance) **2010:** 22.7%; **2011:** 23.1%; **2012:** 21.0%; **2013:** 20.1%; **2014:** 18.3%	US Census Bureau, SAHIE[44]	Annually
Unduplicated patient visits in GNO Area (# of patients seen by FQHC's in GNO area) **2013**: 94, 466; **2014:** 117,439	HRSA, BPHC, Grantee data[45]	Annually
Psychiatric ER holds in GNO Area (Total # of psychiatric ER holds in GNO area overall) **2005:** 555; **2009:** 322; **2013:** 376; **2015:** 365; **2016:** 371	NOHD, Mental Health Dashboard[46]	Monthly

2 Social Determinants of Health

BACKGROUND

Health starts where we live, learn, work and play; however, for most people, health is typically associated with clinical factors, such as receiving primary care services. Although clinical factors are important for health, a growing body of research demonstrates that they only represent a small portion of what makes an individual healthy. It is now known that the social, physical, environmental, and economic circumstances in which people live have the greatest impact on health and, in some cases, can determine health outcomes. These circumstances, known as the *Social Determinants of Health* (SDOH), can include a range of factors such as poverty, education, employment, housing, and transportation.[47] The social determinants are shaped by the distribution of money, power and resources and are largely responsible for the unfair and avoidable differences in health status, or *health inequities*, which exist within and between groups, communities and countries. If you are poor, less educated, or a person of color 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.[48] The reasons behind this fact are nothing inherent to a particular race, ethnicity, or socioeconomic group; health inequities experienced by certain groups are the results of dysfunctional systems which afford more opportunity to some over others.[49]

This focus on the SDOH marks a shift in Public Health and greatly impacts both the way that health is understood and the future of health interventions. Addressing the social determinants and eliminating the subsequent health disparities and inequities is an increasing priority for government at all levels. HHS, through *Healthy People 2020*, has prioritized the achievement of health equity and the elimination of disparities as one of the four overarching health improvement goals for the decade.[50] In addition, state and local health departments work to align with national health improvement efforts and incorporate health equity into their strategic frameworks and health improvement plans. To guide these efforts, *Healthy People 2020* has outlined a SDOH organizing framework identifying five major determinant areas: 1) Economic stability; 2) Education; 3) Social and community context; 4) Health and health care; and 5) Neighborhood and the built environment.

Health Disparities and the Social Determinants of Health

In New Orleans, significant health disparities exist. 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 marginalized 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 to affordable and healthy foods, among other things.

The effects of these conditions can be seen through many health statistics mentioned in the CHA; one of the most drastic instances being the results of a 2012 study conducted by the Joint Center for Political and Economic Studies, *Place Matters for Health in Orleans Parish.*[51] An analysis of zip code level data conducted by the local Place Matters team revealed that a disparity of more than 25 years exists between residents in one of the city's most economically depressed and majority Black neighborhoods compared to those in the most affluent, majority White neighborhoods.[52] The zip code with the highest life expectancy, 70124, included the majority White neighborhoods of Lakeshore, Lake Vista, West End, Lakewood and Navarre. Residents in these areas experience a life expectancy of 80 years from birth, a rate similar to that of countries with the world's highest life expectancies, such as the United Kingdom. In contrast, the zip code with the lowest life expectancy was 70112, an area encompassing portions of the majority Black neighborhoods of Tulane, Gravier, Iberville and Treme. Residents of these areas were found to have a life expectancy of 54.5 years from birth, a rate comparable to those in developing countries

such as Botswana and Uganda.[53] Only one square mile in size, 70112 was also said to be host to the highest percentages of poverty, STD rates, low birth weight rates and heart disease mortality in the city. At that time, heart disease mortality was calculated to be five times greater for those in the 70112 zip code than those in the zip code with the next highest rate in the city.

NEIGHBORHOODS AND THE BUILT ENVIRONMENT

Creating and Sustaining Healthy Places

According to the CDC, "healthy places are those designed and built to improve the quality of life for all people who live, work, worship, learn, and play within their borders -- where every person is free to make choices amid a variety of healthy, available, accessible, and affordable options". [54] There are many components that contribute the creation of a healthy place. The built environment is the man-made environment that surrounds us every day, from park benches and sidewalks, to office buildings and levees. In utilizing healthy community design strategies, a built environment can allow residents to engage in positive health behaviors and protect them from health risks. For example, resources within the built environment such as walking paths, bike lanes, and sidewalks are known to increase physical activity and reduce risk of obesity, heart disease and hypertension.[55] Conversely, the built environment can also prevent or discourage healthy behaviors by accommodating things like blighted property or broken streetlights, shown to increase stress and crime, and reduce community connectedness which can lead to poorer health outcomes. [56]

In addition to the built environment, environmental forces, such as climate change or natural disasters can compound with other life stressors to impact health in significant ways. "Every year, climate change and extreme heat kill more people than hurricanes, lightening, tornadoes, earthquakes and floods combined".[57] Aside from premature death, other adverse health effects related to climate change can include: "increased respiratory and cardiovascular disease, injuries, changes in prevalence and geographical distribution of food-and water-borne illnesses and other infectious diseases, and severe threats to mental health".[58] Children, the elderly, those who are disabled, poor, live alone, or have previous health conditions such as heart disease or asthma are most vulnerable in these circumstances.[59] Over time, the effects of climate change will be experienced more intensely and the effect of localized stressors common to New Orleanians like hurricanes, extreme heat, flooding or mosquito-borne viruses, will become more prevalent. In 2011, Orleans Parish saw 52 days with maximum temperatures above 90 degrees and climate change projections indicate that this number will only continue to rise.[60] The mounting threat posed by climate change, coupled with a sizeable vulnerable population (approximately 4,000 individuals requiring medical assistance in an emergency, 23,000 children, and ¼ of residents in poverty), requires that the local public health system in New Orleans take extensive measures to prepare for challenges ahead.

Efforts to Improve Health of Neighborhoods and the Built Environment

CHI partner efforts to improve the health of neighborhoods span various programs and initiatives which are further highlighted in other priority area sections. Examples of such efforts include: NOHD's lead testing and community education; NOHD's Best Babies Zone aimed at lowering rates of infant mortality in the Hollygrove neighborhood; and Fit NOLA partnership's revitalization of public parks in areas with high rates of physical inactivity and the implementation of healthy food options in city-owned vending machines across the city.

In past years, NOHD has primarily focused on the response to health impacts of environmental forces and the promotion of resident preparedness in the face of emergencies; however, with the creation of their Healthy Environments program, the department seeks to greatly expand its work in this area. In regards to climate change in particular, NOHD's Healthy Environments program is working to develop a comprehensive understanding of how climate change will impact the city and what actions can be taken to mitigate the health effects on citizens. To do so, NOHD will utilize CDC's Building Resilience Against Climate Effects (BRACE) framework in partnership with other city entities such as the Department of Public Works (DPW) and the New Orleans Mosquito Termite and Rodent Control Board (NOMTCB). Partners will employ innovative methods such as climate vulnerability assessments and Geographic Information System mapping technologies to collect and compile data for the

development of place-based interventions at the census block level. All data will be used to set strategic priority areas for NOHD programming and, in the coming months and years, NOHD and City agencies will begin to integrate climate change considerations into all public health related programming and policies.

ECONOMIC STABILITY

The Effects of Poverty on Health

In Louisiana, 695,719 households (40%) struggled to afford basic household necessities in 2013.[61] While 19% of the state's population lives below the FPL, barriers to economic stability- such as the rising cost of living, increasing numbers of low wage jobs, lack of affordable housing and the limited relief provided by public and private assistance- are preventing those living *above* the poverty line from affording their most basic needs. The Louisiana Association of United Ways *ALICE* report documents the harsh reality of life in the state as an Asset Limited, Income Constrained, Employed (ALICE) household, many of which are "living paycheck to paycheck – unable to save and often one health emergency, one car repair or one harsh storm away from poverty".[62] According to the report, income inequality in Louisiana increased 12% from 1979 to 2013 and, as of 2016, the top 20% of the population earns more than half of all income earned in the state, while the bottom 20% earns only 3%.[63]

In New Orleans, the effects of poverty on health can be seen through lack of access to affordable housing, food, healthcare services, as well as higher rates of unemployment, infant mortality and morbidity, and obesity than the national average. 2014 Census data shows that 28% of Orleans Parish residents and over 40% of children live in poverty.[64] United Way's *ALICE* report classifies close to half (47%) of households in the parish as either in poverty or as ALICE households; a reality that may be explained by the large number of low-wage workers making under $17,500 annually.[65] Of full-time workers in the city, 12% earn less than $17,500 per year compared to only 8% nationally. Women in New Orleans are more likely than men to earn low wages. Men on the other hand, and African American men in particular, may have more difficulty with employment. In a city that is approximately 60% African American, less than half of working age African American men are employed.[66]

Efforts to Reduce Economic Disparities

The United Way of Southeast Louisiana (UWSELA) has set out to achieve the ambitious goal of ending poverty in the 7 parish region it serves: Tangipahoa, Washington, St. Tammany, Orleans, Jefferson, St. Bernard, and Plaquemines. Recognizing the bold nature of their vision, UWSELA looks to employ a collective impact approach where cross-sector partners will collaborate through the alignment of programs and resources and in setting shared goals. The *Blueprint for Prosperity*, gleaned from months of input and feedback from local residents and professionals in related fields, outlines a plan to achieve the shared vision and will serve to guide implementation of poverty reduction activities. UWSELA and partners will collect regional and parish level data to track progress on a variety of factors affecting poverty.

SOCIAL AND COMMUNITY CONTEXT

Finding a Common Language

As the need to address the SDOH increases, so does the need to communicate the impact of these determinants on health to others. The organizing framework outlined in *Healthy People 2020* suggests the use of cross-sector collaborations and interventions within social and community contexts, promoting social cohesion and civic participation. However, due to the complex and interrelated nature of the social determinants, it can be difficult to find a common language that resonates with whole cities or communities. A study conducted by RWJF reinforced the popular belief that most people in the community can easily come to understand the impact of social factors on health, although it is not what typically comes to mind. Successfully bridging the gap between the social determinants and health outcomes will require intentional communication while utilizing specific techniques. Findings from the study show that communicating about the SDOH using simple and emotionally compelling language, incorporating the role of personal responsibility, and offering solutions to the problems presented are techniques that resonated most with community audiences.

Efforts to Strengthen Social and Community Context

While the NOHD currently addresses SDOH through many of its initiatives, the Department (in collaboration with members of the CHI Steering Committee and Fit NOLA Healthy Community Design sector) seeks to broaden its response to include other City departments and ensure that health is considered in decision-making efforts across sectors and policy areas. By using an approach mirroring that of RWJF, partners look to engage City departments in conversations about SDOH through use of data and examples relevant to their area of work and specifically tailored for that department. In Public Health, this type of work is popularly referred to as Health in All Policies[67]. The overall goal of this approach is to ensure that a health equity lens is embedded in processes throughout City government, eventually leading to more equitable policies and systems across the city and improved health outcomes for all. Within the Department, NOHD looks to closely assess current policies, community partnerships and workforce development for ways in which equity may be integrated into departmental processes.

While an equitable framework is being embedded within City government creating pathways for the development of more equitable policies and processes, community partners are working to engage residents in equity related education and advocacy efforts; crafting meaningful messages that resonate with residents and move them to act, while also providing them with skills and tools that empower them to create change. Genuinely engaging the community in this process is critical for an equitable future. CHI partners have created opportunities for New Orleans residents to learn about the forces and systems that influence health and to develop their skills as advocates. Partner efforts include projects such as Tulane Prevention Research Center's (PRC) NOLA LEADS 8 week curriculum and Crescent City Media Group's (CCMG) voter engagement toolkit and training. These efforts require a broadening of the way residents traditionally think about health, the relationship between health and the systems they participate in, and the role of their communities in creating environments that promote health for all.

PARTNER IMPLEMENTATION PLAN

GOAL: Create social and physical environments that promote good health for all (HP2020-SDOH)[68]

Objective 1: Promote the incorporation of health and equity in City-wide initiatives			
Policy Changes Needed: A Health and Equity in All Policies approach must be formally adopted by City departments and agencies and integrated into City-level decision-making processes to address inequities			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Participate in City of New Orleans sponsored equity initiative	TBD	July 2017	NOHD
Engage City departments in SDOH and Equity discussion through "Lunch and Learn" series	3 City departments reached 3 presentations given to City staff	July 2017	Fit NOLA Healthy Community Design Sector*, NOHD, SDOH work group*
Provide resources and technical assistance to City departments interested in applying a health lens to their work	# of City projects that incorporate a health lens	TBD	Fit NOLA Healthy Community Design Sector, NOHD, SDOH work group
Develop communications strategy highlighting City projects that incorporate a health lens	Communications strategy developed and implemented	July 2017	NOHD, SDOH work group

* Please see Planning Initiative Partners section for a full list of sector and work group participants

Objective 2: Promote the development and use of an equity framework across NOHD programs			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Release NOHD equity framework to guide the department's efforts to address health disparities	Report published Launch events hosted	Nov 2016	NOHD
Establish a Health Equity Action Team (HEAT) to guide NOHD's ongoing transformation toward an equity focused department	HEAT established and consists of staff from various levels of leadership and programming Regular convenings of HEAT Collaborative activities set	Dec 2016 Ongoing Ongoing	NOHD
Provide training and support in core skills related to health equity to NOHD program staff	90% of NOHD staff trained in core skills related to health equity	Feb 2017	NOHD HEAT

Objective 3: Engage the community in making health a shared value and addressing SDOH through education and awareness			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Train community members in SDOH and advocacy	# of community members complete curriculum	July 2017	PRC
Engage college aged students in political advocacy and training	TBD	July 2017	CCMG
Partner with the Office of Neighborhood Engagement (ONE) to increase community participation in CHI processes	# of events # of opportunities for community engagement	July 2017	NOHD, ONE

Objective 4: Reduce the impact of climate change on the health of New Orleans communities and vulnerable populations			
Evidence Base: CDC BRACE Framework[69]			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Conduct a climate vulnerability assessment to determine current climate projections and potential impact on health outcomes	Climate data collected Potential health outcomes determined Risk factors increasing citizen vulnerability identified and geographically located	June 2016	Lead: NOHD Partners: CNO, DPW, EMS, LPHI, NOMTC, NORA, NWS, SWB, TPL
Conduct an overlay risk analysis to set strategic priority areas for future NOHD projects	GIS maps projecting areas most susceptible to health outcomes created GIS maps identifying priority areas where resources and education should be targeted	Oct 2016	Lead: NOHD Partners: DPW, EMS, NOHD-HSNO, LPHI, NOMTC, PPW, TPL

Objective 4 (cont.): Reduce the impact of climate change on the health of New Orleans communities and vulnerable populations			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Create an NOHD adaptation plan considering both immediate and long term strategies to mitigate the health effects of climate change	List of adaptive strategies created with community input NOHD staff trained on project assessment results Adaptation plan distributed	May 2017	NOHD
Integrate climate projection modeling into annual department and city planning	Projection used to develop future plans	May 2017	Lead: NOHD Partners: CNO
Form a targeted response to projected changes in health outcomes using GIS maps	Targeted health interventions and programs supporting vulnerable populations created	July 2017	NOHD

Objective 5: Reduce poverty through collective impact using United Way of Southeast Louisiana's *Blueprint for Prosperity* framework			
Policy Changes Needed: To bring economic prosperity to low income families and communities the following policy changes are needed: Improved systems of care for children aging out of Foster Care; Continued support of Equal Pay for Women; and Expanded Coverage for 211*			
Activities	**Performance Measures**	**Target Dates**	**CHI Partners**
Strategy: *Invest in programs and collaborations that are focused on poverty*			
Fund programs and collaborations who align with the four population level outcomes	# of programs funded # of collaborations funded	Jan 2017	UWSELA
Strategy: *Inspire others to adopt the poverty agenda*			
Educate donors on the importance of tackling the root causes of poverty	# of Blueprint for Prosperity presentations to donors completed	July 2017	UWSELA
Mobilize a business coalition to work with United Way on the eradication of poverty	Business coalition created # of businesses dedicated to poverty eradication	July 2017	UWSELA
Align the vast network of funders working on the issue of poverty	# of funder events held to increase alignment	Ongoing	UWSELA and other funders**
Focus public policy and advocacy efforts on poverty related issues	Adoption of public policy and advocacy agenda	Ongoing	UWSELA, Public Policy team and partners
Strategy: *Inform others with data and innovative practices so they can accelerate their own impact*			
Create and share a prosperity dashboard to track progress	Prosperity Dashboard created	Ongoing	UWSELA, The Data Center
Strategy: *Initiate new collaborations where they are needed most*			
Continue to collaborate on early care and education	# of early care and education collaborations involved in	Ongoing	UWSELA, Early Care & Education collaborators
Create a new collaborative on financial stability pulling together funders, providers, and business leaders	Collaborative created Action plans developed # of organizations in collaborative	July 2017	UWSELA, Financial Stability Collaborative Partners

*To view UWSELA's Blueprint and 2016 Public Policy Legislative Agenda, visit http://www.unitedwaysela.org/blueprint#blueprint

**UWSELA's Blueprint for Prosperity initiative has partners in 7 parishes; for a full partner list visit http://www.unitedwaysela.org/our-partners

Complementary Initiatives

CHI partners recognize that the scope of the current work outlined in the CHIP to improve the SDOH is limited; however, it is important to note that a significant amount of work is being done by respected groups across the city in addition to this collaborative effort. Some of the City-led initiatives with which CHI partners are collaborating can be seen in the table below.

City-led Collaborative Efforts to Address SDOH	
The Network for Economic Opportunity	
THE NETWORK for Economic Opportunity	The Network for Economic Opportunity emphasizes connecting job seekers and small businesses with pathways to prosperity, and promoting opportunity within the historic Claiborne Corridor. It was founded in 2014 to establish productive partnerships among local industries, small businesses, residents, non-profits, philanthropy, and city agencies to achieve common goals within six priority areas: economic opportunity, housing affordability, cultural preservation, transportation access, sustainable environment, and safe and healthy neighborhoods. *www.thenetworkneworleans.org*
Resilient New Orleans	
RESILIENT NOLA	Resilient New Orleans aims to shape our future city so that the coming generation may be more equitable, adaptable, and prosperous. In August 2015, the City of New Orleans released one of the world's first comprehensive strategies for building city resilience. Resilient New Orleans builds on more than 10 years of planning and visioning for our city and leverages the work we are already doing, while proposing bold strategies with committed partnerships to move from recovery to resilience for the next 300 years. Areas of emphasis include Adapt to Thrive, Connect to Opportunity, and Transform City Systems. *www.resilientnola.org*

SDOH Health Improvement Indicators:		
Indicators	**Sources**	**Frequency**
Fair or poor health in Orleans Parish (Percent of adults reporting fair or poor health) **2006-2010**: 18.3%; **2008-2010:** 18.5%; **2005-2011:** 19.4%; **2006-2012:** 19.5%	CDC, NCHS, BRFSS[70]	Annually
Unemployment in Orleans Parish (% of population age 16+ unemployed and looking for work) **2011:** 8.6%; **2012:** 7.9%; **2013:** 7.4%; **2014:** 7.0%; **2015:** 6.5%	DOL, BLS, LAUS[71]	Annually
Estimated poverty in Orleans Parish (small area estimates of population living below poverty line) **2010:** 27.1%; **2011:** 28.7%; **2012:** 28.8%; **2013:** 26.6%; **2014:** 27.9%	US Census Bureau, SAIPE[72]	Annually
Children in poverty in Orleans Parish (% of children under 18 years of age living in poverty) **2010:** 41.2%; **2011:** 41.5%; **2012:** 41.1%; **2013:** 39.0%; **2014:** 43.3%	US Census Bureau, SAIPE	Annually

3 Violence Prevention

BACKGROUND

Violence in any form is a public health issue. Victims of violence themselves may suffer a myriad of health complications, including temporary or permanent physical harm, emotional trauma, and even death. Witnessing violence can also have a long-term impact on an individual and is linked to lifelong negative physical, emotional, and social consequences.[73] Witnesses of violence and those with prolonged exposure to violence during childhood are at greater risk of being victimized or being a perpetrator of violence in the future.[74] [75] Those who have experienced violence are at elevated risk of PTSD, depression, anxiety, aggression, and problems in school.[76]

In addition to affecting the health of individuals, violence can also affect the health outcomes of whole communities. According to The Prevention Institute, violence and the fear of violence are "major roadblocks to the success of chronic disease prevention strategies".[77] People who feel unsafe in their neighborhood are 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 communities across the nation, further widening the health and safety inequities between these and more privileged communities.

Disparities in Violence

The Prevention Institute states that "the prevention of violence is an important component of achieving equity in health and in communities. Violence and fear of violence are major factors that have been shown to undermine health and worsen health disparities".[78] Across the U.S., communities of color and those that are low income experience a disproportionately high level of violence.[79] According to a 2016 *NOLA for Life* report, there were 164 murders in New Orleans in 2015; 8 neighborhoods of the 73 in New Orleans accounted for 39% of the murders that year.[80] When compared to other neighborhoods in the city, these 8 were said to experience the highest levels of violence and also have lower educational attainment, more single-family households, and higher levels of poverty with annual household incomes 40% lower than the city-wide average. When compared to the country as a whole, New Orleans has higher than average rates of unemployment, poverty, and murder [81] [82] [83]; however, African Americans shoulder a disproportionate share of that burden. African Americans in New Orleans experience higher levels of unemployment (43% of working age men) than their White (23%) or Hispanic (19%) counterparts [84]; higher levels of overall poverty (30.4% versus 27.9%) and children in poverty (46.1% versus 43.3%) than the rest of the city [85]; and are eight times more likely to be victims of homicide than Whites.[86]

From 2011-2014, New Orleans had the largest drop in murder rates among comparable cities and, in 2014, saw the city's lowest murder rate in over four decades.[87] [88] Despite the positive changes seen in recent years, New Orleans still has one of the highest murder rates in the country, other types of violent crime remain significantly higher than the national average, and Louisiana continues to have the highest incarceration rate in the world.[89] Issues of crime and safety have long been a top priority for New Orleans residents, yet, also the area in which they feel the least progress has been made.[90] In 2015, a KFF report revealed that 58% of residents surveyed said that crime was the biggest problem in their city. However, racial disparities were reported on all related survey measures, with African Americans more likely than Whites to say that they are very worried about being a victim of violent crime (36% versus 17%), don't feel safe from crime in their neighborhood (35% versus 21%) and that their neighborhood does not have enough police presence (59% versus 46%).

YOUTH VIOLENCE

Exposure to Violence among New Orleans Youth

Youth vulnerability to violence exposure greatly depends on the neighborhoods and environments youth exist in; all environments contain both risk and protective factors that can either minimize or maximize the likelihood of exposure.[91] The more a child is exposed to violence, the more he or she is at risk for being victimized or being the perpetrator of violence in the future. LPHI and NOHD's 2015 *Youth in Context* report studied the combined impact of a number of factors such as crime, health, physical environment, neighborhood demographics and socioeconomic factors on risk for violence exposure among New Orleans youth.[92] New Orleans neighborhoods were assessed for vulnerability based on the size of their youth population and number of risk factors present in the area. Findings show that the Seventh Ward, Treme-Lafitte, Hollygrove, St. Roch, Tulane-Gravier, St. Claude, Central City, Milan, and Gert Town were most vulnerable, and also clustered together geographically, suggesting a concentrated risk in large areas of the city and "the potential for the carry-over of risk from neighborhood to neighborhood".[93] The report cites approximately 19,500 youth aged 0-23 live in these vulnerable neighborhoods.

Furthermore, witnessing violence and worrying about violence are both strongly associated to negative mental health outcomes such as depression, PTSD, and suicidal ideation.[94] [95] [96] In New Orleans, the Institute of Women and Ethnic Studies' (IWES) *Emotional Wellness and Exposure to Violence* report demonstrates the increased risk of negative mental health outcomes that may be faced by youth as a result of violence exposure. Data shows that New Orleans youth display current and lifetime rates of PTSD which are more than three times that of the national average; with over 37% report having witnessed domestic violence, 39.8% witnessed a shooting, stabbing or beating and 54% report having experienced the murder of someone close to them.[97] Study participants also reported high levels of anxiety related to safety and stability; with over 50% reporting that they worry about violence in their neighborhood, 29.5% worry about not being loved, and 14% of respondents reported feeling suicidal. In another study of New Orleans children aged 6 to 12, 85% of those surveyed had seen someone beaten up, 40% had seen someone shot, and 31% reported having seen a dead body.[98]

That being said, in New Orleans, victims and perpetrators of murder are predominately found to be unemployed, African-American male youth between the ages of 16-25. Since 2010, over 40% of murder victims have been young adults under the age of 25, and 9% have been juveniles under the age of 18.[99] In 2012, the murder rate in New Orleans was more than ten times the national average and more than one third of the city's murder victims at that time were under 25, including 17 victims under the age of 18. In 2014, 43 of the 150 murder victims were young adults under the age of 25 and 12 of which were of children under the age of 18.[100] That year, as with many others, young adults aged 18-24 represented a disparate share of the murder victims (28.7%) compared to their share of the population (10.2%).[101] Although New Orleans has seen a decline in the total population of youth overall, youth violence continues to remain a significant issue.[102]

Efforts to Reduce Youth Violence

Knowing that the environment plays a large role in violence prevention, CHI partner efforts to reduce youth violence are concentrated in many of the vulnerable neighborhoods mentioned in the *Youth in Context* report. NOHD, with the support of the National Forum on Youth Violence Prevention, developed the NOLA For Life PLAY*book*: *Promoting Life for all Youth.*[103] The PLAY*book* is a part of NOLA For Life, Mayor Mitch Landrieu's murder reduction initiative established in 2012, yet is led and coordinated by NOHD and focuses solely on preventing youth violence. The goal set by the PLAY*book* is that by 2020, 95% of youth will feel safe in school and neighborhoods, ultimately leading to reduced violence and improved health outcomes in New Orleans youth. To accomplish this, CHI partners will continue to implement evidence-based practices in target neighborhoods including: group violence reduction strategies, promotion of restorative approaches and improved trauma response in schools, promotion of Positive Behavioral Interventions and Supports, and promotion of the Realtime Resources, a web-based resource for up-to-date listings of social and community-based services. Since the launch

of NOLA for Life in 2012, a total of 5,819 students have been impacted across 11 partner schools through school climate improvement initiatives, gang violence has decreased by 55% and over 300 local organizations across every sector have been actively engaged with NOLA for Life.[104]

DOMESTIC VIOLENCE

Domestic Violence in Louisiana and New Orleans

Following the national trend, women in Louisiana and in New Orleans are more likely to be victims of domestic violence and sexual assault than men. Most often, these acts of violence are at the hands of a male perpetrator, approximately 90% of who are known by the victim.[105] Domestic violence and sexual assault are associated with a myriad of physical and mental health issues. In addition to potential injuries from a single or repeated assault, victims often suffer from chronic pain, gastrointestinal disorders, psycho-somatic symptoms and eating problems; these forms of violence are also strongly associated with an increased risk for mental health problems such as anxiety, PTSD, depression, substance abuse and suicidal ideation.[106] Women who are victims also have an increased risk of unplanned or early pregnancies and STDs, including HIV/AIDS.

According to CDC survey data, over 5,000 adult women per year living in Louisiana will experience domestic violence.[107] In 2012, Louisiana ranked fourth highest out of all 50 states in its rate of females murdered by men; the vast majority (93%) of these women were murdered by someone they knew.[108] In New Orleans, research indicates that as many as one third of women have a history of experiencing domestic violence.[109] Perpetrators of domestic violence in the city are three times more likely to be male, although instances with male victims and/or female perpetrators exist as well.[110] NOPD records show that in 2015, officers responded to 3,368 domestic violence incidences, 2,201 of which resulted in an arrest, 76% of which were male.

Efforts to Prevent Domestic Violence

New Orleans is one of three jurisdictions across the nation chosen by the Office on Violence against Women to adapt The Blueprint for Safety (BFS), a universal model for domestic violence policy. The Blueprint is designed to "maximize safety for victims of domestic violence and hold offenders accountable while offering them opportunities to change".[111] Organized around a common framework, and policies and protocols for each key point of intervention, NOHD and BFS partner agencies look to strengthen the institutional response to domestic violence with increased criminal justice system coordination and to improve victim experiences when engaging with the system. New Orleans was the first of the three demonstration communities to launch the BFS in October 2014. Since the launch, NOHD has been working with partners to train criminal justice practitioners on the Blueprint policies, and develop plans to implement and track the impact of Blueprint policies, with the hope of having improved victim experiences.

Additionally, NOHD leads the Domestic Violence Advisory Committee (DVAC); a body established over 40 years ago of domestic violence practitioners, tasked with making recommendations for systems improvement regarding domestic violence. DVAC members have recently engaged in an objective setting process to increase coordination and collaboration among domestic violence service providers and the criminal justice system; a process that will continue to evolve over time. Objectives include the submission of an annual report for policy recommendations to the Mayor and his team of domestic violence advisors for 2017.

SEXUAL ASSAULT

Sexual Assault in Louisiana and New Orleans

In its recent history, New Orleans has faced challenges in ensuring justice to survivors of sexual assault (SA). In 2013, the Office of the Inspector General notified the NOPD of Uniform Crime Report audits, and in 2014 published a report revealing that the NOPD "misclassified calls for service, reclassified (downgraded) rape offenses to a miscellaneous offense, and failed to complete incident and supplemental reports".[112] The offenses investigated

were the acts of a few individual officers and were not representative of the Department as a whole, yet the audit sparked widespread change. Since then, substantial improvements across the Department have been made.

From the time of the initial report, there has been a 68% increase in the number of rapes reported to the NOPD.[113] In 2015, there were 409 reported rapes, compared to the 244 reported in 2014 and the 176 in 2013. The Mayor's Sexual Violence Response Advisory Committee views this increase as a measure of success and a sign of improved trust in the NOPD by SA victims; they expect an even higher increase for rapes reported in 2016.[114] SA is known to be one of the most underreported crimes, with approximately 34% of incidences reported to police across the country every year.[115] According to LaFASA, in 2012, only 28% of sexual assaults in Louisiana were reported to law enforcement, a number significantly lower than the national average.[116] 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.[117] Based on state and local reporting data, one may assume that SA cases in New Orleans are grossly underreported, yet it is impossible to know undoubtedly whether the current spike in rapes is a result of increased reporting or increased incidence of rape, or both.

Efforts to Prevent Sexual Assault

The NOHD 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. In 2016, SART engaged in goal and objective planning and is working to improve availability and awareness of resources to its members and others working with victims of sexual assault.

PARTNER IMPLEMENTATION PLAN

GOAL: Prevent violence and reduce its consequences

Objective 1: Enhance the capacity of New Orleans public schools to address the effects of violence on school-aged youth			
Evidence Base: CDC High Impact Interventions List[118]			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Develop public health strategy to promote the use of evidence-based initiatives, such as restorative approaches and PBIS, to promote positive school climates in New Orleans public schools	Strategy development	Oct 2016	Lead: NOHD Partners: CRA, OPSB, RSD*
Promote the use of trauma-informed practices in New Orleans public schools	# of schools participating in Trauma-Informed Schools Learning Collaborative # of trauma trainings and professional development sessions provided to schools	May 2017	Lead: NOHD Partners: CBNOLA, IWES LPHI, MHSD, PFDL, SFYD, TU Dept. of Psych

*Many NOLA for Life partners contribute to CHIP activities. Please see Planning Initiative Partners section for a full list

Objective 2: Increase access to violence prevention services for parents and families			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Identify and offer support for victims of family violence through city-operated NOHD-WIC clinics	% of participants who receive family violence screening % of participants identified as at-risk for family violence and accept referral services # of participants who attend parenting trainings	July 2017	NOHD-WIC
Prevent child maltreatment through positive parenting programs	# of participants in Tulane Innovations in Positive Parenting Study (TIPPS)	Ongoing	Lead: TU School of Public Health Partners: CBNOLA, NOHD-WIC

Objective 3: Increase community capacity to address violence through a public health approach			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Enhance data sources related to youth risk and protective factors for violence	New Orleans School Equity Index launched City-wide survey of student experiences and behaviors developed Collective efficacy in NOLA for Life priority neighborhoods assessed	Dec 2017	Lead: LCCR, OPEN, TU Education Research Alliance, Researcher TBD Partners: NOHD*
Participate in the National Forum on Youth Violence Prevention	Update *NOLA FOR LIFE PLAYbook*	May 2017	NOHD*
Engage youth as partners in youth violence prevention	# of youth engaged through program activities	Dec 2017	Lead: NOHD Partners: NOPD*

*Many NOLA for Life partners contribute to CHIP activities. Please see the Planning Initiative Partners section for a full list

Objective 4: Increase coordination of City response to domestic violence through the ongoing implementation and monitoring of the *Blueprint for Safety* protocol			
Evidence Base: Praxis International Blueprint for Safety [119]			
Policy Changes Needed: Each BFS partner agency has signed an MOU outlining implementation of BFS protocol. These policies must be fully adopted for coordination to improve.			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Ensure that all BFS partner agencies are engaging in introductory and ongoing BFS training	BFS training schedules developed Annual BFS training conducted Training completed by all new BFS partner agency staff	Jan 2017	NOHD, agency appropriate trainers

Objective 4 (cont.): Increase coordination of City response to domestic violence through the ongoing implementation and monitoring of the *Blueprint for Safety* protocol			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Monitor domestic violence related calls with a multi-disciplinary team to determine training needs and strengths	2 case review sessions conducted Report on findings submitted to NOPD	July 2017	NOHD, NOPD
Convene interagency BFS Steering Committee to ensure ongoing commitment to and continued use of BFS	4 convenings of BFS Steering Committee	July 2017	NOHD

Objective 5: Reduce disparate impact in criminal justice system response to domestic violence			
Evidence Base: Praxis International Blueprint for Safety[120]			
Policy Changes Needed: Each BFS partner agency has signed an MOU outlining implementation of BFS protocol, including policies to reducing disparities. BFS policies must be fully adopted for reduced disparities.			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Develop a variation of the Duluth Power & Control Wheel representing the experience of DV in the African American community	Tool created Focus groups conducted Tool peer reviewed by experts in DV community Submitted to DAIP for national publication	June 2017	NOFJC, NOHD, Praxis International
Collect qualitative data on disparate impact through focus groups with DV victims who have interacted with BFS partner agencies through the criminal justice process	5 focus groups held Report on findings to BFS partner agencies and BFS Steering Committee	June 2017	NOFJC, NOHD
Code and analyze NOPD DV reports to identify trends in disparate impact	225 police reports coded Major themes identified Disparate impact report developed	June 2017	IWES, NOHD, TU

Objective 6: Improve the quality and cohesion of the community's response to domestic violence through Domestic Violence Advisory Council and its partners			
Evidence Base: Domestic Abuse Intervention Project Coordinated Community Response [121]			
Policy Changes Needed: All BFS partner agencies must adapt current policies to align with those outlined in the BFS; Orleans Parish must also adopt a version of the Louisiana BIP Standards created at the parish level for increased quality of BI services. [122]			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Broaden outreach to victims of DV who cannot access traditional services; those with criminal history, currently in an abusive relationship, etc.	List of service providers developed Number of organizations reached	July 2017	DVAC Outreach & Prevention Committee, NOFJC, NOHD

Objective 6 (cont.): Improve the quality and cohesion of the community's response to domestic violence through Domestic Violence Advisory Council and its partners			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Review DV policies of first responders and decision makers (EMS, NOPD, local hospitals, and Civil/Criminal judges) for best practices and continuity	Policies reviewed Recommendations submitted	July 2017	DVAC Training Committee, NOFJC, NOHD
Map culturally and linguistically specific DV services in GNO, identify gaps in services, and utilize best practices to make recommendations for expansion	DV Resource Guide published in English, Spanish and Vietnamese Service gaps identified Recommendations submitted	July 2017	DVAC Culturally Specific Services Committee, NOFJC, NOHD
Create Orleans Parish specific minimum standards for Batterer's Intervention programs (BIP)	Standards developed Standards accepted/adopted by key stakeholders Create and disseminate list of compliant BIP	July 2017	DVAC BIP Committee, NOFJC, NOHD
Provide recommendations for DV policy to the Mayor's BFS Committee	Recommendations drafted and presented to BFS Steering Committee	Dec 2016	DVAC Committee Leads, NOFJC, NOHD

Objective 7: Improve the quality and cohesion of the community's response to sexual assault through the Sexual Assault Response Team and its partners			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Host SA Prevention Summit targeting professionals who work with middle and high school youth	75 summit registrations Summit agenda	Aug 2016	NOFJC, NOHD, SART Prevention Committee
Draft pilot policy on homeless shelter response to SA disclosures	Homeless Shelter SA Disclosure Policy draft	Jan 2017	NOFJC, NOHD, SART Homeless Advocacy Committee
Distribute SART Quarterly Newsletter to SART partners and community organizations	100 newsletter subscriptions in 2016 4 newsletters sent out in 2016	Dec 2016	NOFJC, NOHD, SART Communications Committee
Develop NOPD training curriculums specific to SA and Child Abuse to assist in meeting consent decree requirements	Approved NOPD SA training curriculum Approved NOPD Child Abuse training curriculum	Dec 2016	NOCAC, NOFJC, NOHD, NOPD, SART Training Committee
Convene a collaborative of local universities to share resources, best practices, and information related to campus SA prevention and intervention	6 of universities in collaborative Meeting minutes	Dec 2016	NOFJC, NOHD, SART University Committee

Violence Prevention Health Improvement Indicators:		
Indicators	**Sources**	**Frequency**
Murder in Orleans Parish (# of deaths classified as murders by NOPD) **2012:** 193; **2013:** 156; **2014**: 150; **2015:** 164	NOPD UCR data[123]	Quarterly
Youth Violence (# of murders with victims under the age of 25) **2012:** 70; **2014:** 55	NOPD UCR data	Annually
Rape in Orleans Parish (# of rapes reported to NOPD) **2013:** 176; **2014:** 244; **2015:** 409	NOPD UCR data	Annually
Youth who feel safe in their school in Orleans Parish (% of students per grade) **2012**: 6th-80.6%; 8th-77%; 10th-78.8%; 12th- 69.2% **2014:** 6th- 87.4%; 8th- 73.7%; 10th: 70.9%; 12th- 70.7%	LA CCYS**[124]	Every 2 years
Youth who feel safe in their neighborhood Orleans Parish (% of students per grade) **2012**: 6th-68.4%; 8th-78.1%; 10th-72.2%; 12th-68.1% **2014**: data not available at this time	LA CCYS	Every 2 years
Improved victim experiences in Orleans Parish (TBD) **2016:** TBD	NOHD, BFS Focus Groups	Annually

***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*

4 Healthy Lifestyles

BACKGROUND

Obesity is a severe health issue that affects an increasing number of children, adolescents and adults in the U.S. every year. Although complex and influenced by a range of factors, it is clear that obesity at any age poses a significant risk to one's quality and length of life.[125] Obesity in childhood drastically impacts the health of a child, the effects of which compound as they reach adulthood. The more immediate effects include an increased likelihood of having high cholesterol, high blood pressure and pre-diabetes, further increasing the risk for chronic diseases such as cardiovascular disease and diabetes later in life. Children and adolescents who are obese are prone to having bone and joint problems, sleep apnea, and often suffer from social and psychological issues such as stigmatization and poor self-esteem. Long term, obese children have an increased likelihood of being obese as an adult, which translates into greater risk for heart disease, type 2 diabetes, stroke, many types of cancer, and osteoarthritis —some of the leading causes of preventable death.[126]

Childhood obesity is a serious problem affecting 12.7 million children and adolescents across the country. Although childhood obesity rates have remained stable at about 17% over the past decade, they are still drastically higher than they were a generation ago, as rates have doubled, tripled, or even quadrupled for various age groups under 19 since 1980. In Louisiana, the National Survey on Children's Health (NSCH) data from 2011 reveals that over 20% of children ages 10-17 are obese, ranking the state 4th of 51 in childhood obesity for that age group. While there is a lack of data regarding childhood obesity in New Orleans, data available from 2007 shows that 16.7% of high school students are obese and 17.4% are overweight.[127]

Louisiana's adult obesity rates have been steadily increasing over time and, according to 2015 BRFSS data, are currently the highest in the nation (32.6%).[128] Mirroring the national trend of increasing obesity rates among adults overall, the state's current rate of 32.6% demonstrates an increase from previous rates of 31.6.6% in 2010 and 28.2% in 2006. In 2000, no state displayed adult obesity rates above 25% yet, by 2015, the rates in four states exceeded 35%- Louisiana being the worst offender. In addition, Louisiana ranks within the top five states in the nation for rates of chronic disease and behaviors associated with obesity such as diabetes (12.7%), hypertension (39.3%), and physical inactivity (31.9%).[129] In Orleans Parish, approximately 30% of adults are obese, contributing to high rates of death from preventable diseases such as heart disease, stroke, type 2 diabetes and cancer. The American College of Sports and Medicine (ACSM) ranked New Orleans 33rd overall in its health and fitness ranking of the 50 most populous metro areas in the U.S. in 2016, an increase from 37th in 2012.[130]

Disparities in Healthy Lifestyles

These statistics do not affect all populations equally. The prevalence of obesity is significantly higher in Southern states, including Louisiana, and in African American and Hispanic populations across the country.[131] 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 were found to be 33% more likely to die of heart disease and three times more likely to die of diabetes than Whites.[132] While behavioral factors drive a portion of these statistics, one's environment has an immense impact on the ability to make and follow through on healthy choices. Low income and minority neighborhoods are less likely to have access to recreational facilities and full service grocery stores and more likely to have higher concentrations of retail outlets for tobacco, alcohol and fast foods, making it harder for healthy choices to be the norm.[133] Furthermore, low income communities are more likely to experience high levels of crime and violence, and/or low levels of perceived safety, severely limiting the likelihood of residents utilizing outdoor spaces for physical activity.

ACCESS TO HEALTHY FOODS

The Importance of Place in Accessing Healthy Foods

According to the dietary guidelines set by the federal government, eating the daily recommended amounts of fruits and vegetables is critical to providing nutrients to protect against disease and obesity, as well as fueling the body for physical activity.[134] In New Orleans, 42.7% of adults report not eating fruit daily, 31.5% of adults report not eating vegetables daily, and only 22% of high school students report eating 5 or more servings of fruits and vegetables per day.[135] Without access to healthy foods, one's nutritional intake and ability to manage weight greatly suffers, leading to higher risk of chronic disease; lack of access to healthy foods is strongly correlated with a high prevalence of overweight, obesity, and premature death.[136] [137] [138]

The U.S. Department of Agriculture and HHS report that food access is influenced by a diverse set of factors including: proximity to food retail outlets, individual resources and neighborhood-level resources.[139] Overall, New Orleans residents experience deficiencies in all of these areas. In New Orleans, proximity to food retail outlets is relatively limited; when comparing the city's 1 supermarket for every 11,800 residents to the national ratio of 1 supermarket for every 8,440 residents, it no surprise that 14.77% of the population live in *food deserts*, or areas with limited access to healthy and nutritious food options. Further compounding the problem, 12.5% of New Orleanians live in *food swamps*, where there is not only limited access to healthy food options, but also an abundance of unhealthy food options that are accessible, convenient, and cheap.[140] [141] Resources of individual residents, overall, are significantly lower than national averages, with a city-wide poverty rate of approximately 28%, versus 15.5% nationally, and a child poverty rate of 43.3%, versus 21.7% of children nationally.[142]

Although reports of amenities in New Orleans neighborhoods have improved significantly over the past several years, large disparities between neighborhoods and among racial groups remain. The *Place Matters* report previously mentioned demonstrates the stark differences in life expectancy between zip codes in the city.[143] Additionally, a 2015 KFF survey report found that African Americans in New Orleans are less likely than Whites to say their neighborhood has sufficient places to buy groceries (63% versus 78% of Whites) and restaurants (55% versus 83%).[144] However, about two-thirds of both African Americans (67%) and Whites (68%) say their neighborhood has enough public transportation.

Efforts to Improve Food Access

Access to healthy food is important in all environments where people make choices about eating. Since 2012, the City's Fresh Food Retailer Initiative has helped to increase healthy food retail availability. Over the past four years, CHI partners, (referred to as "Fit NOLA partners" for the remainder of this section) have worked to improve the food environment in New Orleans using innovative approaches such as: providing fruit and vegetable prescriptions through community clinics; educating residents on farmers markets basics and how to prepare new foods; offering easy access to healthy recipes and where to find healthy restaurant dishes across the city through a Fit NOLA mobile application; and campaigning to promote male support for breastfeeding mothers. Furthermore, partners have also worked to assist City administration in implementing long-term policy changes to improve food access in public spaces. As of February 2016, Fit NOLA has begun implementing highly rated, healthy vending menus in vending machines at city owned parks and facilities across the city. These efforts support the Mayor's 2012 Healthy Vending policy and have earned New Orleans a Silver medal in First Lady Michelle Obama's *Let's Move!* initiative goal related to Model Food Service. Long term, Fit NOLA partners look to broaden the reach of healthy vending by implementing policy recommendations within state owned buildings in the area as well.

ACCESS TO OPPORTUNITIES FOR PHYSICAL ACTIVITY

Physical Inactivity despite Increased Opportunities for Exercise

Regular physical activity is a critical component of living a healthy lifestyle. Engaging in regular physical activity can increase energy, assist in weight management, improve mental health, strengthen muscles and bones, and improve academic achievement in students; doing so can also decrease the risk for cardiovascular disease,

hypertension, type 2 diabetes and some cancers.[145] Similarly, physical *inactivity* can cause adverse health outcomes and is the basis for 11% of premature mortality in the United States.[146] According to the CDC, adults with higher education and adults who live above the poverty level are more likely to meet federal physical activity guidelines than others.[147] In New Orleans, where both the high school graduation (77.5%)[148] and poverty rates (27.9%)[149] are worse than the national average, more than 27% of adults are physically inactive and 64% of high school students do not meet recommended levels of physical activity. [150]

Community resources such as parks, recreational facilities, and greenspaces can make the environment more conducive to healthy choices. Access to well-equipped and safe parks and playgrounds is associated with lower obesity rates and higher physical activity levels. The existence of trails, sidewalks and bike lanes encourages the use of active transportation. New Orleans does well in ensuring residents access to a variety of structures and physical places to exercise, with 95% of New Orleanians estimated to have access to exercise opportunities. Not only is the city designated as a silver-level bicycle friendly community by the American League of Bicyclists[151], but the Trust for Public Land ranked New Orleans 31 out of the 75 largest cities in meeting the need for parks.[152] Currently, New Orleans has the 10th highest percentage of people who bike to work every day, has bike lanes in 25% of its arterial streets, and maintains over 2,000 acres of public green space.[153] [154]

Efforts to Increase Access to Physical Activity

Fit NOLA has worked to utilize its vast partner network and access to City resources, such as community centers and greenspaces, to make physical activity more approachable, affordable and available to all residents. Partnership efforts include: increasing bike lanes and refurbishing public greenspaces; offering free exercise and fitness classes at NORDC parks and facilities; working with the City to offer Playstreet events to children and families; and providing education and training to residents and fitness instructors, alike. The development of the Fit NOLA mobile application has also increased access to physical activity by mapping locations of fitness classes, health events, bike lanes and other resources around the city.

FIT NOLA PARTNERSHIP

Collective Impact for a Healthier City

In February 2011, the City of New Orleans joined First Lady Michelle Obama's *Let's Move!* Campaign and committed to eliminating childhood obesity in one generation. Mayor Mitch Landrieu challenged residents from all sectors of New Orleans to help fight childhood obesity in our city together, through collective impact. In 2012, the City convened key partners through a series of summits, out of which came the Fit NOLA Partnership and a *Shared Action Blueprint* to guide the partnership in achieving its stated goal. Shortly after its creation[155], Fit NOLA expanded its scope from childhood obesity to addressing chronic disease for all New Orleans residents, with a particular focus on nutritional and physical activities. Over the years, the Fit NOLA Partnership has grown to over 200 non-profit organizations, schools, direct service providers, businesses and community members.

Fit NOLA uses a multi-sector approach to achieve the shared goals of building capacity, increasing awareness, and setting institutional policy and standards to improve the health and fitness of all New Orleanians. NOHD serves as the backbone organization yet, strategic planning and decision making for the partnership is guided by a Steering Committee made up of community leaders. Strategic plans are implemented through six sector groups, each of which has defined goals and activities. The six sector groups represented in Fit NOLA are:

Healthy Community Design Sector
School and Out-of-School Sector
Business Sector
Early Childhood Sector
Healthcare Sector
Community Sector

Fit NOLA Progress

Over the past four years, Fit NOLA has successfully convened sector groups and other partners to complete projects and create a vision for future efforts. In that time, New Orleans has increased parks, parkland, and farmers

markets per capita, and exceeded the targets established by ACSM for walkability and percentage of residents biking to work.[156] Although rates of obesity and the percentage of residents meeting dietary and physical activity recommendations remain, Fit NOLA partners have made great progress in supporting healthier lifestyles for all New Orleanians. Specifically, partners have assisted New Orleans businesses in creating healthy workplace environments for over 31,000 employees; collaborated with over 20 New Orleans Public Schools to provide funding and resources to enhance physical activity and nutrition programming; provided free health and wellness programming to over 6,400 residents through Fit NOLA parks classes; and supplied over 850 individuals and families with fruit and vegetable prescriptions through the Fit NOLA Prescription program.

PARTNER IMPLEMENTATION PLAN

GOAL 1: Leverage City and partner resources to address leading causes of poor health outcomes in our community with an emphasis on physical activity and nutrition

GOAL 2: Improve quality of life for all residents wherever they live, learn, work and play

Objective 1: Increase access to physical activity and healthy eating opportunities for youth in New Orleans			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Implement staff trainings on trauma-informed coaching and nutritional programming for 2015-2016 Fit NOLA Schools	Staff from 12 schools receive training	Oct 2016	Cookbook Project , Fit NOLA School Sector*, Up2Us
Recruit Orleans Parish public schools to complete 2016-2017 Fit NOLA Schools assessment	40 schools complete assessment	Oct 2016	Fit NOLA School Sector
Assign designations to highest ranking schools; publicly recognize these schools with Fit NOLA designation level (mini-grant, banner, press release, etc)	30 schools receive designation	Jan 2017	Fit NOLA School Sector, IWES
Provide technical assistance for schools to (1) improve their wellness policies and (2) connect them with resources to improve their ability to provide a healthy environment for students	30 schools receive technical assistance	June 2017	Fit NOLA School Sector
Seek and implement opportunities to connect with school collaboratives and promote Fit NOLA school sector programming	Opportunities identified / collaborations implemented	June 2017	Fit NOLA School Sector
Engage in resource development for the Fit NOLA schools program for subsequent years	Funds raised	June 2017	Fit NOLA School Sector

* Many individuals and organizations have committed to working within a Fit NOLA sector and assist in the development and implementation of these activities. Please see Planning Initiative Partners section for a full list of sector participants

Objective 2: Increase awareness and opportunities for physical and nutritional activities and resources in Orleans Parish			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Maintaining and improving digital presence of the Fit NOLA partnership via social media, email and web	12 monthly Twitter chats # of newsletter subscriptions (increase from 1300) 7000 social media subscribers (increase from 5,700)	July 2017 Jan 2017 Jan 2017	Fit NOLA Community Sector, NOHD, Tulane PRC
Update and market the Fit NOLA smartphone app to populations with greater risk of chronic disease	# of App downloads (increase from 2,500)	Jan 2017	Fit NOLA Community Sector
Develop and implement outreach strategies for faith based groups, neighborhood associations, direct service providers and community leaders & members	# of faith based groups reached # of neighborhood associations reached # of direct service providers	Jan 2017	Fit NOLA Community Sector
Develop and implement strategy to engage youth in wellness advocacy and Fit NOLA program development	# of youth involved in Fit NOLA	July 2017	Fit NOLA Community Sector

Objective 3: Implement early childhood obesity prevention strategies by developing new and supporting existing initiatives designed to: increase physical activity, promote healthy eating, and encourage and support breastfeeding for children in New Orleans			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Develop and implement outreach strategies for early childhood resources/providers	# of service providers	July 2017	Fit NOLA Early Childhood Sector
Encourage and assist childcare centers with the adoption of comprehensive healthy nutrition and physical activity practices and policies	# of childcare centers with adopted policies	July 2017	Fit NOLA Early Childhood Sector
Provide education to parent and caregivers on nutrition, physical activity, and quality standards for childcare environments	Outreach material is created	July 2017	Fit NOLA Early Childhood Sector
Promote breastfeeding through breastfeeding friendly hospitals, workplaces, public spaces and commercial areas	# of breastfeeding places	July 2017	Fit NOLA Business & Early Childhood Sectors

Objective 4: Provide health practitioners with the tools to service the community, with a focus on fitness and nutrition			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Identify health practitioners or champions within each the Broad Street and Broadmoor communities	# of health practitioners attending Healthcare Sector Meeting	Nov 2016	Doc Griggs, NOHD
Identify and map existing resources within each community	Asset map of Healthcare Sector completed	Dec 2016	Fit NOLA Health Care Sector, NOHD

Objective 5: Facilitate access to nutritional and physical activity by way of community design and environment			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Develop a strategic plan for the Food Policy Advisory Committee (FPAC)	Completed strategic plan	Sept 2016	FPAC
Implement healthy procurement policies to ensure the availability of affordable, nutritious food and beverages in government facilities and buildings	# of City owned properties have healthy vending signage # of state owned properties with healthy vending signage	July 2017	NOHD, Tulane PRC
Collaborate with other government agencies to incorporate health considerations in all policies, ordinances and planning that can affect fitness and healthy behaviors	# of agencies and/or collaborations	July 2017	DPW, French Market Corporation, NOHD
Identify resources to conduct food system assessment of GNO area	Funding generated Assessment conducted	July 2017	FPAC

Objective 6: Inform, educate & support businesses to become health conscious workplaces			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Recruit Orleans Parish businesses to complete 2016-2017 Fit NOLA Business assessment	% increase in businesses designations	July 2017	Fit NOLA Business Sector
Provide education to businesses on the advantages of making investments in healthy communities and healthy employees	# of businesses recruited to event Event hosted	July 2017	Fit NOLA Business Sector

Healthy Lifestyles Health Improvement Indicators:		
Indicators	**Sources**	**Frequency**
Obesity in Orleans Parish (% of adults 18 years and older that report BMI >= 30) **2011:** 31.73%; **2012**: 28.71%	CDC, NCHS, BRFSS[157]	Annually
Diabetes in Orleans Parish (% of adults that report having been diagnosed with diabetes) **2011:** 10.79%; **2012:** 12.29%	CDC, NCHS, BRFSS	Annually
Physical Inactivity in Orleans Parish (% of adults that report no leisure-time exercise in past month) **2011**: 34.5%; **2012**: 26.18%	CDC,NCHS, BRFSS	Annually
Low Vegetable Consumption in Orleans Parish (% of adults who consume less than 1 vegetable per day) **2011:** 31.5%	CDC, NCHS, BRFSS	Annually
Low Fruit Consumption in Orleans Parish (% of adults who consume less than 1 fruit per day) **2011:** 42.7%	CDC, NCHS, BRFSS	Annually
Food Insecurity in Orleans Parish (% of people who lack access to enough food for the household) **2012:** 22.3%; **2013:** 22.1%; **2014:** 23.7%	Feeding America[158]	Annually
Access to exercise opportunities in Orleans Parish (% with adequate access to locations for physical activity) **2014:** 95%	DeLorme map data, ESRI, US Census Tigerline	Annually
Access to Healthy Food in Orleans Parish (% of individuals who are low-income and do not live close to a grocery store) **2010:** 12.1%	ERS, USDA[159]	Annually
Rankings	**Sources**	**Frequency**
Health and Fitness Ranking in New Orleans metro area (Overall rank among the 50 most populous metro areas in U.S.) **2013:** 38th; **2014:** 39th; **2015:** 42nd; **2016:** 33rd	ACSM[160]	Annually

5 Family Health

BACKGROUND

Though approximately 6 million women become pregnant in the United States each year, many of those pregnancies do not result in a healthy, live birth. In 2014, the CDC reported over 23,000 infant deaths in the U.S. Infant mortality rates, which are the number of infant deaths under age 1 for every 1,000 births, continue to be the most widely used indicators to measure the health and well-being of a nation. When compared to other developed countries, the U.S. fares poorly, ranking 45th among other World Health Organization (WHO) nations. The infant mortality rate in the U.S. is approximately 5.6, while rates in countries such as Germany (3.1), France (3.5), and the United Kingdom (3.5) are significantly lower, and all boast higher life expectancies and lower health expenditures than the U.S.[161] Reducing infant mortality and related factors such as low birth weight and preterm birth is said to be some of the nation's most pressing challenges by *Healthy People 2020.*[162]

Infant mortality rates are the highest for those infants born with low birth weight (LBW) and mortality rates continue to increase as birth weight decreases.[163] LBW is classified as weighing less than 2500 grams (5lb 8oz) at birth and is a strong indicator of maternal health, as well as current and future child health. Babies born with low and very LBW who survive are more likely than normal weight infants to suffer from a range of adverse health conditions including: brain damage, lung and liver disease, respiratory distress syndrome, heart problems, intestinal disorders, and developmental problems, among others.[164] [165] [166] These adverse conditions remain with LBW infants for the entirety of their lives, making them much more likely to have physical, intellectual, and behavioral impairments. In school-aged children, those born of LBW represent a higher proportion of enrollees in special education classes compared to those born of normal birth weight. As adults, those who were born with LBW are at increased risk for diabetes and heart disease. Risk factors associated with LBW are often the direct result of maternal health status, her access to care, and the conditions of her surroundings; these factors can include medical factors such as inadequate or lack of prenatal care, chronic health conditions, infections, or a previous LBW pregnancy; behavioral factors such as smoking, alcohol and drug use during pregnancy; and social and economic factors such as being unemployed and having low education or income levels.[167] [168]

When assessing the health of communities in Louisiana and Orleans Parish via rates of infant mortality and babies born with LBW, both perform poorly. The *America's Health Rankings 2015 Annual Report* ranks Louisiana 48th in infant mortality and 49th in babies born with LBW when compared to other states in the country.[169] With a rate of 8.4 deaths per 1,000 live births and 10.9% of babies born weighing less than 2500 grams, Louisiana's rates are significantly higher than the national averages of 6.0 and 8%. In Orleans Parish, the Louisiana Department of Health (LDH) reported an infant mortality rate of 5.2 per 1,000 live births for 2014; a rate that is slightly lower than the national average and significantly lower than that of the state.[170] Despite the parish's comparative success in infant mortality rate, it's 11.8% of infants born with LBW exceeds both state and national percentages.

Disparities in Family Health

Significant disparities exist in infant mortality and LBW. In the U.S., infants born to African American women are more likely to die within the first year of life than other women of any other race or ethnicity.[171] [172] This is also true in Louisiana where the mortality rate for African American infants is twice that of any other racial or ethnic group, many of which are born to single mothers of low income.[173] Of the live births reported in 2014, the number of African American births and percentages of LBW babies far exceeded (and in many instances doubled) those of any other group. Of the African American babies born in Orleans Parish that year, 3% had very LBW and 14.3% were born with LBW, compared to 1.1% and 7.5% of White babies. Additionally, teenage mothers 15-19 years of age are more at risk for suffering birth complications, pre-term births, and giving birth to babies with LBW than any other

age group. In Orleans Parish, the large majority of 15-19 year old mothers are African American. In 2014, African American mothers accounted for 280 of the 317 live births to 15-19 year old mothers.[174]

Geographically, the states with the highest rates of infant mortality have historically been congregated in the Southern U.S.[175] When honing in on smaller geographic areas such as neighborhoods, great disparities remain. A 2013 report, *Child and Family Health in New Orleans*, supports this fact by demonstrating the existence of *hotspots* where the highest rates of risk factors exist, in addition high rates of LBW babies[176]. Table 1 shows demographic information for four New Orleans neighborhoods with unusually high rates of babies born with LBW. In addition to exceptionally high rates of infants born with LBW, these hotspots exceed (sometimes vastly) city-wide 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 that health and other inequities locally and nationally typically fall across racial and ethnic lines, these neighborhoods are almost all homogenously African American.

Table 1: *New Orleans Low Birth Weight Hotspot Neighborhood Clusters, 2013*[177]

	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[178]	22.5	18.4	19.8	18.9	12.0
African American (%)	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

IMPROVING PRECONCEPTION HEALTH

Preventing Adverse Health Outcomes for Future Generations

A healthy pregnancy begins long before conception. Pre-pregnancy health behaviors and maternal health status are strong determinants of infant health and directly influences a woman's risk of complications during pregnancy.[179] Preconception health, or the health of women and men during their reproductive years prior to conception, focuses on practicing healthy behaviors and maintaining good health in order to promote healthy pregnancy and birth in the future.[180] Preconception care has been defined as "a set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management" and takes a variety of forms such as: regular exercise and healthy eating to reduce risk of chronic disease; abstaining from smoking, drug use, or excessive alcohol consumption; engaging in family planning; or receiving preconception counseling from a physician.[181] Improving preconception health can provide men and women the opportunity to identify existing health risks and avoid future health complications.[182] There is growing evidence that shows parents who seek preconception care and have better preconception health are more likely to have improved pregnancy outcomes.[183] [184] In a city such as New Orleans, whose population displays high rates of risk factors for pregnancy complications, infant mortality and LBW, promoting preconception health is a critical step in ensuring the health of future generations.

Regardless of one's plans for building a family in the future, working to improve preconception health is an important practice for men and women of reproductive age, considering that approximately half of all pregnancies in the U.S. are unplanned.[185] Working to improve preconception health before unplanned pregnancies occur is

beneficial to the overall health and sustainability of the family. Although unintended pregnancy rates vary by age and race and ethnicity, young African American and Hispanic women ages 15-19 have the highest rates of unintended pregnancy in the country. These disparities are closely associated to increased rates of maternal risk factors such as smoking, alcohol consumption, and chronic disease, in addition to an increased likelihood of experiencing adverse outcomes such as preterm birth, fetal growth restriction, and infant death.[186] Furthermore, there are social and economic risks associated with unplanned pregnancy as a teen. Teen mothers are more likely to drop out of high school and to face unemployment and when compared to children born to older parents, children of teen mothers are more likely to have worse educational, behavioral, and health outcomes.[187] *America's Health Rankings* ranks Louisiana 44th in teen births; ach day there are 14.3 live births to women 15-19 years of age in the state.[188] In Orleans Parish, the teen pregnancy rate (29.3) is equal to the national average and significantly lower than that of the state (43.1) and other parishes across Louisiana. However, the parishes of East Baton Rouge, Jefferson and Orleans together account for over 20% of the teen births among all Louisiana parishes.[189]

Efforts to Improve Preconception Health

To address immediate preconception health concerns, CHI partners including NOHD's Healthy Start New Orleans (HSNO), IWES, and LDH's Office of Public Health (OPH) Bureau of Family Health (BFH) are collaborating with New Orleans public high schools who demonstrate increased teen pregnancy rates to offer services supporting improved preconception health for students, some of which include school-based health education, prevention and health promotion. To provide support for preconception health in the long-term, partners such as LPHI, NOHD, and New Orleans public schools, are working to streamline the establishment of sexual health education policies in public schools so that regular and consistent implementation of comprehensive sexual health education becomes the new norm. At this time, Louisiana does not require schools to provide sexual health education at any grade level, but allows for it in grade 7-12; when taught, it must emphasize abstinence but can include education around other risk reduction methods such as contraception and condoms.[190] Doing so ensures that youth enrolled in public schools have the opportunity to make informed decisions regarding their reproductive health and their future as parents.

Outside of school-based settings, a myriad of partners work to improve preconception health in the community by connecting men and women of reproductive age to services and resources needed for a healthy life. Partners carry out various activities including: distributing health promotion and prevention materials through targeted outreach; providing preventative services and screenings or making referrals to organizations who do; offering assistance with health insurance enrollment and ensuring that medical homes are documented; assisting in the development of reproductive health plans or in obtaining contraception; as well as hosting bi-lingual health education classes and parenting support groups at accessible locations in the community.

ACCESS TO PRENATAL AND POSTNATAL CARE

The Consequences of Limited Access to Care

Access to prenatal care is a critical component of a healthy pregnancy; without access to prenatal care, the effects on family health can be detrimental. Prenatal care, or the clinical care women receive when pregnant, reduces the risk of complications during pregnancy, LBW, and birth defects in infants. The Office of Women's Health states that infants born to mothers who did not receive prenatal care are three times more likely to have LBW and five times more likely to die than those born to mothers who did get care.[191] In Orleans Parish, prenatal care has shown to be unevenly distributed, with neighborhoods that are the most economically disadvantaged such as Gert Town, the Ninth Ward and Seventh Ward, reporting the lowest number of prenatal care recipients. Mothers without prenatal care go are not properly screened and monitored for pregnancy-related complications including gestational diabetes, HIV/AIDS and STDs. Untreated, STDs can lead to ectopic pregnancy or infertility in the mother and blindness, respiratory infections, pneumonia, physical and developmental disabilities, or death in infants. In 2014, Louisiana ranked in the top three states for Chlamydia, Gonorrhea and Syphilis.[192] The same year, the New Orleans

region reported the highest rate of Syphilis, along with the highest number of documented cases of Chlamydia, Gonorrhea and Syphilis of all the nine regions in the state.[193]

In addition to adequate and timely prenatal care, the support and care received postpartum is important in ensuring the long-term health of the family. Once an infant is born there are still many challenges ahead that must be addressed for optimal family health. The early postpartum period is a critical time for addressing issues such as: establishment and maintenance of a breastfeeding regimen; minimizing risk of SIDS (3rd leading cause of infant mortality); screening for and treating postpartum depression; and maintaining maternal and infant physical health.

Efforts to Increase Access to Prenatal and Postnatal Care

CHI partners continue to offer families a strong continuum of care from preconception to years after the birth of a child. At the core of partner efforts is the goal of reducing risk for adverse birth outcomes and promoting overall family health throughout the life course. Both before and after the birth of a baby, partners such as NOHD's HSNO, Fussy Baby Network (FBN), and Nurse Family Partnership (NFP), offer home visitation services as a key method of delivering perinatal case management, risk assessment, depression screening, health education, parenting support services and outreach core services to expecting or new mothers and fathers. Home visitation is an evidence-based model of service delivery, which has proven to be effective in engaging underserved and marginalized families across the country.[194] Similarly, in New Orleans, home visitation has been stated as the main reason 95% of HSNO mothers and families surveyed maintained participation in regular prenatal care and health education courses. Those who received services have shown increased levels of self-efficacy as parents and caregivers and their babies have experienced positive birth outcomes such as healthy birth weight.

Partners ensure that all home-visitation is conducted by trained professionals equipped with skills and resources to connect or provide families with services they need and in their preferred language, whenever possible. Home visitation staff includes a variety of skilled workers from nurses and infant specialists to case managers and social workers, some of which are also Certified Lactation Consultants (CLC) to assist in matters related to breastfeeding and/or Certified Application Counselors (CAC) to provide health insurance enrollment assistance to increase access to necessary clinical care. Outside of the home, the state based Gift program will continue working with local birthing facilities to ensure that in the hours before and after birth, evidence based practices are implemented to optimize health of the mother and child through increased breastfeeding rates, improved quality of maternity services, and enhanced patient-centered care.

STRENGTHENING AND ENHANCING COMMUNITY SYSTEMS

Looking at the Big Picture

CHI Family Health partners employ the Life Course Perspective, which takes into account one's life within structural, social, cultural contexts. The Life Course Perspective states that an individual's health is highly dependent on the quality of the environments they exist in and that those environments will remain a strong influence on health from birth until death; adverse birth outcomes are also linked to challenges throughout the life course, including decreased educational attainment, asthma, cardiovascular disease, and diabetes. The 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, they must experience reduced risk and enhanced protective factors across all sectors.[195]

Efforts to Strengthen and Enhance Community Systems

CHI partners work to improve maternal and child health through an assets-based, family centric framework, and recognize the impact that one's community and environment has on the health of a family. Using that knowledge, partners seek to improve health outcomes by enhancing the environments and systems families exist and participate in. At the community level, partners assist in increasing community awareness, shifting community

perception, developing networks to share information, and establishing strong systems of support. For example, partners such as the Greater New Orleans Breastfeeding Awareness Coalition, LDH-OPH-BFH, Tulane Mary Amelia Center, and NOHD's HSNO and Women, Infants and Children (WIC) programs, have put significant effort into increasing breastfeeding awareness through consistent messaging to the community; making breastfeeding more accessible by increasing the number of safe and convenient spaces to breastfeed; and increasing access to systems of support for those, such as fathers, teens, or Spanish speakers, who often face significant barriers. At the systems level, partners work to cultivate local advocacy networks around major issues, such as employer-based paid family leave and lactation support policies, known to facilitate or further the development of health inequities experienced by families across the city. NOHD's HSNO acts as a national partner to the Raising of America campaign by hosting documentary screenings in neighborhood hotspots, facilitating discussions, and educating community leaders about issues affecting early childhood development.

PARTNER IMPLEMENTATION PLAN

GOAL: Ensure that each child and his/her family may achieve and maintain their optimal well-being

Objective 1: Improve preconception health among men and women of reproductive age [196]			
Evidence Base: CDC Recommendations to Improve Preconception Health and Health Care[197]; County Health Ranking Evidence Rating for Comprehensive Risk Reduction Sex Education[198]			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Assist in the completion of "Map Your Life" reproductive health plans	# of reproductive life plans completed	July 2017	NOHD-HSNO
Ensure that potential mothers and fathers have a medical home	# of mothers with a medical home	July 2017	NOHD-HSNO
Ensure that all local education agencies have policies regarding administration of sex education	# of LEAs with sex education policies		LPHI, NOHD
Provide education on safer sex practices and pregnancy prevention in public schools	# of education classes taught		IWES, LDH-OPH, NOHD-HSNO
Provide potential mothers and fathers with information and referrals to programs supporting healthy lifestyles	# of Fit NOLA app users	July 2017	NOHD-Fit NOLA
Provide free HIV testing	# of free HIV tests conducted	July 2017	LDH-OPH, NOHD-HCH

Objective 2: Increase the proportion of pregnant women who receive early and adequate prenatal care (HP2020 MICH-10)[199]			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Conduct outreach activities linking pregnant moms to prenatal care	# of outreach events # of resident engagements	July 2017	NOHD-HSNO
Provide home visitation to pregnant women and their families	# of mothers receiving home visitation	July 2017	FBN, NFP, NOHD-HSNO,
Encourage pregnant women to complete well woman visits	# of mothers who report having a well-woman visit	July 2017	NOHD-HSNO

Objective 3: Increase the proportion of infants who are breastfed (HP2020 MICH-21)[200]			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Increase community awareness and education around the benefits of breastfeeding through a communications campaign	# of social media posts # of radio ads	July 2017	NOHD-HSNO, NOHD-WIC
Provide lactation counseling and support to new mothers	# of CLC's # of breastfeeding support groups hosted	July 2017	NOHD-HSNO, NOHD-WIC
Ensure that women have safe and accessible spaces to breastfeed	# of spaces provided at City sites and offices # of businesses providing quality lactation rooms	July 2017	NOHD-HSNO, NOHD-WIC, TU Mary Amelia Center
Assist businesses in developing lactation support policies	# of businesses with lactation support policies City lactation support policy passed	July 2017	NOHD-HSNO, TU Mary Amelia Center
Ensure that mothers have access to affordable breastfeeding supplies	# of breast pumps distributed	July 2017	NOHD-WIC
Assist N.O. hospitals in implementing the Baby-Friendly Hospital Initiative's Ten Steps to Successful Breastfeeding	# Hospital Regional Collaborative Meetings	July 2017	LDH-OPH-BFH
Conduct trainings on consistent breastfeeding messaging within communities	# of trainings	July 2017	LDH-OPH-BFH

Objective 4: Increase access to services and resources for parents and caregivers			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Conduct postnatal depression screenings for parents and provide referrals and treatment for those in need of additional services	# of screenings completed # of referrals made # receiving follow-up service	July 2017	NOHD-HSNO, NOHD-WIC
Provide support and education to parents in the community	# of Group Connections # of Group Connections provided in Spanish	July 2017	NOHD-HSNO
Host parenting education and support groups	# of education classes held # of support groups held	July 2017	NOHD-HSNO, NOHD-WIC
Assist businesses with creating paid family leave policies	# of businesses with paid family leave policies	July 2017	NOHD-HSNO

Objective 5: Increase the proportion of fathers who are engaged in activities related to pregnancy and child development			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Ensure that fathers have resources needed to fully engage in their partner's pregnancy and their child's birth and development	# of fatherhood education classes provided	July 2017	NOHD-HSNO

Objective 6: Increase awareness of how social and physical environments can affect the health outcomes of children and families			
Activities	**Performance Indicators**	**Target Dates**	**CHI Partners**
Educate families about the adverse impact of lead on health and best practices for child safety	#of HSNO families educated #of Home Safety Checklists completed by Case Managers	July 2017	NOHD-HSNO, LDH-Lead Program
Engage the community in sharing personal experiences of how the environment has shaped the health of their family	# of Photovoice projects held in hotspot communities	July 2017	NOHD-HSNO, TU
Partner in the national Raising of America campaign to promote systems level change in areas affecting early childhood development	# of America screenings and discussions hosted # of neighborhoods with screenings	July 2017	NOHD-HSNO
Educate child care center staff on important health and safety topics	# of staff trained # of centers trained	July 2017	LDH-BFH-CCHC
Educate the community and partners about the effects of Adverse Childhood Experiences	# of people trained	July 2017	LDH-BFH

Family Health Improvement Indicators:		
Indicators	**Sources**	**Frequency**
Infant Mortality in Orleans Parish (rate of all infant deaths within 1 year) **2012:** 8.0; **2013:** 9.3	CDC, NCHS, Linked Birth/Infant Death data set[201]	Annually
Low Birth Weight in Orleans Parish (% of live births that are low birth weight) **2013:** 12.5%; **2014:** 11.8%	CDC, NCHS, NVSS-N[202]	Annually
Sexually Transmitted Infections in Orleans Parish (# of chlamydia cases per 100,000 people) **2010:** 1,329.4; **2011:** 1,655.2; **2012:** 1,160.4; **2013:** 1073.1; **2014:** 1134.4	CDC, NCHHSTP Atlas[203]	Annually
Teen Births in Orleans Parish (% of all live births to mothers less than 18 years of age) **2013:** 30.6; **2014:** 29.4	CDC, NCHS, NVSS-N	Annually

2016-2017 Planning Initiative Partners

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BLUEPRINT FOR SAFETY

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Department of Corrections Probation and Parole
Domestic Violence Monitoring Court
Municipal and Criminal District Court
New Orleans Family Justice Center
New Orleans Health Department
New Orleans Police Department
Office of the Mayor
Orleans Parish Communication District
Orleans Parish District Attorney's Office
Orleans Parish Sheriff's Office

DOMESTIC VIOLENCE ADVISORY COMMITTEE

E. Nelle Noble, New Orleans Health Department (chair)
Eva Lessinger, New Orleans Family Justice Center (chair)

Partner Agencies

Breakout
Catholic Charities of New Orleans
Celebration Hope Center
Covenant House
Crescent House
Department of Corrections Probation and Parole
Domestic Violence Monitoring Court
Family Services of Greater New Orleans
Harmony House
Kingsley House
LCADV
Leaders Education and Counseling LLC.
Louisiana Department of Children and Family Services
Metropolitan
Municipal and Criminal District Court
New Orleans Children's Advocacy Center
New Orleans Children's Bureau
New Orleans Police Department
No Abuse Coalition
NOLA Dads
Orleans Parish CSO
Orleans Parish District Attorney's Office
Orleans Parish Public Defender's Office
Orleans Parish Sheriff's Office
Planned Parenthood
Project SAVE
Silence is Violence
SLLS
St. Bernard
Tulane University
UNITY
Vietnamese Initiatives in Economic Training
Women with a Vision

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Emelia Clement, LSU Ag Center
Emery Van Hook Sonnier, Market Umbrella
Keelia O'Malley, Tulane PRC
Kelly McDonogh, Louisiana Public Health Institute
Leonetta Terrell, Friends of Lafitte Corridor
Lisa Collins, Baptist Community Ministries
Millette White, New Orleans Ballet Association
Molly Pucillo, NORDC
Naomi Englar, Tulane PRC
Rashida Ferdinand, Sankofa CDC
Taffy Morrison, Slidell Memorial Hospital

Early Childhood Sector Work Group

Mary Alexander, Healthy Start New Orleans (chair)
Bertina McGhee, LSU Ag Center
Betsy Dancisak, Louisiana Department of Health
Caitrin Alb, Mary Amelia Center
Connie Bellone, Early Childhood and Family Learning Foundation
Dr. Kathryn Parker-Karst, Market Umbrella
Jeanette Gustat, Tulane PRC
Jennifer Macias, GNO Breastfeeding Awareness Coalition
Julie Hagan, New Orleans Health Department WIC
Lauren Futrell Dunaway, Mary Amelia Center
Leslie Lewis, Louisiana Department of Health
Nikki Hunter Greenaway, Nurse Nikki
Teresa Falgoust, Agenda for Children

Healthcare Sector Work Group

Eric Griggs, Doc Griggs Enterprises LLC (chair)
Avery Corenswet, Ochsner Health System
Dr. Flint Mitchell, Greater New Orleans Foundation

Healthy Community Design Work Group

Elisa Munoz, French Market Corporation (chair)
Jennifer Ruley, LPHI/Department of Public Works (chair)

School Sector Work Group

Christine Neely, New Orleans Health Department (coordinator)

Kim Walsh, ReNew Schaumburg (chair)
Luella Williams, Up 2 Us (chair)
Alisha Johnson, Edible Schoolyard New Orleans
Anneke Dunbar-Gronke, IWES
Ashley Hooper, Alliance for a Healthier Generation
Avery Corenswet, Ochsner Health System
Bertina McGhee, LSU Ag Center

School Sector Work Group (cont.)

Bradley Cruice, Louisiana Department of Health
Coretta LaGarde, American Heart Association
Danielle Burrell, Treux North Wellness
Dr. Flint Mitchell, Greater New Orleans Foundation
Guenevere Hoy, LPHI/School Health Connection
James Graham, Healthy School Food Collaborative
Nellie Catzen, Friends of Lafitte Greenway

NOLA FOR LIFE

Partner Agencies

For a full list of NOLA for Life partnerships, please see p. 94 of the 2014 NOLA for Life PLAY*book* available at: http://www.nola.gov/getattachment/Health/Data-and-Publications/NOLA-FOR-LIFE-PLAYbook_for-web-9-2-14.pdf/

SEXUAL ASSAULT RESPONSE TEAM

Amanda Tonkovich, New Orleans Family Justice Center (chair)
E. Nelle Noble, New Orleans Health Department (chair)

Partner Agencies

Celebration Hope Center, Healing Hearts NOLA
Department of Children and Family Services
Dillard University
Family Services of Greater New Orleans
Fleet and Family Services
Kingsley House
Louisiana Foundation Against Sexual Assault
Louisiana National Guard
Louisiana Office on Women's Policy
Loyola University
Metropolitan Center for Women & Children
New Orleans Children's Advocacy Center
New Orleans Family Justice Center
New Orleans Health Department
New Orleans Police Department
Orleans Parish District Attorney's Office
Sexual Assault Nurse Examiners, University Medical Center
Sexual Trauma Awareness & Response
Silence is Violence
Triumph Krav Maga
Tulane University
University of New Orleans
VIET
Xavier University
Women with a Vision

UNITED WAY OF SOUTHEAST LOUISIANA

Blueprint for Prosperity Partner Agencies

To view a list of partner agencies, please visit: http://www.unitedwaysela.org/our-partners

Endnotes

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