

Getting People Healthy in New Orleans



SECTION III: **INFRASTRUCTURE AND** **SUSTAINABILITY FOR CHANGE**

The Healthy Louisiana 2010 Project and the Seven Point Plan of the New Orleans Health Department

ESTABLISHING A *HEALTHY PEOPLE 2010* INITIATIVE THROUGH LEGISLATION

The Healthy Louisiana 2010 program is Louisiana's version of the national *Healthy People 2010* plan. The program is based on the national *Healthy People 2010* process, yet tailored to meet the needs of Louisiana's citizens. The Louisiana Department of Health and Hospitals' Office of Public Health established the program to create partnerships with each of the state's parishes, helping them to develop and implement local health initiatives. The program will provide for a broad-based effort aimed at addressing the needs of health promotion and disease prevention in the communities within each parish.

While the Healthy Louisiana 2010 program will provide leadership and support to individual parish partnerships, each parish will be responsible for meeting the criteria for partnership certification. This allows for minimizing state directives and maximizing community involvement and ownership. Louisiana was the first state to enact legislation to establish a statewide Healthy People program. The legislation mandated that the *Healthy People 2010* Planning Council, shown in Appendix B, be established first, which would have representation from state agencies, community-based organizations, and health-related organizations. This group was charged with collaborating with the Department of Health and Hospitals to identify the top ten health priorities or Leading Health Indicators (LHI) for the state, and then to develop and implement a statewide *Healthy People 2010* strategic plan.

Through a series of meetings, the Healthy People Council's work culminated in the formal adoption of Louisiana's Ten Leading Health Indicators (LHIs) that serve as the priorities for Louisiana's health promotion and disease prevention agenda. The Healthy People Council and the Louisiana Legislature's Health and Welfare Committee approved the statewide strategic plan for the program in 2003.

HOW IS THE HEALTHY LOUISIANA 2010 PROCESS STRUCTURED?

One of the most effective tools for improving health in communities is the establishment of broad-based community partnerships. The goal of these partnerships will be to develop and implement local action agendas that are tied to local and state Healthy Louisiana 2010 objectives. This process will result in the creation of partnerships between the Healthy Louisiana 2010 program office and each parish with the state. These partnerships will be composed of parish and local leadership, representing the racial/ethnic makeup of the parish, from the following groups:

- Public and private health associations
- Civic groups and other nonprofit organizations
- Schools and universities
- Public Health entities
- Businesses
- Churches and faith-based organizations
- Local and state governments
- Hospitals, clinics and physicians
- Law enforcement

Each of the nine administrative regions under the Office of Public Health (OPH) will designate a community liaison to work with their communities and the Healthy Louisiana 2010 Program office. These community liaisons will be the contact people for the Healthy Louisiana 2010 Program office and will provide education and technical assistance to local partnerships engaged in the Healthy Louisiana 2010 “Healthy Community” certification process.

In addition to the headquarters and regional staff, it is recommended that each parish partnership hire a local “Community Project Coordinator.” The Community Coordinator will be responsible for performing a community health assessment identifying community programs with *Healthy People 2010* initiatives; promoting the communities’ initiatives by maintaining high visibility in the community; maintaining an on-going health promotion media campaign; and providing leadership and education to the community partnerships. This coordinator must be funded by local sources (i.e. local health departments/hospitals, parish commissions, foundations, etc.) and will likely be a skilled health professional, such as a nurse or a health educator.

DEVELOPING COMMUNITY PARTNERSHIPS AND REGIONAL NETWORKS

Parishes in Louisiana will be asked to develop broad-based community partnerships that represent the needs of their communities and whose missions are prevention-based. These partnerships will be composed of local leadership from businesses, churches, universities, public health agencies, hospitals, etc., representing the racial/ethnic make-up of the community. The goal of these partnerships will be to develop and implement local action agendas that are tied to local and state Healthy Louisiana 2010 objectives. The Healthy Louisiana 2010 program staff will provide assistance in recruiting and developing structure for community-based coalitions.

COMMUNITY CERTIFICATION AWARD

The “Healthy Community” Certification Award will provide statewide and national recognition of the valuable work of community members and agencies. Through the “Healthy Community” process, parishes will be certified and recognized by the Governor as “Healthy Communities.” The Governor, or his/her designated official, will present the awards on an annual basis at a statewide

conference sponsored by the Louisiana Department of Health and Hospitals' Office of Public Health. Statewide community and public health leaders, as well as partnership team members, will be invited to the conference where their efforts will be showcased and shared with other parish partnerships, and workshops will be available for training in building successful partnerships and coalitions; influencing change at the community level; performing and interpreting community assessments; tips for finding funding; influencing policy; the importance of evaluation, etc.

ACHIEVING THE COMMUNITY CERTIFICATION AWARD

The first step in the community certification process will be to perform a community health assessment. Through the health assessment process, community members will gain a better understanding of the health of their community and will be able to identify available resources, including health care systems in their community. The health assessment will culminate in a report that includes current information about the health of the citizens in the parish, as well as an inventory of available resources and existing programs. This report will also provide the basis for discussion and action.

Following the community health assessment, the community coalition will write and submit their application for certification. This application should demonstrate that the parish has adopted the state's ten Leading Health Indicators and has begun an initiative to address **at least two** of these health priority objectives. These objectives must be measurable and realistic. By receiving this certification award, a parish will enhance its access to grant opportunities from federal, state, and other funding agencies. Certification can even serve to attract economic investment in the parish.



THE SEVEN POINT PLAN

This plan for "Getting People Healthy in New Orleans" has been designed to be consistent with the state initiative. The Seven Point Plan addresses the state's selection of the ten leading health indicators and will be monitored through the attainment of those objectives found in the *Healthy People 2010* methodology and process. These Seven Points include objectives from each of the 28 focus areas identified in the introduction, reflecting the depth of scientific knowledge as well as the breadth of diversity in the U.S. More importantly, they are designed to help the state and the nation achieve *Healthy People 2010's* two overarching goals and realize the vision of healthy people living in healthy communities. In addition, many objectives focus on interventions designed to reduce or eliminate illness, disability, and premature death among individuals and communities. Others focus on broader issues, such as improving access to quality health care, strengthening public health services, and improving the availability and dissemination of health-related information. *Healthy People 2010* also provides an overview of the issues, trends, and opportunities for action in each of the 28 focus areas with detailed language for each objective, the underlying rationale, a target for the year 2010, and national data tables of its measures.

NOHD will use a modified *Healthy People 2010* in concert with Healthy Louisiana 2010 health indicators to target the unique needs of the citizens of New Orleans. Objective goals to be achieved by 2010 are discussed in the Seven Point Plan.

INFRASTRUCTURE CHANGES TO SUPPORT THIS PLAN:

General activities required to achieve these goals, many of which are already in place, will include upgrades in physical plant, information management infrastructure and service activities as follows:

- Implement process analysis and a TQM approach to identifying strengths and weakness in the organization and opportunities for improvement;

- Evaluate data collection methodology and processes to move towards a rapid recall, paperless system and a more efficient patient experience;
- Institute an integrated geographic analysis of socioeconomic, education, crime, housing and transportation data;
- Improve internal coordination of clinical services with grant program activities as well as activities in government agencies;
- Collaborate with community organizations, churches and schools to identify specific interventions, points of distribution of those interventions and assess results of interventions by using surveys and responding with customized health fairs which address disease conditions, insurance coverage, prevention, etc.;
- Upgrade clinic physical plant, equipment, administrative processes and expand to full primary care services for all age groups to improve access;
- Participate with local university affiliates in public health, epidemiology and medical research initiatives for targeted problem populations and organizational and administrative challenges.

NOHD CURRENT INTERVENTION STRATEGIES AND PROGRAMS

Many of the programs of the New Orleans Health Department already target the health issues outlined in this plan. A complete list of programs can be found in Appendix A. Significant community initiatives and programs of the NOHD that are currently in place are described below, as well.

NOHD Collaborative Community Health Education Initiative:

The City of New Orleans is undertaking the largest coordinated community health education initiative in its history. This public-private partnership project will eventually be all encompassing and will exceed the expectations of the many health fairs that currently occur in terms of touching the lives of the many racial and ethnic groups that reside in the City of New Orleans and surrounding parishes. The large-scale nature of this of this project will result in improvements in targeting appropriate interventions, which will ultimately improve the outcomes of health status among the insured and uninsured alike.

The NOHD is seeking commitments to a set of activities that will provide a distribution network for health-related information to thousands of New Orleanians via the City of New Orleans' Clinics and other mechanisms, which are described briefly below. This initiative includes education on general and specific health issues in various 'drop-in' curricula and program templates, information on service organizations, and pre- and post-intervention questionnaires with feedback to the sponsoring organizations.

These and future activities will provide information and assistance on many levels to all age groups. It is the intention of the New Orleans Health Department to have built-in mechanisms for information provided at children's activities to spread to the adults in their households and neighborhoods.

The cornerstone activities for 2005 in this initiative include:

- **Ministries Initiative:** A partnership with Total Community Action, which will ultimately access 847 congregations in southeastern Louisiana. This partnership, which will include a modified HRA questionnaire (also administered in Spanish), will help determine focused interventions at the community level (2005 target: 10,000-20,000 persons).
- **CNO Employees Initiative:** The administration of a similar confidential HRA to the City of New Orleans' employees (2005 target: 7,000 employees)
- **CNO Summer Camp Curriculum Initiative:** A curriculum for summer camps for the New Orleans Recreation Department, Cops for Kids, Special Needs groups, Dryades YMCA (2005 target: 10,000 children).

Commodities Supplemental Food Program and WIC (Women, Infants and Children) Nutrition:

Funded through specific grants, these programs both target improving nutrition among target populations in the City of New Orleans, including low-income women and children. Through preparation of specific recipes, preparation of sanitary conditions and distribution of nutritional food products, these programs directly impact our citizens who are most in need. The goals of these programs are outlined in the terms of the grants that fund them.

Community and School-Based Clinics:

Providing primary and secondary health care to specific communities and schools, these comprehensive clinics can diagnose and provide treatment and follow-on recommendations for the health conditions described throughout this document, including obesity, overweight, proper nutrition and physical activity, diabetes, and cardiovascular disease.

Services are provided through the Maternal and Child Health clinics and programs. In addition to community-based clinics, school-based clinics address the health needs of school-aged children, including those in need of maternity care. These clinics provide a comprehensive array of health services. Services provided through these clinics address the need for education for women who are pregnant or may become pregnant, appropriate obstetrical care, addressing issues related to prenatal substance exposure, and prenatal and newborn screening for specific treatable diseases, among others.

Specific goals for the coming year related to these clinics include:

- Gain and maintain Federally Qualified Health Clinic status for each clinic, which will increase the resources available to provide comprehensive health care services at each site.
- Increase participation rates in health care programs that support receipt of services (i.e., LaCHIP, WIC)
- Provide services in a well-organized, high-quality manner in each clinic.

Step Together New Orleans:

The New Orleans Chronic Disease Task Force has organized a large, broad-based community consortium to create a comprehensive Community Action Plan for the prevention of obesity, diabetes, and asthma in the city. The community consortium that has been actively engaged in developing this plan includes state and local public health agencies, the local public school system, two health science centers, a school of public health, voluntary organizations, and community-based and faith-based organizations. This plan encompasses both primary and secondary prevention approaches and includes components for:

- Community-based health promotion, including a mass media campaign
- Environmental changes to facilitate physical activity and healthy eating
- Screening and treatment of persons with pre-diabetes and obesity to prevent progression of disease
- Improved treatment of persons with diabetes to prevent long-term complications, including development of a computerized diabetes management registry to be used by an established network of clinics serving 10,000 diabetics
- Initiatives to connect asthmatic children with primary care providers and to enhance the quality of their care
- Policies and initiatives in public schools to promote physical activity and healthy eating in children.

The New Orleans Health Department and a Leadership Team central to the Community Consortium will direct the plan. The plan will be implemented by the Louisiana Public Health Institute and other subcontracting organizations. This will include a strong plan to evaluate the effectiveness of the initiative and to disseminate the results to local and national partners includes local BRFSS and YRBS surveys.

Great Expectations Healthy Start (GEHS):

To address the disparities noted earlier in this document (Point Four: Maternal-Child Health), Great Expectations Health Start (GEHS) has defined fourteen core interventions, in conjunction with the

Maternal-Child Health clinics and programs of NOHD. The following are major objectives for the core interventions for the project:

- 1) Enrollment of 30% of the pregnant African American women residing in the project area into the GEHS program,
- 2) Initiation of prenatal care in the first trimester for 90% of pregnant African American women who are enrolled into GEHS,
- 3) Increase receipt of adequate prenatal care during the first trimester (as defined by the Kessner index) for 90% of clients that are enrolled in GEHS,
- 4) Decrease deliveries of low birth weight infants to 5% for African American woman who are enrolled in GEHS,
- 5) Decrease deliveries of very low birth weight infants to 3% for African American woman who are enrolled in GEHS,
- 6) Increase the number of participating 2-year-olds who receive age-appropriate immunizations to at least 90%,
- 7) 40% of the women enrolled in Great Expectations Healthy Start program will be screened for depression,
- 8) Increase community awareness of prenatal depression, its effects and resources by 40%,
- 9) 70% of postpartum women enrolled in GEHS will receive interconceptional services,
- 10) 80% of GEHS clients that receive health education for smoking cessation/ substance abuse will self report a decrease or elimination of this risk behavior,
- 11) Complete 85% of referrals for clients in GEHS case management services,
- 12) 90% of clients will report being satisfied with services provided through GEHS,
- 13) GEHS will be able to document that at least 35 consumers will be active participants in the consortium,
- 14) Host four forums/conferences to increase provider awareness regarding health disparities and other health related issues.

Great Expectations Healthy Start Program provides coordinated community-based services at three community care centers and two satellite sites in each of five targeted areas. The program provides free pregnancy tests and counseling services. An initial screening tool is used to assess client history regarding pap smears, fetal demise, and low birth weight babies and to identify women in need of interconceptional care services. Using a multidisciplinary case management model, clients are assessed for health, psychosocial and socioeconomic risk factors by a multidisciplinary team.

The GEHS program concentrates heavily on risk reduction and health promotion education. Education includes one-on-one family planning counseling, prenatal and parenting education. The parenting and prenatal curriculum includes education surrounding harmful effects during and around pregnancy, such as smoking, substance abuse, and domestic violence. All clients are encouraged to attend prenatal and parenting classes.

One-on-one sessions are conducted with clients in the home setting. Caseworkers are responsible for reinforcing the subject matter covered in prenatal and parenting classes. GEHS uses a community/home-based approach to increase awareness regarding SIDS.

Great Expectations Healthy Start is one of the original Healthy Start Projects and continues to produce positive results. Some major accomplishments have been an increase in the percentage of women receiving prenatal care in the first trimester, adequate prenatal care and an increase in the proportion of infants that receive age-appropriate immunizations.