

The New Orleans Prosperity Index: Tricentennial Collection

# Advancing Health Equity in New Orleans: Building on Positive Change in Health

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## Introduction

Health equity is the attainment of the highest level of health and well-being for all people. It requires efforts to ensure all people have full and equal access to opportunities that enable them to lead healthy lives.<sup>1</sup> Conversely, health disparities are avoidable differences in health that are the result of unequal distributions of social, economic, and environmental factors. Examples include wealth, income, safe housing, quality education and quality health care—all of which influence health from an early age.<sup>2</sup> Moreover, health is a determining factor in many people's ability to work or work consistently<sup>3</sup> and, as such, health equity contributes to the overall productivity of a region.

Despite decades of advancements in medical care and public health research and practice, vast racial disparities in health (differences in health on the basis of race—a social, cultural, and political classification) endure. A landmark report by the U.S. Department of Health and Human Services (HHS) in 1985 documented major disparities in health outcomes nationwide.<sup>4</sup> It showed that blacks, Hispanics, Native Americans, and people of Asian and Pacific Islander descent had shorter life expectancies and higher mortality rates from cancer, heart disease, diabetes, homicide, infant mortality, and chemical dependency than whites. The Institute of Medicine published a report in 2003 exploring these disparities in mortality rates, and found that people of color had less access to health care and that the care these populations did receive was often of lower quality compared to white patients.<sup>5</sup> Since that time, more than a decade of research has explored how physicians' implicit bias—unconscious and involuntary attitudes about race—can influence their communication, treatment recommendations, pain management decisions, and empathy, depending on the race of the patient in front of them.<sup>6</sup> A study in the Proceedings of the National Academy of Sciences reported that black patients are systematically undertreated for pain relative to white patients, due in part to white medical students' and residents' false beliefs about inherent or biological differences between racial groups (for example, that “black people's skin is thicker than white people's skin”).<sup>7</sup>

In addition to the harmful effects of individually-held racial biases and prejudice, there is growing evidence of how our society impacts the health of black Americans by failing to address conscious and unconscious discrimination across interconnected systems (e.g. health care, housing, education, employment, earnings, media, criminal justice).<sup>11</sup> With this knowledge, public health efforts are beginning to move beyond a focus on individuals' actions to explore more broadly the conditions in which people are born, grow, interact, and age.<sup>12</sup>

While New Orleans has come a long way in understanding and acknowledging the policies and systems that shaped our unequal city over 300 years, there remains a steep ladder to climb in developing policies and programs to promote healthy lives for all New Orleanians. Addressing all the factors that influence health and shape the communities in which people live is bound to be complex. Public health and health care alone cannot re-shape the economic, physical, social, and service environment of New Orleans to ensure



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all people have resources and opportunities to live healthy lives. Doing so will require a collaborative approach—including public health and other governmental sectors, local nonprofit, business, and community voices.<sup>13</sup> In this essay, we focus on the black experience of health and health inequities over the past 300 years, including progress, setbacks, ongoing challenges, and recommendations that may apply to more recently growing population groups—Hispanic, LGBTQ, and Vietnamese, to name a few. Guided by the community’s wants and needs, city leaders and advocates can begin to close the gaps caused by historical inequality and build pathways of opportunity to optimal health and well-being for all people who call New Orleans home.

## History of Health Inequity in New Orleans

Since the city was founded in 1718, New Orleanians have faced adversities that directly impact their health and well-being. The French colonial Compagnie des Indes imported European criminals and contract laborers to build the city and later imported enslaved Africans after the contract laborers quickly died of disease and starvation. Without the institution of slavery, New Orleans would not exist because only force could keep these workers at their labor while European contract farmers and workers arriving in the city moved on to more hospitable territory further inland.<sup>14</sup> Though mortality rates were high among enslaved people, those who survived built levees, dug drainage ditches, cleared forests, and prepared timber for building boats and houses.<sup>15</sup> As the number of new immigrants from Germany and Ireland arriving in the city expanded, the need for health services and medical care increased.<sup>16</sup> The first hospital, Hospital des Pauvres de la Charite (Charity Hospital for the Poor), opened its doors at Chartres & Bienville Streets in New Orleans in 1736.<sup>17</sup> From its inception, Charity Hospital served as the medical safety net dedicated to the impoverished residents of New Orleans.<sup>18</sup>

After the Louisiana Purchase in 1803, New Orleans became one of the wealthiest and most powerful cities in the nation, attaining a population larger than all but two cities by 1840.<sup>19</sup> No single threat was more menacing in 19th century New Orleans than diseases that periodically swept through the population. From 1830 to 1850 repeated epidemics killed thousands, including a cholera outbreak that took the lives of 5,000 people in 1832.<sup>20</sup> One of the most devastating diseases of the era was yellow fever, which plagued the city for more than 150 years. In 1878, as the last major outbreak of yellow fever in New Orleans killed over 4,000 people, an estimated 40,000 whites fled the city, with thousands arriving at the north shore of Lake Pontchartrain<sup>21</sup> seeking tuberculosis sanatoria, health clinics, and natural springs available to white patrons only.<sup>22</sup> Medical specialists of the time pointed to immorality, criminality, and racial characteristics as the causes of many illnesses. Until the late 19th century, many thought that the poor—primarily enslaved African Americans—brought the disease upon themselves through their unsanitary living conditions and poor personal hygiene. Scientific racism, the attempt to use scientific techniques and hypotheses to sanction a belief in the racial superiority of whites over blacks,<sup>23</sup> permeated health care during this era. The connection between racial identity and physical health was codified.<sup>24</sup> This ‘scientific belief’ was illustrated by the medical theories of a New Orleans physician named Samuel Cartwright when in 1851 he identified a disorder observable only in slaves. This disorder, Drapetomania, Cartwright argued, “caused African slaves to flee captivity.”<sup>25</sup> To prevent the spread of this disease, Cartwright prescribed, “whipping the devil of them.”<sup>26</sup>

Enhanced understanding of microbiology and public health by the 1910s and 1920s did not negate perceived connections between race and disease. Instead, racist attitudes such as Cartwright’s became institutionalized as ‘unhealthiness’ among African Americans and associated with their supposed inferiority as a race. For example, The Louisiana State Board of Health of 1919 viewed the higher incidence of tuberculosis among black people as a reflection on their inferior morality, civility, and capabilities as human beings rather than as a result of poor living conditions, poor nutrition, and poor education about the spread of the disease.<sup>27</sup> Health officials asserted,

*“Even though we lay aside the humanitarian and economic interests associated with the Negro race, we still have to face the obvious biologic(sic) fact that this race of people is both potentially and actually more capable of disseminating disease among the White people than are the White people among themselves. Never having had the opportunity to develop natural immunity and resistance to bacterial invasion that is normally acquired through the evolution of ages, and having had artificially thrust upon them a civilization to which they are not biologically adapted, it is only natural that tuberculosis and syphilis should invade*

### WHAT IS RACE?

*Race as it is understood in the U.S. today by scholars from health, medicine, biology, anthropology, history, and sociology is a classification of humans invented in the 18th century by European colonialists in colonial America as a means of establishing power over and justifying the treatment of indigenous peoples and enslaved Africans.<sup>8</sup> Inequality was central to the concept of race which assumed the existence of “natural” or God-given differences between these groups. A hierarchy of exclusive racial categories was established by fabricating and arbitrarily ascribing superior cultural and behavioral traits to Europeans and inferior traits to non-European peoples.<sup>9</sup> Over time, these false beliefs became deeply embedded in American society, institutions, and thought. Scientific advancements in genetics and biology have confirmed there are no genetically—or biologically—defined categories of human beings.<sup>10</sup>*

*the race until they become exterminated.... The White race cannot hope to materially decrease their communicable disease incidence until the health standard of the Negro is raised.”<sup>28</sup>*

Throughout Louisiana in the 1910s and 1920s, syphilis and gonorrhea were frequently the leading causes of death, outnumbering deaths by influenza, smallpox, malaria, and tuberculosis. In New Orleans, black men and women had an infection rate six times higher than white men and women, and the sexually-transmitted nature of these diseases was used to strengthen the association between race and immorality.<sup>29</sup> But limited access to health services exacerbated the impact of these ailments until local governments came together to legally decree in 1943 that all infected black men have treatment for their venereal diseases.<sup>30</sup> This mandate was not motivated by the commitment to health equity, but instead to prevent black men from being deferred or rejected from military service during World War II due to venereal disease.

To address the longstanding inequities and racist institutions that governed health care in New Orleans, Flint-Goodridge Hospital was built in 1931.<sup>31</sup> The hospital grew out of the Phyllis Wheatley Sanitarium and Training School for Negro Nurses, founded in 1896.<sup>32</sup> From 1896 to 1983 it served predominantly African American patients and was owned and operated by Dillard University for most of that period. Flint-Goodridge was important because it was the only place where black nurses could receive professional training, and the only private hospital in the city that granted black doctors staff privileges throughout the Jim Crow era.<sup>33</sup> It was not until 1965 that the Louisiana Department of Health and Human Resources (now the Department of Health) ordered the desegregation of all state hospitals; however, some hospitals—including Charity Hospital—took years to fully integrate.<sup>34</sup>

Even after legally mandated desegregation of state hospitals, racism continued to permeate local policies, institutional practices, and cultural representations in the late 1960s and beyond. Data from 1966 shows that fewer than 10 percent of Louisiana’s hospitals were compliant with federal integration guidelines.<sup>35</sup> When many hospitals finally opened their doors to black patients in the late 1960s and early 1970s it was in response to a federal requirement for hospitals to become racially integrated in order to receive Medicaid funds. Finally in the late 1960s and 1970s, black physicians were allowed to practice in private and state hospitals in Louisiana<sup>36</sup> and state medical colleges began to desegregate.<sup>37</sup>

By the 1980s and 1990s the fight for health equity in New Orleans expanded into battles over disproportionate exposure to environmental toxins for black residents. One such example is the class action lawsuit brought against the City over the Agriculture Street landfill in New Orleans’ 9th ward. The black subdivisions of Gordon Plaza and Press Park were developed on top of the Agriculture Street landfill, although no one disclosed to the buyers that their new homes were built on top of a dump that was closed in 1965. Moreover, the Orleans Parish School Board built Moton Elementary School on the same site in 1983, an area later proven to be a few feet above the 20 feet of compacted industrial waste containing a number of noxious chemicals.<sup>38</sup> More than 900 children attended the school when it opened and the student body reflected the community’s demographics, which was 97 percent African American according to the 1990 Census.

In 1994, the Environmental Protection Agency (EPA) named the area a toxic Superfund site in need of cleanup of abandoned and hazardous waste, meaning it was so contaminated that it should be remediated to protect people and the environment. The EPA results detected a variety of heavy metals, petroleum chemicals, pesticides, industrial solvents, and phthalates (chemicals in plastics)—contaminants that can pose significant long-term health risks. In 2002, a class action lawsuit was filed after the site was proven to contain hazardous levels of lead, mercury, and arsenic. According to a 2005 article from the National Resources Defense Council,

*“These contaminants pose a significant long-term health risk to residents in these neighborhoods... Cancer-causing polyaromatic hydrocarbons (PAHs) were notably high compared to many other areas sampled and were above the level at which may require soil cleanup. The level of one of the most hazardous PAHs was more than 200 times higher than the EPA cleanup level at three locations in this area...Arsenic levels also were above EPA safety levels, in some cases up to 70 times higher. Arsenic is known to cause cancer in humans.”<sup>39</sup>*

In 2015, a class action lawsuit against the City, the Housing Authority of New Orleans, and the Orleans Parish School Board was finally settled with a \$14.2 million payout to be dispersed among the 5,053 people eligible for settlement payments (although more than \$7 million of the award was to be divided among the five lawyers who worked on the case). Settlements were determined by the number of years residents lived on the site and how long they owned their homes, which in the end amounted to a few thousand dollars for each person.<sup>40</sup>

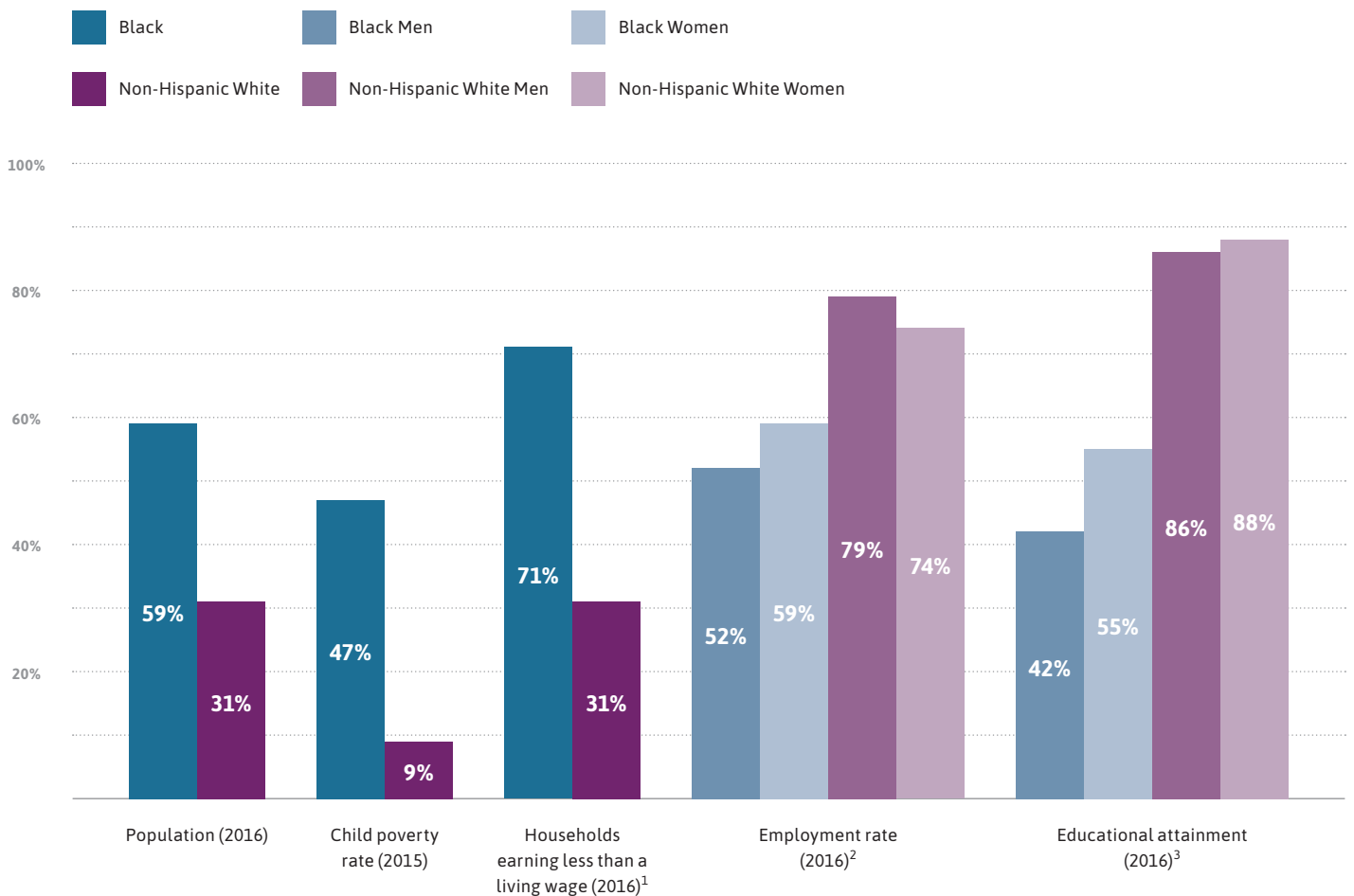
Just before Katrina struck in 2005, the majority of low-income residents (80 to 90 percent) received care at Charity Hospital. The New Orleans Health Department (NOHD) operated primary care clinics serving the rest of the city’s low-income residents. The devastation wrought by Hurricane Katrina and the levee failures permanently altered the landscape of public health and health care in New Orleans. Sustaining significant damage from Hurricane Katrina, Charity Hospital closed permanently in 2005, effectively eliminating

the health safety-net and leaving a large gap in services for the city’s most vulnerable residents.<sup>41</sup> After the closing of Charity Hospital, the system was transformed to one of decentralized service delivery through a growing network of community-based providers and Federally Qualified Health Centers (FQHCs) intended to meet the needs of the city’s uninsured and underserved.<sup>42</sup>

## Current Inequities

The historical and perpetuated oppression of black Americans, from the time of the city’s founding to present day policies and practices, has resulted in inextricable ties between race, socioeconomic conditions, and population health.<sup>43</sup> Bolstered by centuries of stereotypes and false myths about human differences and group behaviors, racial stratification in societal treatment, and access to power, resources, and opportunities remains.<sup>44</sup> The deep embedding of racial discrimination and privileges associated with being white is evident in the unequal distribution of income, education, and a broad range of health-promoting resources and opportunities, neighborhood conditions, and the generational accumulation of wealth as documented in the essays that make up this Tricentennial Collection.<sup>45</sup>

**Figure 1. A SNAPSHOT OF RACIAL INEQUITIES IN THE SOCIAL DETERMINANTS OF HEALTH, NEW ORLEANS**

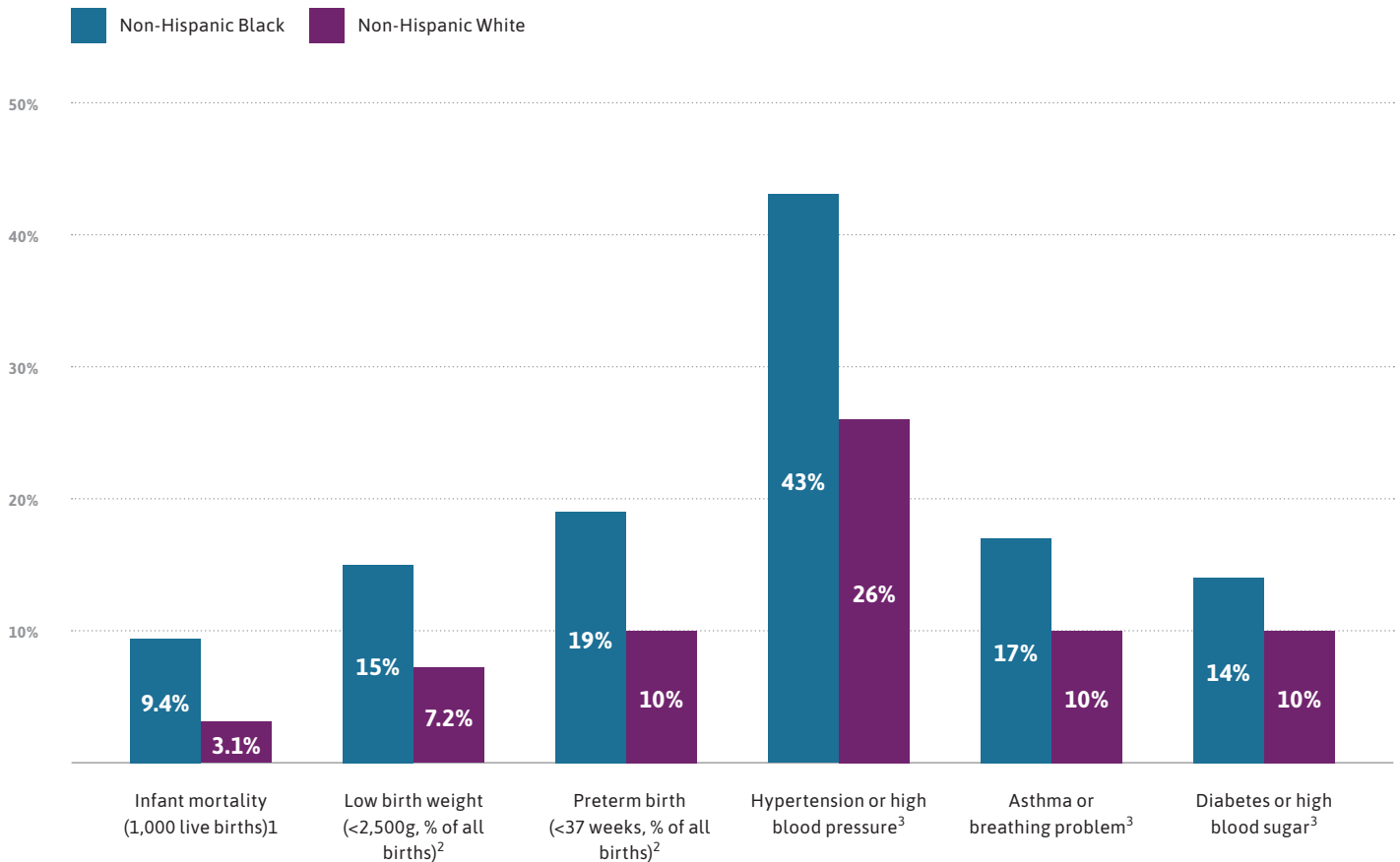


Source: Plyer, A. & Gardere, L. (2018). *The New Orleans Prosperity Index: Tricentennial Edition*. New Orleans, LA: The Data Center.

1. Annual living wage for 1 Adult 1 Child in New Orleans is \$47,611. These data represent households earning less than \$45,000.
2. Percent of population age 16–64.
3. Percent of population 25 years and older with at least some college education

Emergent research is beginning to explore how the privileges and health benefits associated with whiteness have been purposefully maintained and reinforced through societal systems of housing, education, employment, income, benefits, credit, media, health care, and criminal justice.<sup>46</sup> The result is a health advantage favoring whites over non-whites by most measures of population health.

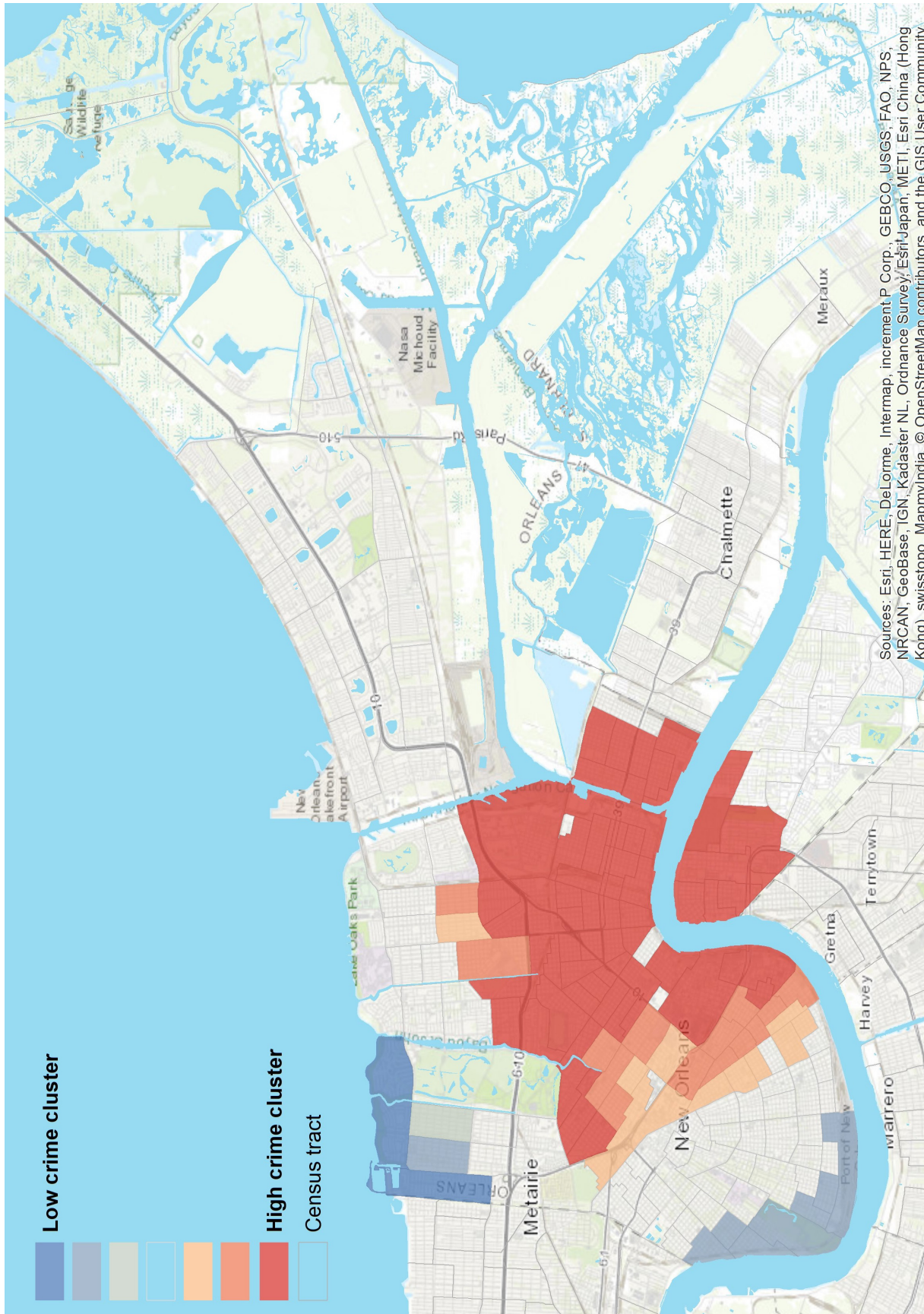
**Figure 2. A SNAPSHOT OF RACIAL INEQUITIES IN POPULATION HEALTH OUTCOMES, NEW ORLEANS**



1. 2011–15 five-year mortality rate. Source: United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2007-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database. Retrieved from <http://wonder.cdc.gov/lbd-current.html>
2. 2010–15 five-year average. Author analysis of National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS) 2015 Restricted Use Natality Data File.
3. 2010 prevalence estimate. Source: The Kaiser Family Foundation. (2010). *New Orleans five years after the storm: A new disaster amid recovery*. Menlo Park, CA.

Today, some 300 years after the city's founding, there is a 25-year difference in the life expectancy of residents in New Orleans ZIP codes 70124 and 70112, where residents are 3 percent and 75 percent black, respectively, and separated geographically by fewer than five miles.<sup>47</sup> Indeed, health outcomes and the underlying conditions that place residents at risk of poor health map onto the city's neighborhoods. For example, neighborhoods with high rates of violent crime have greater incidence of low birthweight babies (See Figures 3a and 3b on pages 6 and 7).<sup>48</sup>

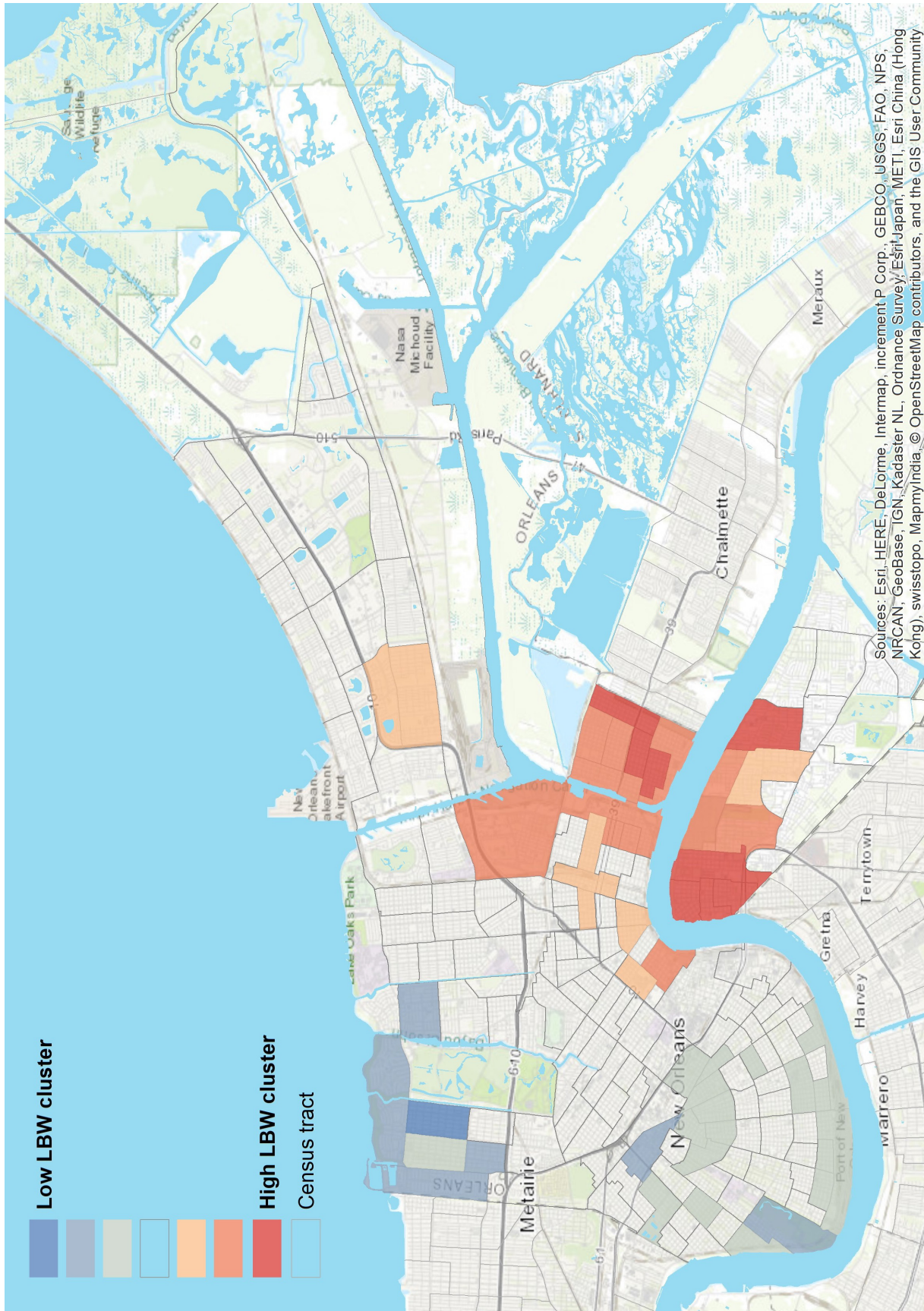
Figure 3a. HOTSPOT ANALYSIS<sup>1</sup> OF VIOLENT CRIME RATES<sup>2</sup> IN NEW ORLEANS, 2015



Sources: Esri, HERE, DeLorme, Intermap, increment P Corp., GEBCO, USGS, FAO, NPS, NRCAN, GeoBase, IGN, Kadaster NL, Ordnance Survey, Esri Japan, METI, Esri China (Hong Kong), swisstopo, MapmyIndia, © OpenStreetMap contributors, and the GIS User Community

1. Hot spot analysis uses statistical analysis to determine whether high or low values of a particular feature (violent crime rate in this case) cluster spatially. The analysis shown above identifies where Census tracts have neighboring tracts with similarly low or high violence crime rates.
2. Violent crime incidents per 1,000 Census tract residents. Author analysis of New Orleans Police Department 911 call data, 2015.

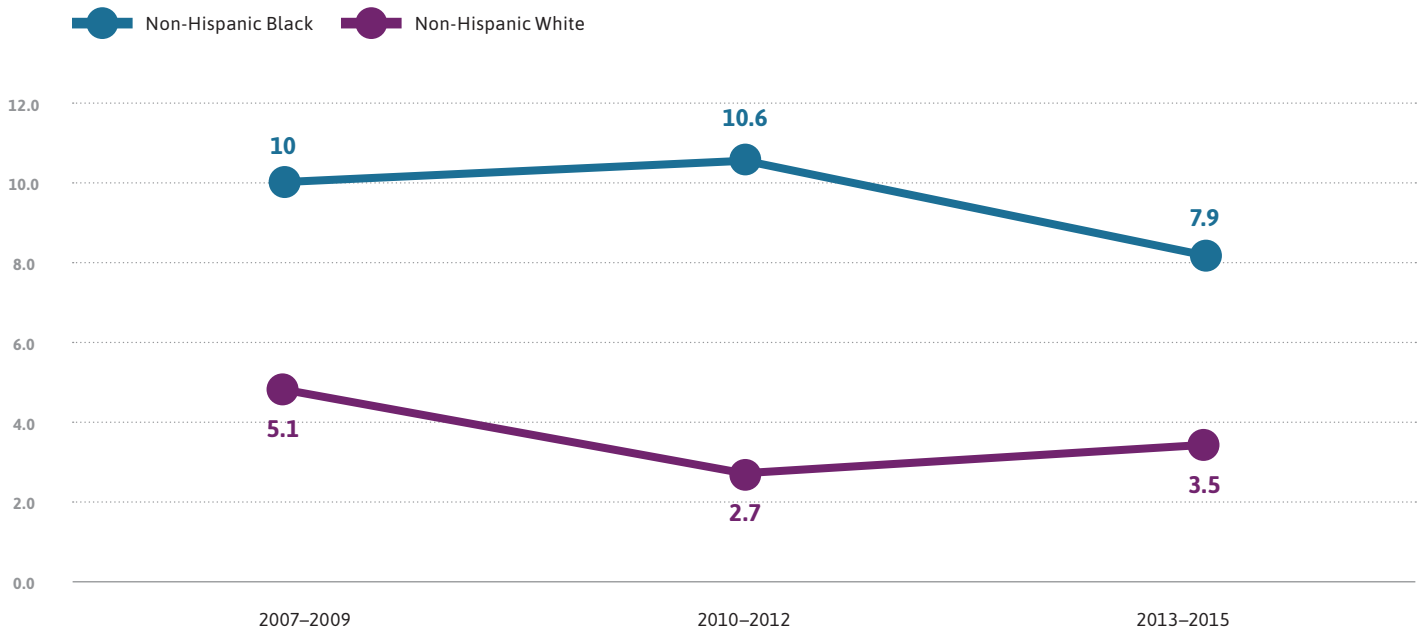
Figure 3b. HOTSPOT ANALYSIS<sup>1</sup> OF LOW BIRTH WEIGHT (LBW) RATES<sup>2</sup> IN NEW ORLEANS, 2014-2015



1. Hot spot analysis uses statistical analysis to determine whether high or low values of a particular feature (LBW rates in this case) cluster spatially. The analysis shown above identifies where Census tracts have neighboring tracts with similarly low or high LBW incidence.
2. Percentage of Census tract births that are low birth weight. Author analysis of Louisiana birth records, 2014-2015.

While recent trends suggest some improvements in overall population health indicators since Hurricane Katrina, racial inequities persist. For example, infant mortality rates for babies born to women in New Orleans have declined to 6.5 deaths per 1,000 live births in 2015, down from 11.1 in 2000-05.<sup>49</sup> However, in 2015, the rate among non-Hispanic black women remained at least two times higher than the rate among non-Hispanic white women, with an additional seven black infant deaths per 1,000 live births for every one white infant death.

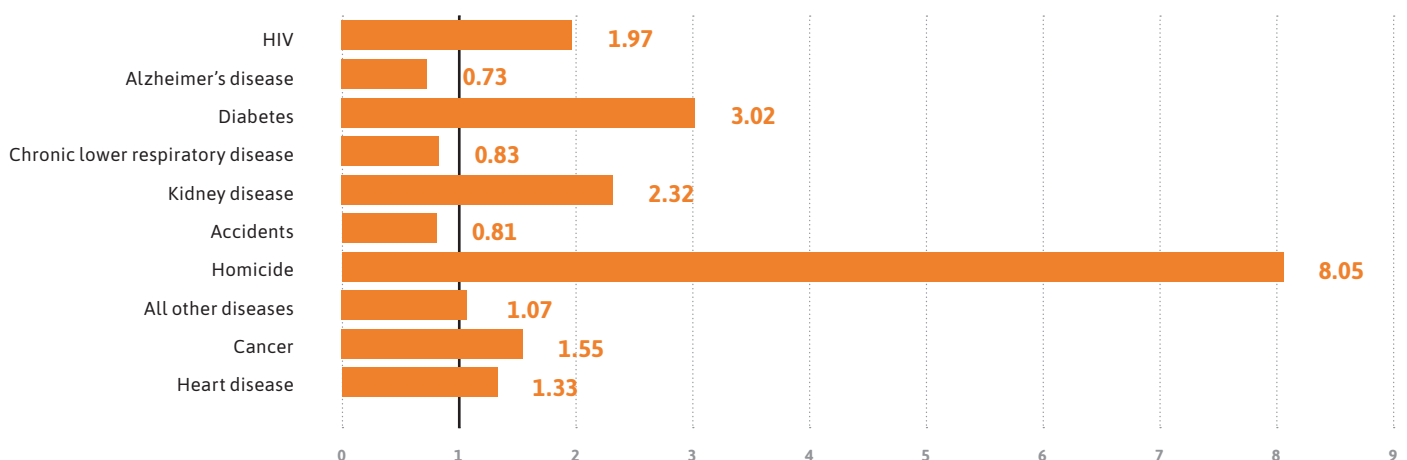
**Figure 4. THREE-YEAR INFANT MORTALITY RATES PER 1,000 LIVE BIRTHS BY MATERNAL RACE, NEW ORLEANS**



Source: Author analysis of National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS) Restricted Use Linked Birth / Infant Death Records 2007-2015.

During 2008-10, black residents were eight times more likely to die of homicide, and at least two times more likely to die from HIV, kidney disease, and diabetes.<sup>50</sup>

**Figure 5. BLACK-TO-WHITE MORTALITY RATE RATIOS FOR THE TOP TEN CAUSES OF DEATH IN NEW ORLEANS, 2008-10**



Source: New Orleans Health Department. (2013). Community Health Data Profile: Health Disparities in New Orleans. Retrieved from <https://www.nola.gov/health-department/data-and-publications/reports/health-disparities-in-new-orleans-community-2013/>

In addition, members of the black community endure chronic health conditions at higher rates relative to white New Orleanians, with greater proportions living with hypertension, asthma, and diabetes.<sup>51</sup>

During the city's rebuilding in the aftermath of Hurricane Katrina, little priority was given to addressing the human recovery and psychosocial needs of the poor, vulnerable communities of color, and women and children in particular. Since the storm in 2005, there has been a 39 percent decrease in adult psychiatric beds, a 25 percent decrease in child/adolescent psychiatric beds, and a 31 percent reduction in detox beds in the greater New Orleans area.<sup>52</sup> The result is a system with limited capacity to serve the city's population—one disproportionately exposed to traumatic events. In 2015, New Orleanians reported an average of 4.4 days per month of poor mental health, more than the state and national averages (4.3 and 3.6, respectively).<sup>53</sup> Individuals suffering severe mental illness increasingly rely on hospital emergency departments in times of a crisis.<sup>54</sup>

The decentralized community-based healthcare system that emerged post-Katrina has been somewhat successful in increasing access to primary care and prevention for the poor and uninsured by increasing the number of clinic sites.<sup>55</sup> As of late 2016, there were 12 Federally Qualified Health Center organizations (FQHCs) with over 40 health center locations in the greater New Orleans area, up from just six in 2013.<sup>56</sup> In a survey conducted among New Orleans residents just one year after Katrina, a full 93 percent of respondents reported they did not think there were enough healthcare services available for uninsured and low-income people in the city at that time.<sup>57</sup> This proportion dropped to 64 percent in the survey's most recent wave (2015), reflecting improvements in perceptions of access to health care in New Orleans. Still, more than half of respondents (54 percent) in 2015 remained very or somewhat worried that healthcare services may not be available to them if needed. Among the city's working poor (those with incomes below 200 percent of the federal poverty level), one-third of respondents in 2015 said they had skipped or postponed medical care in the previous six months. This was also true for nearly half (47 percent) of uninsured respondents.<sup>58</sup>

Effective July 1st 2016, the state's Medicaid program was expanded, extending eligibility to individuals earning up to 138 percent of the federal poverty level. Data are beginning to reveal the positive implications of Medicaid expansion for improving access to care as the proportion of uninsured residents fell from 22 percent in 2013 to 13 percent in 2016.<sup>59</sup> The uninsured rate remained relatively flat in Louisiana after federal implementation of the Patient Protection and Affordable Care Act as many uninsured residents fell into the "coverage gap" during 2014 and 2015.<sup>60</sup> However, with the expansion of Medicaid in 2016, the insurance coverage increased notably. An estimated 61 percent of new Medicaid enrollees were women. Medicaid expansion is expected to substantially increase the number of residents receiving preventative care, and decrease catastrophic out-of-pocket costs.<sup>61</sup>

Both the increase in insurance coverage and the growing network of community-based providers hold promise for filling service gaps experienced by low-income residents. However, policies and actions that ensure sustained funding (currently generated from federal and philanthropic sources) are critical to the maintenance of this model.<sup>62</sup> Moreover, ensuring high-quality, unbiased care remains a significant challenge even as clinic access improves. A large body of research has documented the adverse health impacts of implicit provider bias in their differential provision of care to patients of color,<sup>63</sup> evidence of persisting systemic racism in the healthcare system.<sup>64</sup>

Maintaining a healthy life extends beyond access to medical care. In order to promote access to health-promoting resources such as quality education, employment, good housing, and safe and clean environments, health care and public health systems are beginning to change how they conduct their business, translate data, work across sectors, engage with community, and craft policy options in order to achieve health equity.<sup>65</sup> The growth of patient navigators as well as community health worker models have great promise, and the capacity of electronic medical record systems to aid in holistic and coordinated care is beginning to transform the industry.<sup>66</sup> Moreover, cross-sector collaborations in governmental agencies and philanthropic-supported efforts among university and community organizations are working to promote a health lens on housing, criminal justice, trauma-informed care, and social-emotional development training.<sup>67</sup>

## Implications for Future Policy and Actions

Health equity cannot be achieved until there are deliberate and sustained efforts to address the root causes of inequities. As described above, many of these root causes fall within other sectors (e.g., education, housing, employment, etc.) and are outside the direct reach of public health or the healthcare system. Thus, advancing equity through public health and clinical practice will require innovation and cross-sector partnerships as described below.

### **PREPARE THE PUBLIC HEALTH AND HEALTHCARE SYSTEMS SO THAT THEY CAN ADDRESS HEALTH EQUITY**

Courses to teach public health and medical students about not only health disparities, but also what health equity is and how it can be achieved are increasing. These learning opportunities are often innovative and have expanded not only to schools of medicine and public health, but also to other disciplines such as psychology, sociology, and social work, as reflected in university curricula across New Orleans.<sup>68</sup>

Preparing the public health and healthcare workforces with an orientation toward equity will also increase the capacity of these professionals to address health equity at the systems-level. Having public health and healthcare practitioners bring about systems-level changes to promote health for all New Orleans residents requires acknowledging that existing systems were built from racist frameworks as well as acknowledging the need for larger changes in social norms to appropriately and sufficiently address equity. Both the NOHD and the Bureau of Family Health (BFH) within the Louisiana Office of Public Health (OPH) have engaged staff in trainings to advance equity, including the *Undoing Racism* workshop offered by the People's Institute for Survival and Beyond<sup>69</sup> as well as communication around racism and the importance of eliminating inequities. Preparing staff with an understanding of the enduring effects of racial oppression is essential for the success of programs such as the NOHD's Trauma-Informed Approaches Learning Collaborative for Schools. This program assists public schools in developing environments that address the social, emotional, and behavioral needs of their students, many of whom have experienced trauma such as being exposed to violence.<sup>70</sup> Efforts to address racism are growing and are at all levels within these systems so that, even with a change in administration, the hope is that the increased capacity to address equity will remain.

Staff at several local health clinics and care centers have also participated in the *Undoing Racism* workshops. However, the representation of black physicians (particularly those in primary care) and the cultural awareness of local healthcare providers are areas in which the local healthcare system can be improved. A diverse physician workforce has been associated with greater access to healthcare services for low-income and Medicaid patients, racial and ethnic minorities, and non-English speaking patients.<sup>71</sup> Yet black physicians (and black male physicians in particular) are underrepresented in the U.S. physician workforce.<sup>72</sup> And despite representing over one-third of the state's population, only 4 percent of students enrolled in Louisiana's medical schools are black.<sup>73</sup> The need for cultural competence training for providers and frank discussions about race is underscored by recent research.<sup>74</sup> Enhancing cultural competence—developing and improving the knowledge, skills, and attitudes necessary to effectively communicate with and understand the needs of patients of color—must be viewed as an ongoing process. Cultural competence training should be a required component of the medical school curriculum as it is in other states including the state of Washington,<sup>75</sup> and perpetual training should be required by the Louisiana State Board of Medical Examiners as it is within the state of California.<sup>76</sup>

## ADDRESS THE FACTORS UNDERLYING PERSISTENT HEALTH DISPARITIES IN NEW ORLEANS

Health disparities arise from unequal access to resources and opportunities to achieve a healthy life. These disparities are largely based in the social, economic, and environmental conditions that shape people's lives, but are also impacted by the systems that serve them. In response, influential governmental public health systems, namely the NOHD and the Louisiana Department of Health (LDH), are beginning to restructure the way that public health services are provided and utilize novel methods of responding to health disparities and community health needs.

The NOHD, a nationally-accredited health department since 2014, underwent a major transformation beginning in 2010, moving from clinical care and direct service to population-based policy and program implementation.<sup>77</sup> In 2016, NOHD began the planning process for the creation of an equity-focused Health Department.<sup>78</sup> Fundamental to the NOHD's Health Equity Initiative is institutionalizing equity principles in the strategic plan as well as through staff training, quality improvement measures, and other strategies that build the department's capacity to address health inequities. This initiative will require deep engagement of community members in order to be successful, and one of the key actions of this work is to ensure that the city's residents and neighborhoods are connected to the city's assets and opportunities.<sup>79</sup> Effectively communicating the services, programs, and health promotion resources that the City and the NOHD have to offer to community members is an ongoing challenge, one that may require developing innovative approaches. Examples of innovative and successful efforts come from other urban U.S. cities, such as the Strong Neighborhoods initiative in San Jose, CA, which expands successful neighborhood-based initiatives into other neighborhoods within a community.<sup>80</sup> The NOHD's Best Babies Zone Initiative—which aims to reduce disparities in infant mortality and birth outcomes by increasing equity in such areas as health, education, economic opportunity, and housing—presents an opportunity in this regard.<sup>81</sup> This Initiative leverages relationships with families already being served by the Healthy Start New Orleans program to deliver important services to expecting parents in New Orleans' Hollygrove neighborhood.<sup>82</sup> The Initiative could be extended into other neighborhoods also experiencing adverse infant health outcomes. Another NOHD program aimed at addressing the factors that underlie disparities, and which has the potential to advance equity throughout the community, is Fit NOLA. Fit NOLA is a network of partnerships between the City of New Orleans and over 200 nonprofit organizations, schools, direct service providers, businesses, and community members working to promote "access to nutritious food and safe spaces to play and exercise [for all New Orleanians], regardless of geography, gender, race, ethnicity and income."<sup>83</sup>

Governmental public health agencies and many other local public health organizations and academic institutions have also engaged in cross-sector efforts to confront the factors that underlie health disparities. One such example is the Louisiana Adverse Childhood Experiences (ACE) Educator Program, which was created through a partnership between the LDH OPH Bureau of Family Health and the Tulane Institute of Infant and Early Childhood Mental Health Institute.<sup>84</sup> This program offers free trainings about trauma and how it impacts youth social-emotional development and resilience. The trainings are offered to community members around the state, including parents in New Orleans.<sup>85</sup>

Other partnerships have facilitated the conduct of health impact assessments (HIAs). HIA is an equity-focused examination of the potential health impacts of proposed policies, programs, and projects through the use of scientific data, health expertise, and input from community stakeholders, including residents.<sup>86</sup> In 2015, the NOHD released findings from a HIA report on the types of outreach and incentives needed to motivate residents in Central City, a community with high rates of chronic health conditions, to take advantage of a fresh food market in the neighborhood.<sup>87</sup> And in late 2016, the Louisiana Public Health Institute (LPHI) and the Alliance for Affordable Energy (AAE) released a HIA report describing the potential health impacts of a natural gas combustion turbine plant proposed for construction in New Orleans East.<sup>88</sup>

There are also several examples of success using the cross-sectoral, health-promoting HIA model across the nation including in Galveston, Texas, which used the approach following a natural disaster. After Hurricane Ike in 2008, the University of Texas Medical Branch partnered with an array of government agencies and engaged with various community stakeholders to integrate health into the city's rebuilding plans. And, a HIA in Baltimore, Maryland, conducted in response to proposed revisions to the city's zoning codes, resulted in amended versions of the proposed zoning codes that placed limitations on the number of alcohol retailers and increased lighting to improve safety and walkability within neighborhoods. These efforts, as well as local HIA collaborations and the significant information that result from them, reflect a "health in all policies" approach and highlight the importance of considering health impacts during the decisionmaking process for new policies and projects in all sectors.<sup>89</sup>

### **TRANSFORM HOW THE HEALTHCARE SYSTEM INTERACTS WITH AND ENGAGES THE NEW ORLEANS COMMUNITY**

Traditionally, communities have been prescribed solutions to health problems, and decisionmaking about what communities need in order to be healthy has been dictated by the systems that serve them. This approach to health has been met with limited success. Rather, people-driven and community-centered approaches should be the foundation for health programs. It should be a priority for healthcare systems to build trusting relationships with community leaders, community-based organizations, and community members. These important stakeholders should be engaged in decisionmaking and priority-setting processes that build on community assets and knowledge, and increase community acceptance of system efforts. Successful and meaningful community relationships require the healthcare system to partner with the community, respond in culturally relevant ways, and integrate local expertise with scientific evidence into health equity initiatives and programs. In Baltimore, the University of Maryland Medical Center (UMMC) partners with a community group that supports women and their partners in order to improve birth and infant outcomes.<sup>90</sup> Through this partnership, UMMC staff go to the schools, barbershops, shopping malls, and other community anchor institutions in neighborhoods served by the UMMC, and where community members are facing the greatest health challenges, to provide information and guidance on health topics such as smoking cessation, breastfeeding, and safe infant sleeping positions.

The shift away from emergency department-based health care to community health centers providing primary care for the city's most vulnerable citizens presents an opportunity to practice this approach. As in the UMMC example, efforts to work with and truly understand the patient populations served within these health centers would require healthcare providers to step outside of the confines of the medical system and go directly into neighborhoods to meet community members in the environments in which they live. Through their involvement in a Community-Centered Health Home demonstration project, two New Orleans community healthcare centers have engaged in work to address factors in the social, economic, and physical environments that impact health within the neighborhoods they serve.<sup>91</sup> Both healthcare centers had already served as patient-centered medical homes where patients can access a variety of services at one site. And now, as community-centered health homes, they have expanded their focus from the patients who walk through their doors to all residents within the community. In this role, they advocate for the community at the systems-level and push for policy changes that will improve the health of the surrounding community<sup>92</sup> (through, for example, increasing the stock of quality affordable housing, providing greater access to reliable public transportation, and making fresh and healthy food options more accessible).

### **INCREASE ACCESS TO HIGH-QUALITY POPULATION-BASED HEALTH DATA AND CONSIDER NEW STRATEGIES FOR PUBLIC HEALTH PRACTICE THAT ADVANCE HEALTH EQUITY**

Many indicators are available to measure future progress on equity in New Orleans, including the indicators in *The New Orleans Prosperity Index*.<sup>93</sup> Where we continue to fall short, however, is with data on health outcomes, and in particular, outcomes that are broken down by race, ethnicity, or socioeconomic position. While the availability of health data is likely to increase with the potential monitoring of medical record data as well as improved statistical methods (such as small area estimation for some of our statewide health surveys), population-level data to monitor the health of New Orleans' residents remains limited, particularly for key outcomes such as mental health. Although the local technical capacity to monitor key health outcomes is currently in place, such data are often unavailable or infrequently collected at the local level. Furthermore, monetary resources to measure many key indicators are scarce. Therefore, state and federal agencies as well as philanthropic entities must increase their commitment to funding community-level data collection efforts.

There is also a need to reframe the paradigm of local public health, a change that has been happening through growing movements on the national level.<sup>94</sup> The first step in this direction locally has been the NOHD's pledge to include equity as a key principle within all its policies and practices. The authors of this essay conducted an environmental scan of local practices and policies relevant to the social determinants of health, inequities, and community engagement, and proposed recommendations for continued public health system efforts to advance health equity in New Orleans.<sup>95</sup> Our recommendations are in line with 14 internal and external recommendations for advancing health equity within local public health practice defined by the Human Impact Partners (an organization that works to transform policy and decisionmaking by increasing the weight given to both health and equity)<sup>96</sup> and can serve as a roadmap for the NOHD and other local and state governmental public health agencies as they become more equity-focused.

## Conclusion

Achieving health equity is beyond the scope of public health and medicine alone, but is essential to a prosperous New Orleans. Our public health systems can and should be catalysts for change in a range of social determinants that impact health (in addition to catalysts for change within the healthcare system), but doing so will require substantial investment and coordination across a range of sectors. Health disparities are reduced or eliminated not by worsening the health of those who are better off, but by improving the health of excluded or marginalized groups. Without acknowledgement of how health is shaped by both advantage and disadvantage, unfair, unjust, and avoidable race-based differences in population health will endure. Health equity will be reached when we can no longer predict health outcomes based on race, ethnicity, class, or any other characteristic.<sup>98</sup>

### HUMAN IMPACT PARTNERS' RECOMMENDATIONS FOR ADVANCING HEALTH EQUITY WITHIN LOCAL PUBLIC HEALTH PRACTICE<sup>97</sup>

#### *Eight internally focused practices:*

- *Focus on addressing the “causes of the causes of health inequities” – oppression and power*
- *Prioritize improving the social determinants of health through policy change*
- *Build understanding of and capacity to address equity across the organization*
- *Support leadership, innovation, and strategic risk-taking to advance equity*
- *Change the narrative of what leads to health*
- *Commit the organization and its resources to advance equity*
- *Use data, research, and evaluation to make the case*
- *Change internal practices such as hiring and contracting*

#### *Six externally focused practices:*

- *Build alliances and networks with community partners to protect against risk and build power*
- *Build alliances with other public agencies*
- *Engage strategically in social justice campaigns and movements*
- *Change the administrative and regulatory scope of public health practice*
- *Join broader public health movements to advance equity*

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## About The Data Center

The Data Center is the most trusted resource for data about greater New Orleans and Southeast Louisiana. Since 1997, The Data Center has been objective partner in bringing reliable, thoroughly researched data to conversations about building a more prosperous, inclusive, and sustainable region.

The Data Center (formerly known as the Greater New Orleans Community Data Center) became the local authority for tracking post-Katrina recovery with *The New Orleans Index*, developed in partnership with Brookings Institution.

## About The New Orleans Prosperity Index: Tricentennial Collection

*The New Orleans Prosperity Index: Tricentennial Collection* includes contributions from more than a dozen local scholars. These reports will assess the long reach of historical practices on contemporary policies and practices contributing to today's racial disparities across multiple systems (criminal justice, education, housing, business ownership, health care, etc.), and provide recommendations for furthering future progress. In addition, The Data Center will release a comprehensive set of metrics that address the question: "Have black New Orleanians experienced increased economic inclusion since the end of the Civil Rights era?"

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## Disclaimer

*The New Orleans Prosperity Index: Tricentennial Collection* includes studies and reports on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to The Data Center, its trustees, or its funders.