HEALTHY BALTIMORE 2015

INTERIM STATUS REPORT

October 2013

Stephanie Rawlings-Blake, Mayor
Oxiris Barbot, M.D., Commissioner of Health
Baltimore City Health Department

ACKNOWLEDGEMENTS

The Baltimore City Health Department would like to thank its staff members for their contributions to this report and to the projects and interventions that are described herein. We also thank the following agencies, whose contributions appear throughout the report for their partnership and collaboration: The Maryland Department of Health and Mental Hygiene (The Vital Statistics Administration, The Health Services Cost Review Commission, Center for HIV Surveillance, Epidemiology and Evaluation, and The Office of Health Policy and Planning), The Johns Hopkins Bloomberg School of Public Health (Center for Livable Future and the Department of Epidemiology), Mayor's Office of Information Technology, Baltimore City Liquor Board, Baltimore Substance Abuse Systems, and the Maryland State Department of Education. Thank you also to Erin Hyland from Jack Out of the Box Designs for the graphic design of this report.

HEALTHY BALTIMORE 2015: INTERIM STATUS REPORT COMMITTEE

Lead Authors:

Aruna Chandran, Chief of Epidemiologic Services
Christian Fuller, Performance Measurement Quality Improvement Coordinator
Sarah Morris-Compton, Director of Office of Policy and Planning
Valerie Rogers, Chief of Staff
Oxiris Barbot, Commissioner of Health

Contributors:

Patrick Chaulk
Francine Childs
Rebecca Dineen
Jacqueline Duval-Harvey
Arnold Eppel
Laura Fox
Jana Goins
Jonathan Gross
Suzan Mankarious
Rafiq Miazad
Ravikiran Muvva
Glen Olthoff
Paul Overly
MaryGrace White

Suggested citation:

Chandran A, Fuller C, Morris-Compton S, Rodgers V, Barbot O. Healthy Baltimore 2015: An Interim Report. Baltimore City Health Department, October 2013.

ELECTRONIC ACCESS:

This report can be accessed electronically at www.baltimorehealth.org. For any questions or comments, please call 410-396-4398.

TABLE OF CONTENTS

LETTER FROM THE MAYOR . . . 2

LETTER FROM THE HEALTH COMMISSIONER . . . 3

FRAMEWORK . . . 4

PRIORITY AREAS

1. Promote Access to Quality Health Care for All . . . 6
2. Be Tobacco Free . . . 12
3. Redesign Communities to Prevent Obesity . . . 16
4. Promote Heart Health . . . 21
5. Stop the Spread of HIV and Other Sexually Transmitted Infections . . . 24
6. Recognize and Treat Mental Health Needs . . . 28
7. Reduce Drug Use and Alcohol Abuse . . . 31
8. Encourage Early Detection of Cancer . . . 35
9. Promote Healthy Children and Adolescents . . . 37
10. Create Health Promoting Neighborhoods . . . 42

TECHNICAL NOTES . . . 47

LETTER FROM THE MAYOR

Dear Fellow Baltimore City Resident:

The prosperity of our city is dependent on the health of our residents.

In May of 2011 we issued *Healthy Baltimore 2015* to articulate our health priorities for action. The priority areas emphasize that ensuring the health of our city includes not only access to direct clinical services, but more broadly require us to consider where we live, work, learn and play as critical factors that influence the health of our communities. As such, we all play a role in improving the health of our communities.

This interim progress report represents the successes and in some cases, challenges that we still face in meeting the ambitious goals set out in *Healthy Baltimore 2015*. Since first issuing this report, I directed the creation of the Cross Agency Health Task Force to promote greater collaboration between City agencies to promote health through programming and policy. Working across silos to promote health is one of the ways in which we'll realize better health outcomes faster.

Improving the health of our city calls on each of us to lend our talents in support of our communities. Throughout this report we highlight programs and initiatives that reflect collaborative work between city and local agencies. I encourage you to review the data, get involved in your community and help make Baltimore a city where all residents realize their full health potential.

Sincerely,

Stephanie Rawlings-Blake
Mayor
Baltimore City

LETTER FROM THE HEALTH COMMISSIONER

Dear Fellow Baltimore City Resident:

I am pleased to share this interim progress report on *Healthy Baltimore 2015*. Two years ago, we released *Healthy Baltimore 2015* as a way to chart a course towards improving the overall health of our city. It is a robust and ambitious plan that incorporates measures of the quality of where we live, work, learn and play along with measures on more traditional health outcomes. By incorporating these measures, collectively known as the social determinants of health, we can more broadly address underlying causes that continue to drive health inequities.

We present here a snapshot of the changes that have occurred in each of the indicators in the past two years, reflecting both forward strides towards our goals as well as areas in which further work needs to be done. We also highlight the programs and projects that are underway, reflecting not only health department initiatives but also collaborative efforts with other agencies and community organizations across the city.

The achievements depicted here represent a health in all policies approach intent on breaking down silos between sectors of our society which is our best hope for success. We remain focused on our simple vision: a city where all residents realize their full health potential.

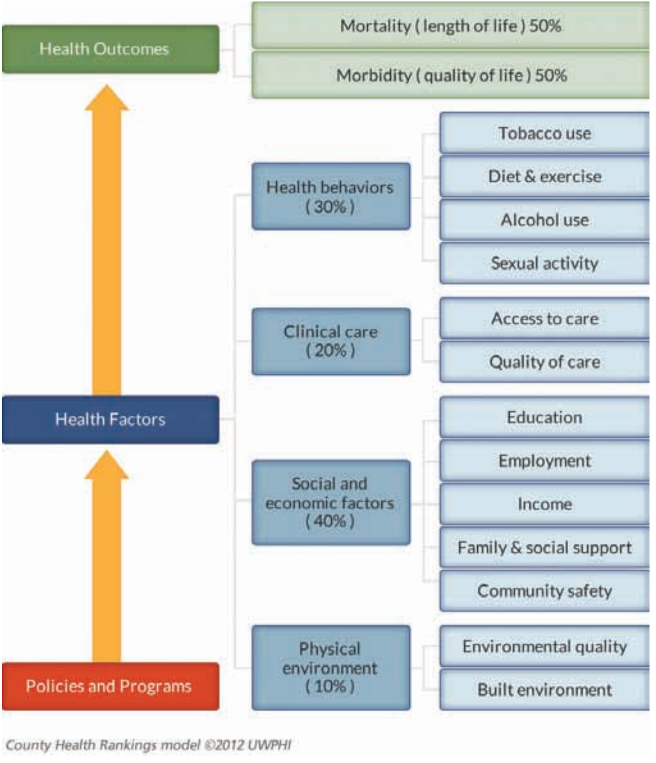
Sincerely,

Oxiris Barbot, M.D.
Commissioner of Health
Baltimore City

FRAMEWORK

Healthy Baltimore 2015 is Baltimore City's comprehensive health policy agenda, articulating priority areas and indicators for action. This plan highlights areas where the greatest impact on reducing morbidity and mortality and improving the quality of life for City residents can be realized. *Healthy Baltimore 2015* includes leading indicators to track our progress as a city in ensuring that all of our residents realize their full health potential. The leading indicators also bring attention to where inequalities by race, gender, education or income are most pronounced to further highlight opportunities for addressing health inequities. Each priority area is equally important.

This interim status report reflects progress made over the past two years for each of the indicators within all of the priority areas. This report also spotlights Baltimore City Health Department projects and initiatives currently in place to ensure further improvement. In addition, we highlight projects and initiatives being undertaken by the Baltimore City Health Department in collaboration with our partners so that further progress can be made.



County Health Rankings model ©2012 UWPHI

VISION

A city where all residents realize their full health potential

Health outcomes are not determined by individual clinical care alone; in fact, according to the County Health Rankings Model, clinical care contributes only 20% to an individual's ultimate health outcomes. Other important contributing factors include health behaviors, social/economic factors, and the physical environment. Collectively, these are referred to as the social determinants of health. *Healthy Baltimore 2015* incorporates both traditional public health measures and social determinants of health to emphasize the overall importance of where we live, work, learn and play on community health.

THE IMPORTANCE OF PARTNERS

Healthy Baltimore 2015 recognizes that individuals and communities must have the opportunity to make choices that impact their health regardless of race, income, or education. This agenda for change also acknowledges that a local public health department cannot successfully implement the plan working alone as the authority and expertise to act on and influence many root causes of health inequities frequently lies within other sectors of society.

Partners can contribute to the success of *Healthy Baltimore 2015* in many ways. These levels of engagement include, but are not limited to:

1. **Communication** – Displaying or distributing health information materials within each of the ten priority areas
2. **Facilitation** – Actively participating in interventions such as incorporating wellness at work programs into the business day
3. **Integration** – Actively considering the potential health impacts of pending business or policy decisions

STRATEGIES

Achieving the aggressive goals set forth by *Healthy Baltimore 2015* requires a multi-pronged approach that organizes collaborative efforts inclusive of various sectors within civil society and creates synergies to improve the health of all Baltimore residents. This is often referred to as a "Health in all Policies" approach.

As part of this process, the Baltimore City Health Department leads the Mayor's Cross-Agency Health Task Force, a group comprised of senior representatives from all City agencies dedicated to improving health outcomes in Baltimore.

Our primary strategies in advancing indicators within each priority area are:

1. **Policy Development** – Drafting and advocating for laws, regulations, and other policies to improve environmental, economic, and social conditions affecting the health of Baltimore City.
2. **Prevention, Quality and Access** – Emphasizing preventive health care, improving quality of care, and expanding access to care for all populations
3. **Community Engagement** – Informing, educating and engaging Baltimoreans to improve their health and the health of their communities

To further support community health improvement efforts, the Baltimore City Health Department developed the "Neighborhood Health Profiles" (http://www.baltimorehealth.org/neighborhoodmap.html) in which health outcome information is presented for each of the city's 55 Community Statistical Areas. These highlight the disparities in health and social determinants of health metrics within the city, and encourage the development of targeted community-driven interventions. An updated version of the NHPs will be published in early 2016.

In summary, *Healthy Baltimore 2015* promotes a cross-sectoral approach to reversing the City's poorest health outcomes; and reframes the lens through which we view and address longstanding health priorities to incorporate social determinants of health.

1. PROMOTE ACCESS TO QUALITY HEALTH CARE FOR ALL

Photo credit: Baltimore Aerial - Wiki credit: Fletcher6, November 2008

OPTIMIZE OVERALL HEALTH.

MINIMIZE DISPARITIES.

Access to timely, appropriate, high quality healthcare is critical to optimizing the health of all Baltimore City residents and minimizing disparities in health outcomes based on race/ethnicity, socioeconomic status, gender, or community of residence.

KEY INDICATORS

Why were certain indicators chosen for measuring health access?

- Diabetes, hypertension and asthma represent three diseases that can be managed optimally in an outpatient setting; these ambulatory care sensitive indicators are an important representation of how well city partners are able to help patients get healthier.
- Racial disparities are prominent in each of these three diseases, with African Americans having substantially higher rates than Whites in nearly every age group.
- Management of these disease conditions in emergency department or hospital settings cause significant increases in medical costs, both to the individual and the healthcare system.

[Goal 1A]: Decrease hospitalization rate for ambulatory care sensitive indicators by 15%

TABLE 1.1: RATES OF HOSPITALIZATION DISCHARGE FOR DIABETES TYPE I AND II AND HYPERTENSION BY RACE *2009, 2010, 2012*

Age-Adjusted Rate (per 100,000 population)	*2009*	*2010*	*2012*	*% Change 2009-12*
DIABETES TYPE I				
All Races	**98.5**	**96.9**	**91.7**	**-6.9%**
White	49.7	65.2	55.3	11.4%
Black	129.9	119.0	116.0	-10.7%
DIABETES TYPE II				
All Races	**270.5**	**274.7**	**232.3**	**-14.1%**
White	106.6	156.8	117.1	9.8%
Black	371.1	351.2	303.6	-18.2%
HYPERTENSION				
All Races	**274.8**	**254.3**	**217.5**	**-20.9%**
White	58.4	68.5	58.0	-0.7%
Black	403.9	362.7	308.1	-23.7%

Source: HSCRC hospital discharge data; Categorized as primary discharge diagnosis

TABLE 1.2: RATES OF HOSPITALIZATION DISCHARGE FOR ASTHMA BY RACE AND AGE *2009, 2010, 2012*

Age-Specific Rate (per 100,000 population)	*2009*	*2010*	*2012*	*% Change 2009-12*
ALL RACES				
Total	**426.3**	**405.8**	**380.8**	**-10.7%**
Less than 5 years	671.7	780.0	665.5	-0.9%
5-17 years	356.6	378.8	428.6	20.2%
18-44 years	248.6	221.5	190.7	-23.3%
45-64 years	674.7	625.5	585.0	-13.3%
65 years+	477.2	410.6	386.9	-18.9%
WHITE				
Total	**184.6**	**156.7**	**148.1**	**-19.8%**
Less than 5 years	312.1	318.1	214.6	-31.2%
5-17 years	120.1	158.6	120.8	0.6%
18-44 years	89.3	61.7	60.4	-32.3%
45-64 years	310.2	249.5	263.8	-14.9%
65 years+	289.2	255.3	239.2	-17.3%
BLACK				
Total	**575.3**	**551.8**	**517.5**	**-10.0%**
Less than 5 years	854.7	951.5	855.9	0.1%
5-17 years	459.2	446.5	522.9	13.9%
18-44 years	367.8	350.4	291.9	-20.6%
45-64 years	883.7	815.8	751.3	-15.0%
65 years+	594.9	510.5	517.5	-19.1%

Source: HSCRC hospital discharge data; Categorized as primary discharge diagnosis

AT-A-GLANCE

- Hospitalization rates due to Diabetes Type I and Type II declined between 2009 and 2012, with the exception of White residents in whom substantial increases occurred.
- Hospitalization for hypertension decreased in this time period, with an overall decline of 20.9%.
- Between 2009 and 2012, hospitalization rates for asthma declined as a whole and within most age groups except ages 5-17 years. White residents also showed substantial declines in all but the 5-17 year age category. Among Black residents, declines of up to 20% occurred in all age groups except children 5-17 years of age, where there was an increase in hospitalizations by nearly 14%.

CLOSING THE GAP

- Between 2009 and 2012, there was a reduction in the disparity in hospitalization rates between Black and White residents of 24.4% for Type 1 Diabetes, 29.5% for Type 2 Diabetes, and 27.6% for Hypertension.
- There was a 5% reduction in the disparity in asthma hospitalization rates between Black and White residents from 2009 to 2012.

Technical Note: Calculations in this report were done using newly standardized definitions and methods to increase ease of comparison over the years. Therefore, some numbers will differ from what was reported in the original Healthy Baltimore 2015 report.

Photo credit: Patterson High School - Released into the public domain

HIGHLIGHTING WORK UNDERWAY: ASTHMA IN SCHOOLS

Asthma is a leading cause of absenteeism among Baltimore's school-aged children. The Centers for Disease Control and Prevention's 2007 Youth Risk Behavior Survey showed that 28% of high school students in Baltimore City report having been diagnosed with asthma, compared with 20% nationwide.

The Bureau of School Health (BSH) is leading the charge to improve asthma care in schools. Through generous funding from the Mayor's Office, Abel Foundation, Weinberg Foundation and in partnership with City Schools, BSH has implemented a new electronic health record system. This new electronic health record (EHR) enables school nurses to better manage students with asthma and ensure we maximize the number of students with asthma who have access to rescue medications in school. Additionally, EHR affords the opportunity to improve tracking of children with poorly controlled asthma and provide information to parents and medical providers regarding which students would benefit from additional controller medications.

HIGHLIGHTING WORK UNDERWAY: REDUCING ASTHMA AND REACTIVE AIRWAY DISEASE (RAD)

The Baltimore City Health Department 's Healthy Homes Division conducts home visits for children ages 3-18 years of age who suffer from moderate to severe asthma and whose parents agree to participate in this pilot program. Trained nurses and community health workers assist families with asthma management through providing asthma education, assistance in creating Asthma Action Plans, assisting with risk factor exposure reduction, provision of supplies to reduce home-based triggers, ensure medication access, enhance provider communication, and establish community-based support networks.

SUCCESS!

According to an evaluation by the Hilltop Institute, in the 234 participants enrolled in the program, there was a statistically significant reduction in the likelihood of an asthma-related emergency department visit or hospitalization.

With promising preliminary results, and Baltimore City Health Department is working to continue and expand this program. For more information, please contact 410-396-3848. The referral form is available from http://www.baltimorehealth.org/info/RAD-CAP-clinic-fax-referral-form-041410.pdf.

[Goal 1B]: Decrease rate of emergency department visits for ambulatory care sensitive indicators by 10%

TABLE 1.3: RATES OF EMERGENCY DEPARTMENT DISCHARGE FOR DIABETES TYPE I AND II AND HYPERTENSION BY RACE
2009, 2010, 2012

Age-Adjusted Rate (per 100,000 population) <75 years	*2009*	*2010*	*2012*	*% Change 2009-12*
DIABETES TYPE I				
All Races	**18.3**	**20.0**	**36.3**	**98.5%**
White	9.7	9.9	21.5	120.7%
Black	24.0	24.2	45.3	88.7%
DIABETES TYPE II				
All Races	**221.0**	**279.2**	**359.1**	**62.5%**
White	89.1	125.9	150.5	68.8%
Black	303.3	369.7	482.9	59.2%
HYPERTENSION				
All Races	**261.7**	**344.5**	**439.1**	**67.8%**
White	55.0	86.7	117.1	112.9%
Black	385.6	490.4	621.9	61.3%

Source: HSCRC hospital discharge data; Categorized as primary discharge diagnosis

TABLE 1.4: RATES OF EMERGENCY DEPARTMENT DISCHARGE FOR ASTHMA BY RACE AND AGE ***2009, 2010, 2012***

Age-Specific Rate (per 100,000 population)	*2009*	*2010*	*2012*	*% Change 2009-12*
ALL RACES				
Total	**1,281.9**	**1455.0**	**1,837.2**	**43.3%**
Less than 5 years	3,257.0	4259.8	4,651.7	42.8%
5-17 years	2,199.4	2483.6	3,096.6	40.8%
18-44 years	1,145.5	1244.6	1,700.8	48.5%
45-64 years	869.6	1034.2	1,286.8	48.0%
65 years+	221.5	214.3	312.5	41.1%
WHITE				
Total	**303.3**	**369.4**	**499.1**	**64.5%**
Less than 5 years	788.4	1533.6	1,250.3	58.6%
5-17 years	443.1	660.9	773.0	74.5%
18-44 years	292.2	364.3	492.4	68.5%
45-64 years	273.7	240.7	460.0	68.1%
65 years+	48.8	56.3	115.9	137.3%
BLACK				
Total	**1,867.8**	**2068.6**	**2,593.4**	**38.9%**
Less than 5 years	4,651.6	5489.9	6,200.0	33.3%
5-17 years	2,933.0	3011.9	3,803.6	29.7%
18-44 years	1,773.2	1945.7	2,645.1	49.2%
45-64 years	1,198.9	1417.9	1,685.0	40.5%
65 years+	331.9	309.4	437.1	31.7%

Source: HSCRC hospital discharge data; Categorized as primary discharge diagnosis

AT-A-GLANCE

- Emergency department visits for Type I and Type II Diabetes and Hypertension increased from 2009 to 2012.
- Emergency department visits due to asthma increased by 30 percent or more in all age groups from 2009 to 2012.

CLOSING THE GAP

- Between 2009 and 2012, there was an increase in the disparity of ED visit rates between Black and White residents of 66.9% for Type 1 Diabetes, 55.2% for Type 2 Diabetes, and 52.7% for Hypertension.
- The disparity in ED visit rates for asthma between Black and White residents increased by 34% between 2009 and 2012.

Technical Note: Calculations in this report were done using newly standardized definitions and methods to increase ease of comparison over the years. Therefore, some numbers will differ from what was reported in the original Healthy Baltimore 2015 report.

[Goal 1C]: Decrease percent of insured individuals who report having unmet medical needs in last 12 months by 20%

Ensuring access to available health services is critical in redesigning the health care delivery system to improve a population's quality of life and life expectancy. Increasing health insurance coverage is one important aspect of improving access to care.

AT-A-GLANCE

- Insurance coverage improved by 15 percent or more among most Baltimore City residents between 2009 and 2012; however, significant access issues persist for Latino residents.
- In 2011, 18.2% of Baltimore City residents reported not having been able to afford to see a doctor in the past 12 months. The problem was more signficant among individuals without health insurance, and in people with an annual household income of <$15,000.

CLOSING THE GAP

- Unfortunately, the disparity in lack of health insurance coverage between White and Black residents increased by 39% between 2009 and 2012.

TABLE 1.5: RESIDENTS WITH NO HEALTH INSURANCE COVERAGE

	2009	*2012*	*% Change 2009-12*
Total non-institutionalized population	**15.2%**	**12.3%**	**-19.1%**
AGE GROUP			
Under 18 years	7.8%	5.4%	-30.8%
18 to 64 years	20.3%	16.6%	-18.2%
65 years and older	0.7%	1.1%	5.7%
GENDER			
Male	18.9%	15.5%	-18.0%
Female	12.0%	9.6%	-20.0%
RACE			
All White	13.7%	10.1%	-26.3%
All Black	15.5%	12.6%	-18.7%
ETHNICITY			
Hispanic or Latino (of any race)	37.4%	36.1%	-3.5%

Sources: U.S. Census Bureau (Health Insurance Coverage Status: 2009, 2012 ACS 1-Year Estimates)

TABLE 1.6: PERCENT OF BALTIMORE RESIDENTS WHO REPORTED A TIME IN THE PAST 12 MONTHS WHERE THEY COULD NOT AFFORD TO SEE A DOCTOR

	2009	*2011*
Total	**19.2%**	**18.2%**
RACE		
White, Non-Hispanic	8.6%	14.0%
Black, Non-Hispanic	22.0%	20.1%
HOUSEHOLD INCOME		
Under $15,000	35.3%	15.6%
$75,000 and over	1.8%	9.4%
HEALTH INSURANCE STATUS		
Insured	12.0%	10.3%
Not insured	49.9%	62.9%

Source: Maryland Behavioral Risk Factor Surveillance System, 2009, 2011;
Cannot directly compare numbers from 2009 and 2011 due to methodological changes

Technical Note: Calculations in this report were done using newly standardized definitions and methods to increase ease of comparison over the years. Therefore, some numbers will differ from what was reported in the original Healthy Baltimore 2015 report.

Photo credit: Washington Monument View - Wiki credit: Iracaz, December 2008

HIGHLIGHTING WORK UNDERWAY: HCAM AND THE MARYLAND HEALTH CONNECTION

According to 2011 U.S. Census estimates, roughly 82,000 Baltimore residents, including almost 7,000 children, do not have any form of health insurance. The Affordable Care Act stipulates that all states create health benefit exchanges as a way to increase the number of individuals and families with affordable health insurance.

The Maryland Health Connection, operated by the Maryland Health Benefit Exchange, is an online portal where individuals, families and small businesses can compare health insurance options, determine eligibility for tax credits and cost-sharing reductions, and enroll in qualified health plans or public programs. Baltimore City residents can get more information or sign up for updates by visiting www.MarylandHealthConnection.gov, or by texting "CONNECTED" to 69302.

Since 1997, HealthCare Access Maryland, Inc. (HCAM) has helped Baltimore-area residents navigate the complex health care system and enroll in public healthcare coverage. HCAM has been selected as the state's Central Region Connector, serving Baltimore City, Baltimore County and Anne Arundel County. HCAM and its Central Region partners employ approximately 100 "navigators" and "assisters" to provide outreach and education, with a particular focus on hard-to-reach populations. Trained and certified navigators will counsel and enroll residents into qualified health plans and Medicaid through the Maryland Health Connection. Non-certified personnel, known as "assisters," will be trained to provide information, assistance and enrollment into Medicaid.

2. BE TOBACCO FREE

Photo credit: BCHD Photo File

REDUCE PREVENTABLE DEATHS

Tobacco use is a major contributor to heart attacks, stroke, chronic lung disease and cancers. It is one of the most preventable causes of death and disease for men and women.

KEY FACT

There are no safe tobacco products, nor is there a risk-free exposure level for adults, children or pregnant women.

KEY FACT

Second hand smoke has a harmful impact on nonsmokers and children who suffer from respiratory infections.

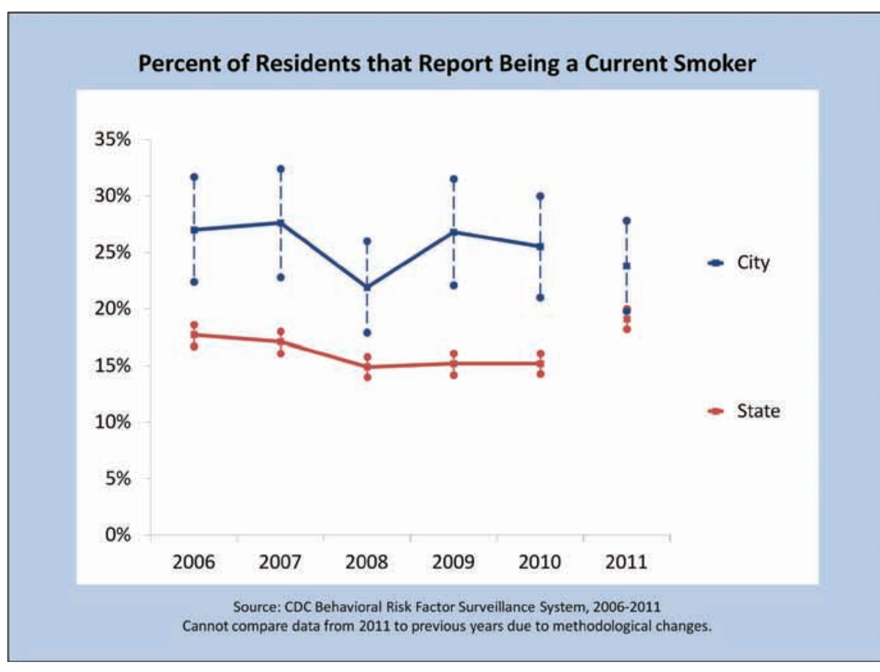
[Goal 2A]: Decrease percent of adults who currently smoke by 20%

TABLE 2.1: PERCENT OF RESIDENTS WHO REPORTED BEING A CURRENT SMOKER		
	2009	*2011*
Total	**26.8%**	**23.8%**
GENDER		
Male	29.6%	20.4%
Female	24.8%	26.2%
RACE		
White, Non-Hispanic	26.4%	22.9%
Black, Non-Hispanic	28.5%	23.7%
HOUSEHOLD INCOME		
Under $15,000	39.4%	31.2%
$75,000 and over	6.7%	5.4%

Source: Maryland Behavioral Risk Factor Surveillance System, 2009, 2011;
Cannot directly compare numbers from 2009 and 2011 due to methodological changes

AT-A-GLANCE

- Nearly a quarter of Baltimore City residents surveyed in 2011 reported that they were a current smoker.
- Residents with a household income under $15,000 were substantially more likely to report currently smoking than those with a household income over $75,000.



KEY FACT

Baltimore City has consistently had a higher smoking prevalence than the State of Maryland.

Technical Note: The original Healthy Baltimore 2015 Report showed data from the 2009 Baltimore City Community Health Survey to reflect residents reporting having unmet medical needs. The next iteration of the Baltimore City Community Health Survey will be done in Fall 2013; upcoming updates to the Healthy Baltimore 2015 Report will feature the new Community Health Survey data.

[Goal 2B]: Decrease percent of teens who currently smoke by 20%

AT-A-GLANCE

- In 2007, at least 10% of high school students had smoked once in the previous month.
- The next update of data is anticipated to be available from the Center for Disease Control and Prevention's 2013 Youth Risk Behavior Surveillance System Survey.

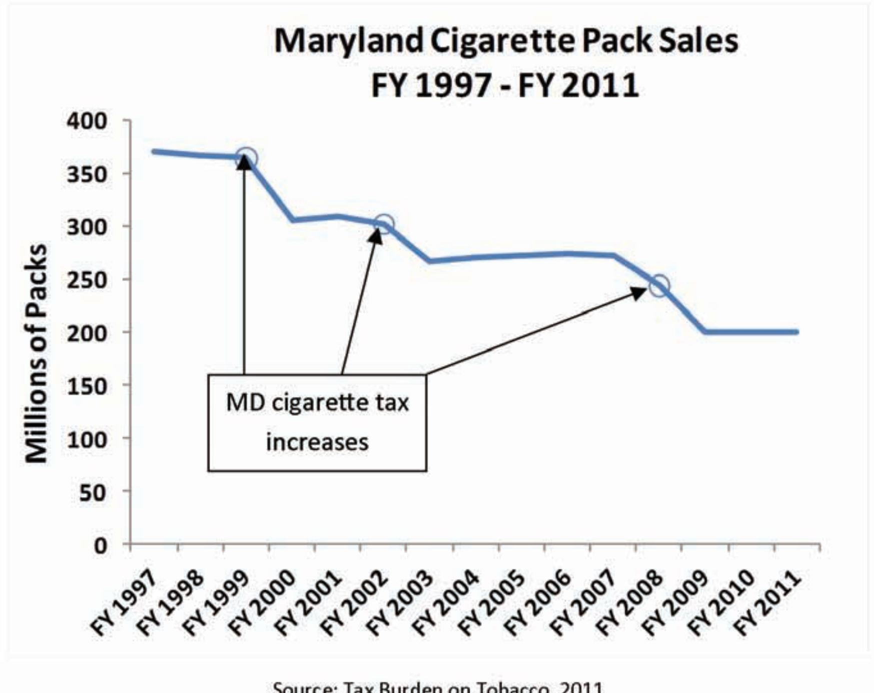
KEY FACT

Historically, cigarette tax increases have corresponded with decreases in cigarette pack sales

TABLE 2.2: PERCENT OF HIGH SCHOOL YOUTH WHO REPORTED SMOKING TOBACCO PRODUCTS AT LEAST 1 DAY DURING THE PREVIOUS 30 DAYS, BY GENDER, 2007

	2007
Total	**11.7%**
GENDER	
Male	10.0%
Female	13.8%

Source: Center for Disease Control and Prevention's Youth Risk Behavior Surveillance System Survey (YRBSS), 2007



Source: Tax Burden on Tobacco, 2011

HIGHLIGHTING WORK UNDERWAY: TOBACCO TAXES AND SMOKING CESSATION

Previous increases in the tobacco tax have reduced smoking in Maryland twice as fast as the national average, saving lives and taxpayer money by reducing the need for health care utilization. Three cigarette tax increases in the last two decades have been associated with a 32% decrease in smoking rates in Maryland. Research has shown that raising tobacco taxes reduces both experimentation and established smoking among adolescents.

Based on the increase of tobacco and cigar use among youth in Baltimore, the Baltimore City Tobacco Program is allocating funding towards the development of a teen smoking prevention campaign. The campaign will be developed by youth engaged in a photovoice process. This campaign will be initiated in early 2014.

Technical Note: Shown here is data from the Centers for Disease Control and Prevention's 2007 Youth Risk Behavior Surveillance System Survey, which was also highlighted in the original Healthy Baltimore 2015 Report. Iterations of the YRBSS survey since have not had a high enough response rate from Baltimore City to report city-level data. The Baltimore City Health Department is working closely with the CDC and the Maryland Department of Health and Mental Hygiene to increase the sampling from Baltimore City for the 2013 survey so that this data can once again be reported.

[Goal 2C]: Decrease rate of births to women who report smoking during pregnancy by 15%

TABLE 2.3: RATES OF SMOKING DURING PREGNANCY AMONG WOMEN GIVING BIRTH IN 2009 AND 2011 BY RACE AND EDUCATIONAL ATTAINMENT			
Rates per 1,000 live births	*2009*	*2011*	*% Change 2009-11*
MATERNAL RACE			
All	**94.8**	**106.7**	**12.5%**
Black	97.0	116.9	20.5%
White	121.4	120.5	-0.8%
EDUCATIONAL ATTAINMENT FOR AGES 20 YEARS AND OLDER			
HIGH SCHOOL (HS) OR LESS			
All	**148.8**	**182.2**	**22.5%**
Black	134.6	178.3	32.9%
White	199.8	200.2	0.2%
MORE THAN HIGH SCHOOL			
All	**24.4**	**45.1**	**85.1%**
Black	29.7	52.5	76.5%
White	21.0	40.0	90.7%

Source: Maryland Vital Statistic Birth Files

AT-A-GLANCE

- Rates of smoking during pregnancy increased overall, particularly among Black women from 2009 to 2011. A greater increase occurred in women with more than a high school education.

CLOSING THE GAP

- There was a 44% increase in the disparities in rates of smoking during pregnancy between Black and White residents with more than a high school education.

Technical Note: Calculations in this report were done using newly standardized definitions and methods to increase ease of comparison over the years. Therefore, some numbers will differ from what was reported in the original Healthy Baltimore 2015 report.

HIGHLIGHTING WORK UNDERWAY: "JUST SPEAK UP"

Babies exposed to tobacco smoke are five times more likely to die from Sudden Infant Death Syndrome (SIDS). In 2011, B'More for Healthy Babies launched "Just Speak Up", an educational campaign that encourages pregnant women who smoke to "Just Speak Up" and ask their medical providers for help quitting tobacco.

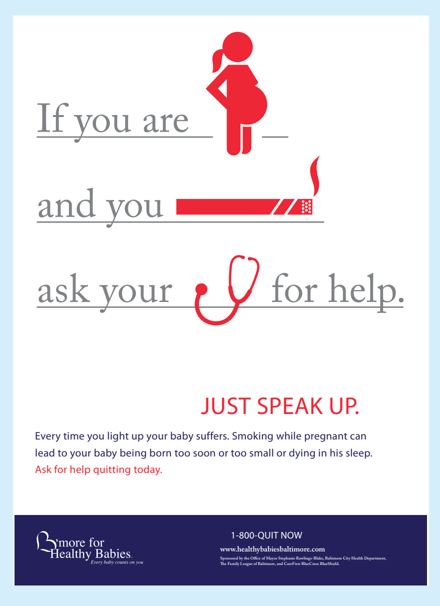


Photo credit: Nina Matthews, August 2011

3. REDESIGN COMMUNITIES TO PREVENT OBESITY

Photo credit: BCHD Photo File

HEALTHY FOOD.

HEALTHY RESIDENTS.

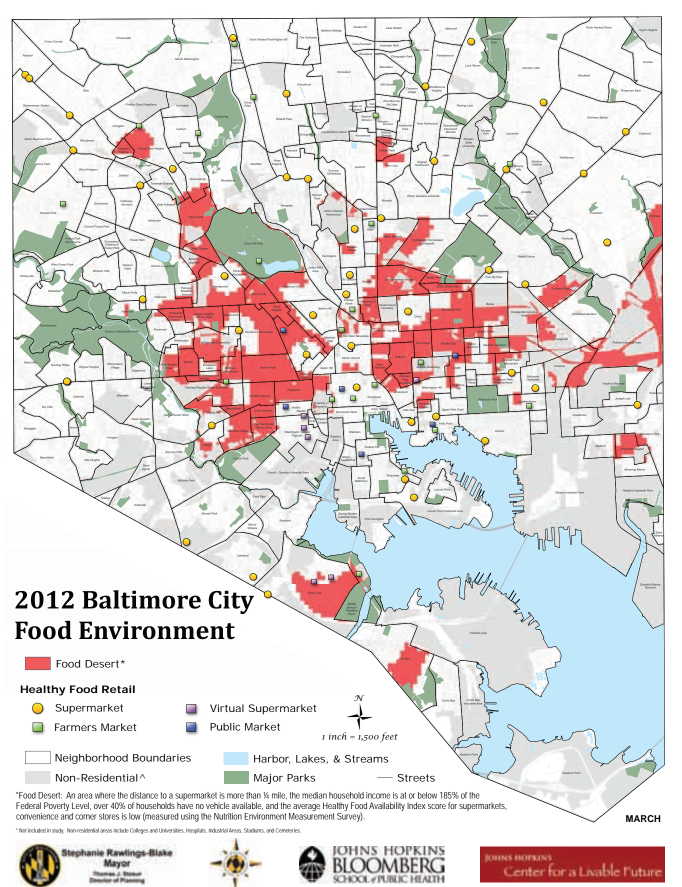
Obesity is a serious public health issue in Baltimore City. Preventing and reducing obesity requires addressing key social and environmental characteristics:

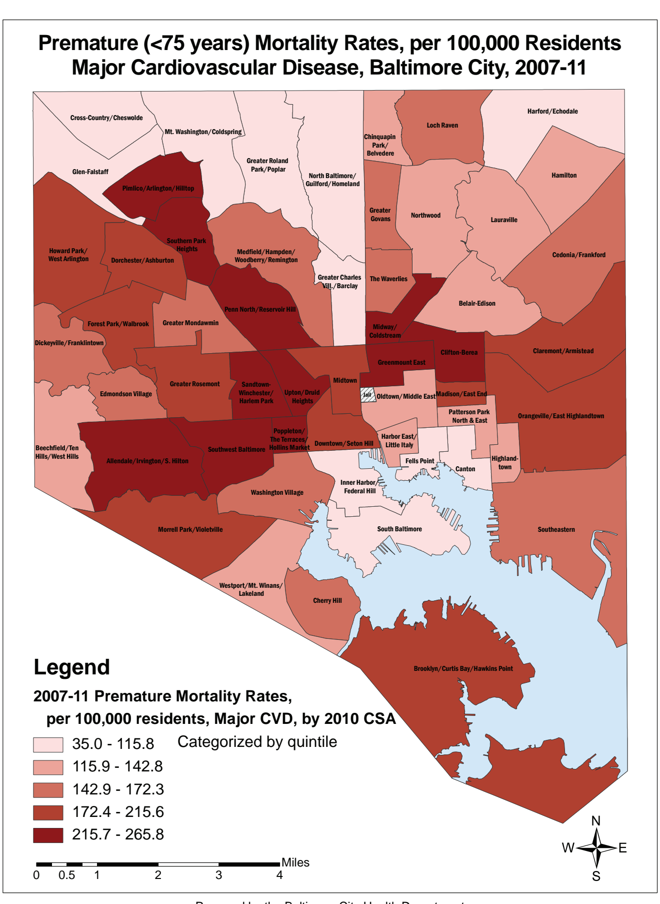
- Increasing access to healthy foods including fresh fruits and vegetables
- Increasing physical activity by redesigning local environments to promote safe and healthy physical activity opportunities

[Goal 3A]: Decrease inequities in supermarket access by 15%

FOOD DESERTS & PREMATURE MORTALITY

A food desert is an area with little or no immediate access to healthy foods. Data show a direct correlation between living in a food desert and having a higher rate of early death from cardiovascular disease. Redesigning communities to prevent obesity includes increasing access to healthy and fresh food by improving public transportation and other creative strategies that reduce the impact of food deserts.





Prepared by the Baltimore City Health Department
Mortality data provided by Vital Statistics Administration

HIGHLIGHTING WORK UNDERWAY: INTER-SECTORAL POLICY TASK FORCE RESULTS IN LAUNCHING OF INITIATIVES

A comprehensive strategy for food access in Baltimore city began with a task-force led by the Baltimore City Department of Planning and the Baltimore City Health Department. This collaboration led to the formation of a Baltimore Food Policy Taskforce which presented 10 recommendations for improving access to healthy and affordable foods in Baltimore. Bourne of these recommendations are several current initiatives, three of which are outlined below.

Virtual Supermarket Program (VSP)

The Virtual Supermarket Program is an innovative way to increase healthy food access by using an online grocery ordering system to bring food to food desert neighborhoods. It enables residents to place and receive their grocery orders at their local library, senior, disabled, or public housing building for no delivery cost. In 2012, the VSP expanded beyond a service-based library model to two sites in public housing and two sites in senior/disabled housing.

- Over 300 unique customers have been served, 2,000 orders placed and $75,000 worth of groceries purchased
- VSP has partnered with USDA to advocate for online-SNAP benefits
- VSP has worked with Baltimore's Departments of Planning and Housing on food policy for the city.

SNAP Benefits at Baltimore farmers markets

The Baltimore Food Policy Task Force partnered with Baltimore Office of Promotion and The Arts to launch SNAP benefits at the Baltimore Farmers' Market & Bazaar in 2012.

- In 2012, five farmers markets in Baltimore City processed 3,294 SNAP transactions and $54,148 in SNAP sales.
- Baltimore Farmers' Market & Bazaar had $18,600 in SNAP, $12,500 in debit, and $9,000 in Baltimore Bucks incentive dollars sales.

Neighborhood Food Advocates (NFA)

The Neighborhood Food Advocates program is a community-based approach to food desert elimination. NFA's goal is to empower members in the community to bring about change in personal behaviors, social attitudes, and the food environment in Baltimore City, by organizing to address food insecurity. Advocates are community residents who are passionate about improving their community's food environment and health. Examples of NFA projects include the creation of community gardens and community operation of branches of the Virtual Supermarket.

Photo credit: BCHD Photo File

[Goal 3B]: Increase percent of adults getting recommended levels of physical activity by 20%

Photo credit: BCHD Photo File

TABLE 3.1: PERCENT OF RESIDENTS WHO MEET PHYSICAL ACTIVITY RECOMMENDATIONS		
	2009	*2011*
Total	**29.4%**	**43.9%**
GENDER		
Male	28.4%	37.5%
Female	30.1%	48.4%

Source: Maryland Behavioral Risk Factor Surveillance System, 2009, 2011;
Cannot directly compare numbers from 2009 and 2011 due to methodological changes

AT-A-GLANCE

- In 2011, 43.9% of Baltimore City residents reported getting the recommended levels of physical activity.

RECOMMENDED PHYSICAL ACTIVITY

The Centers for Disease Control and Prevention recommends the following for adults and seniors:

- 2½ hours of moderate intensity or 75 minutes of vigorous intensity aerobic activity per week; AND
- 2+ days/week of muscle strengthening activity

Technical Note: The original Healthy Baltimore 2015 Report showed data from the 2009 Baltimore City Community Health Survey to reflect physical activity in Baltimore City residents. The next iteration of the Baltimore City Community Health Survey will be done in Fall 2013; upcoming updates to the Healthy Baltimore 2015 Report will feature the new Community Health Survey data.

[Goal 3C]: Decrease percent of adults who are obese by 15%

AT-A-GLANCE

- Over one-third of Baltimore City residents have been classified as obese by a healthcare provider.
- Obesity prevalence is nearly 50% in those with lower household income.

TABLE 3.2: PERCENT OF RESIDENTS WHO ARE OBESE		
	2009	*2011*
Total	**34.0%**	**36.1%**
HOUSEHOLD INCOME		
Under $15,000	37.5%	44.8%
$75,000 and over	26.3%	22.2%

Source: Maryland Behavioral Risk Factor Surveillance System, 2009, 2011;
Cannot directly compare numbers from 2009 and 2011 due to methodological changes

Photo credit: Mark L. Dennis

CALL FOR CHANGE: LESS THAN HALF OF BALTIMORE CITY RESIDENTS GET RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Mayor Stephanie Rawlings-Blake convened the Cross Agency Health Taskforce (CAHT) in spring 2011 to advance the city's health policy agenda. CAHT is focused specifically on "Redesigning Communities to Prevent Obesity" through a "Health in all Policies" approach. Full implementation of this layered approach to increasing safe spaces for physical activity will be underway by late 2013.

- Baltimore Development Corporation is working with Main Streets and farmer's markets efforts to make communities more walkable and increase access to healthy foods.
- City Schools are hosting a "movement" challenge that will give funds to 3 schools to use toward a wellness project of their choosing.
- Human Resources is working with city agencies and health care insurance providers to coordinate wellness programs and activities through an array of wellness consultation services.
- Libraries launched the Get Fit @ Your Library program, providing exercise classes at the selected branches.
- Mayor's Office of Employee Development has incorporated 30 minutes of physical activity in all of their youth programs.
- Recreation and Parks has changed its permit structure and fee schedule, making it easier and cheaper for communities to get permits to host programs in the parks.

4. PROMOTE HEART HEALTH

Photo credit: le vent le cri, February 2008

Cardiovascular disease (CVD) is the leading cause of death in Baltimore City, as it is in the rest of the state and the nation. The major risk factors for CVD are smoking, high cholesterol, high blood pressure, physical inactivity, overweight/obesity, and diabetes.

There are other factors that contribute to CVD, such as stress, excessive drinking, and poor outdoor air quality. The leading indicators within this priority area illustrate premature death from cardiovascular disease and self-reported access to medical care once a major risk factor, high blood pressure, has been identified.

CONTROL BLOOD PRESSURE.

LESSEN HEART DISEASE.

[Goal 4A]: Decrease rate of premature deaths from cardiovascular disease (CVD) by 10%

AT-A-GLANCE

- Premature deaths (deaths before age 75 years) due to major cardiovascular disease declined from 2009 to 2011 among Black residents by 9.9%, but remained unchanged among White individuals.
- Deaths declined among those 25-75 years of age with a high school education or less by 6.8%, but increased slightly among those 25-75 years of age with at least some college education.

CLOSING THE GAP

- There was a 36% reduction in the disparity in rates of premature CVD death between Black and White residents between 2009 and 2011.

TABLE 4.1: AGE-ADJUSTED PREMATURE DEATH RATES DUE TO CARDIOVASCULAR DISEASE BY RACE AND EDUCATIONAL ATTAINMENT

Rate per 100,000	*2009*	*2011*	*% Change 2009-11*
Total non-institutionalized population	**15.2%**	**13.5%**	**-11.2%**
PREMATURE (<75 YEARS) DEATHS			
All Races	**165.3**	**151.2**	**-8.5%**
Black	190.2	171.4	-9.9%
White	143.6	143.5	0.0%
DEATHS IN ADULTS (25 YEARS-75 YEARS)			
High School or Less	308.6	287.5	-6.8%
Some College or More	100.0	104.5	4.4%

Source: BCHD Analysis of Maryland Vital Statistics data

HIGHLIGHTING WORK UNDERWAY: THE NEIGHBORHOOD HEALTH INITIATIVE AND PLACE-BASED PROJECTS

As part of the Neighborhood Health Initiative, residents across the city identified their top health concerns and pinpointed existing resources in their communities that could help mitigate these concerns. Chief among these concerns was addressing the root causes and mitigating the negative impacts of poor cardiovascular health. Place-based projects emerging from the Neighborhood Health Initiative emphasize food access and promotion of physical activity for senior citizens in the Sandtown and Oliver Neighborhoods. The Delmarva Foundation's **Baltimore HELPS** project (Healthy Eating and Leading Partnerships for Seniors) aims to reduce diabetes, COPD, chronic heart failure, and kidney disease, by improving programming for food access, nutrition, physical activity, and health screenings through a "one-stop shop" model at Hollins Homes and the Oliver Senior Center. Each week, seniors are encouraged to participate in lectures, classes, and hand-on demonstrations. Each month is themed, with a corresponding set of classes or workshops. Senior facility residents/users and staff provide feedback to ensure that programming meets their needs in an effective, efficient, and culturally appropriate manner. More information can be obtained from the Delmarva Foundation at www.dfmc.org.

Technical Note: Calculations in this report were done using newly standardized definitions and methods to increase ease of comparison over the years. Therefore, some numbers will differ from what was reported in the original Healthy Baltimore 2015 report.

[Goal 4B]: Increase percent of adults with high blood pressure on medication by 10%

TABLE 4.2: PERCENT OF RESIDENTS WITH HIGH BLOOD PRESSURE WHO REPORT CURRENTLY TAKING MEDICATION		
	2009	*2011*
Total	**82.5%**	**84.3%**
GENDER		
Male	77.7%	83.4%
Female	86.3%	84.9%

Source: Maryland Behavioral Risk Factor Surveillance System, 2009, 2011;
Cannot directly compare numbers from 2009 and 2011 due to methodological changes

ACCESS TO QUALITY CARE STRATEGIES: *KNOW YOUR NUMBER, KNOW YOUR RISK, KNOW YOUR HEART CAMPAIGN*

Baltimore is one of five initial cities selected by the U.S. Department of Health and Human Services to launch Heart Health Mobile, a mobile application that allows residents to assess their risk for heart disease; track changes in risk factors, such as weight or smoking status; and find resources, such as pharmacies and clinics, that offer blood pressure and cholesterol screenings.

The Heart Health Mobile app is part of a larger education campaign dedicated to helping individuals better understand their risk for heart disease, encouraging them to get cholesterol and blood pressure screenings, and promoting lifestyle changes to improve overall heart health. This campaign itself rolls into the Million Hearts™ initiative, a national, public-private initiative of HHS to prevent 1 million heart attacks and strokes by 2017.

For more information, please see http://millionhearts.hhs.gov/

AT-A-GLANCE

- In 2011, 84.3% of Baltimore City residents reported currently taking blood pressure medication.

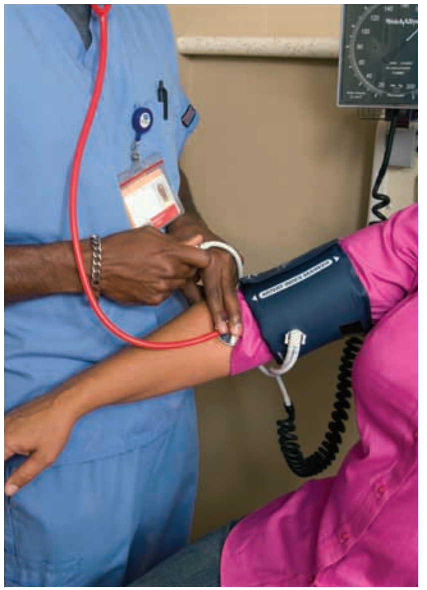


Photo credit: BCHD Photo File

5. STOP THE SPREAD OF HIV AND OTHER SEXUALLY TRANSMITTED INFECTIONS

Photo credit: Mark L. Dennis

KNOW YOUR STATUS.

POWER IN KNOWLEDGE.

Baltimore City has been disproportionately affected by HIV and other Sexually Transmitted Infections (STIs) including Chlamydia, Gonorrhea and Syphilis. The effects of STIs can be additive—that is, individuals with HIV who have other STIs are more likely to transmit HIV to their partners, and individuals with other STIs are more likely to become infected with HIV if they come into contact with the virus. Identifying populations at high risk for HIV/STI transmission is a key step in effective prevention, treatment and control of these infections.

[Goal 5A]: Decrease number of Syphilis cases by 25%

TABLE 5.1: PRIMARY AND SECONDARY SYPHILIS INCIDENCE RATES BY GENDER AND RACE			
Rate per 100,000	*2009*	*2012*	*% Change 2009-12*
Total	**22.3**	**39.1**	**75.3%**
GENDER			
Male	39.5	72.8	84.3%
Female	7.0	9.1	30.0%
RACE			
Black	30.9	55.8	80.6%
White	6.1	9.8	60.7%

Source: Baltimore City Bureau of HIV/STD Services

AT-A-GLANCE

- Syphilis rates have increased substantially between 2009 and 2012, mainly among males.

CLOSING THE GAP

- There was a 85% increase in the disparity in Syphilis rates between Black and White residents from 2009 to 2012.

Photo credit: CDC/PHIL, James Gathany, 2007

HIGHLIGHTING WORK UNDERWAY: EXPANDING TESTING FOR SYPHILIS

Identification of individuals in the early stages of Syphilis is critical for instituting treatment before serious consequences can develop and for limiting the spread of the disease. BCHD takes several measures to promote testing, such as:

- Encouraging co-testing for HIV and Syphilis at community events, as each STD is a risk factor for developing the other
- Supporting development of mobile applications that would allow clients to see their STD results online so that clients receive more immediate feedback

[Goal 5B]: Decrease new HIV infections by 25%

PROGRESS

Between 2009 and 2011, new HIV infections in Baltimore City decreased by 25.4%.

TABLE 5.2: REPORTED NEW HIV DIAGNOSES IN ADULTS/ ADOLESCENTS (≥13 YEARS) BY GENDER AND RACE

	2009	*2011*	*% Change 2009-11*
Number of Total Diagnoses	**544**	**406**	**-25.4%**
GENDER PROPORTIONS			
Male	63.6%	69.0%	8.5%
Female	36.4%	31.0%	-14.8%
RACE PROPORTIONS			
Black	84.7%	86.0%	1.5%
White	10.3%	7.4%	-28.2%

Source: Maryland DHMH Baltimore City HIV/AIDS Epidemiology Profile

HIGHLIGHTING WORK UNDERWAY: "HAVE BALLS, GET TESTED"

Offering HIV testing through community events that attract individuals at high risk for HIV infection is a key strategy for reducing new HIV infections. To that end, BCHD, the Baltimore Ballroom Coalition, and Connect 2 Protect sponsor an annual free mini-ball and conference for Baltimore's house and ball community. This is the first ball developed and sponsored by a city agency to bridge the relationship between city/state government agencies and the gay, lesbian, bisexual, and transgender (GLBT) community. The free ball provides necessary information and resources to the GLBT community, including dental care, HIV testing, educational opportunities, and linkages to housing.

SUCCESS!

Of the 124 individuals tested at the Third Annual Mini-ball in November 2012, 7% were diagnosed as new HIV infections. This percentage is significantly higher than in other testing venues, where positivity rates typically range from 0.5% to 1.5%.

The annual Mini-ball is part of Status Update, a larger campaign to reach individuals of several sexual minority groups at significant risk for HIV. Status Update was developed in partnership with the Baltimore GLBT community. Status Update involves a range of activities that include targeted community engagement and prevention messages such as bill board and bus ads; fliers for GLBT frequented venues; a customized condom distribution effort ("Baltimore's Biggest"); and a GLBT-friendly website at www.baltimorestatusupdate.com.

[Goal 5C]: Decrease rates of Gonorrhea and Chlamydia in Adolescents by 25%

Photo credit: Couple in Grass - Wiki credit: Faraz, November 2006

TABLE 5.3: RATES OF YOUTH (10-19 YEARS) WITH GONORRHEA OR CHLAMYDIA BY RACE			
Rate per 100,000	*2009*	*2012*	*% Change 2009-12*
GONORRHEA			
All	**1,234.3**	**744.1**	**-39.7%**
Black	1,329.8	871.9	-34.4%
White	141.5	63.2	-55.3%
CHLAMYDIA			
All	**4,778.9**	**4,221.7**	**-11.7%**
Black	5,589.1	4,435.6	-20.6%
White	449.9	385.9	-14.2%

Source: Baltimore City Bureau of HIV/STD Services

AT-A-GLANCE

- From 2009 to 2012, the Gonorrhea rate decreased by 39.7% overall, with a more dramatic 55.3% decrease among White youth. Chlamydia rates decreased by 11.7% overall.

CLOSING THE GAP

- There was a decrease in the disparity in rates between White and Black youth from 2009 to 2012 of 32% for Gonorrhea and 21% for Chlamydia.

6. RECOGNIZE AND TREAT MENTAL HEALTH CARE NEEDS

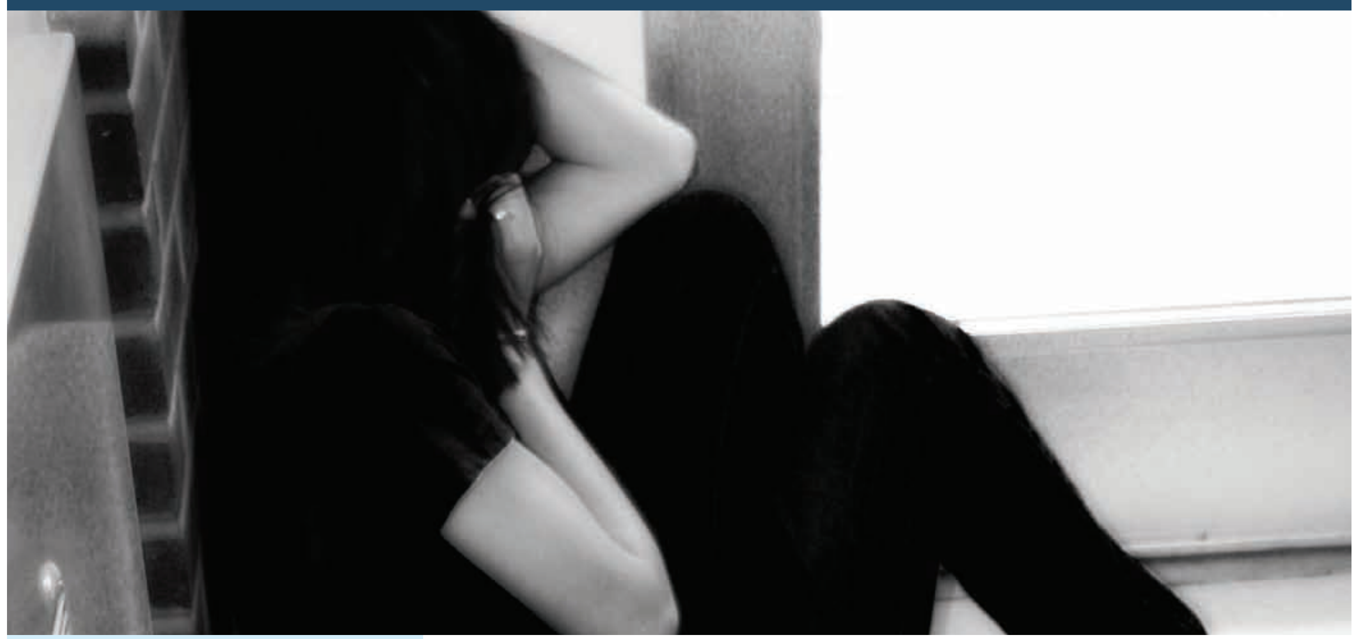


Photo credit: Depression - Released into the public domain

PROMOTE WELL-BEING

Mental health is an essential component of overall health. Untreated mental illness can lead to devastating consequences, including homelessness, incarceration, unemployment and drug or alcohol abuse. Therefore, progress towards decreasing the number of adults who report having unmet mental health care needs is a key indicator in this priority area.

[Goal 6A]: Decrease percent of adults with unmet mental health care needs by 25%

TABLE 6.1: PERCENT OF RESIDENTS WHO REPORTED THEIR MENTAL HEALTH WAS "NOT GOOD" FOR 8 OR MORE DAYS OUT OF THE PAST 30 DAYS		
	2009	*2011*
Total	**19.1%**	**20.9%**
RACE		
White	21.8%	15.1%
Black	17.1%	19.5%
EDUCATIONAL ATTAINMENT		
Less than a Bachelor's Degree	21.3%	23.8%
Bachelor's Degree and Above	14.1%	12.4%

Source: Maryland Behavioral Risk Factor Surveillance System, 2009, 2011;
Cannot directly compare numbers from 2009 and 2011 due to methodological changes

AT-A-GLANCE

- In 2011, 20.9% of Baltimore City residents reported poor mental health in at least 8 of the past 30 days.
- Significant numbers of Baltimore residents continue to have mental health issues that are not adequately managed or treated.

HIGHLIGHTING WORK UNDERWAY: MENTAL HEALTH FIRST AID

Baltimore Mental Health Systems, Inc. (BMHS), now under the umbrella organization Behavioral Health Systems Baltimore, is a non-profit agency whose primary activities focus on improving access to mental health care expanding and improving the range of services available to Baltimore City residents with a mental illness, and ensuring accountability and active collaborations with City and State agencies.

One such collaboration, Mental Health First Aid Maryland, stems from a partnership between BMHS and the Mental Health Association of Maryland. Mental Health First Aid Maryland is a public education program designed to help the general population identify, understand, and respond to signs of mental illnesses and substance use disorders. There are 34 instructors in Baltimore City and the surrounding suburbs certified to facilitate this 12-hour course. For more information on Mental Health First Aid, courses and instructors in the area, please go to www.mentalhealthfirstaid.org.

Technical Note: The original Healthy Baltimore 2015 Report showed data from the 2009 Baltimore City Community Health Survey to reflect mental health in Baltimore City residents. The next iteration of the Baltimore City Community Health Survey will be done in Fall 2013; upcoming updates to the Healthy Baltimore 2015 Report will feature the new Community Health Survey data.

[Goal 6B]: Decrease percent of adolescents expressing feelings of sadness or hopelessness by 20%

AT-A-GLANCE

- In 2007, nearly 20% of males and 35% of females reported feelings sad or hopeless on a daily basis
- The next update of data is anticipated to be available from the Center for Disease Control and Prevention's 2013 Youth Risk Behavior Surveillance System Survey.

BRIGHTER FUTURES

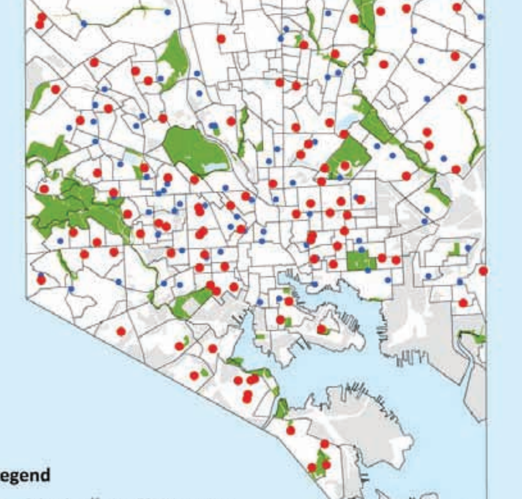
Identifying signs of mental illness early and targeting at-risk youth can prevent or lessen the impact of serious mental illness later in life. By decreasing the number of adolescents who report regular feelings of sadness or hopelessness, we ensure brighter futures for our children.

TABLE 6.2: PERCENT OF HIGH SCHOOL YOUTH WHO REPORTED FEELING SAD OR HOPELESS NEARLY DAILY FOR 2 OR MORE CONSECUTIVE WEEKS, BY GENDER, 2007

	2007
Total	**27.7%**
GENDER	
Male	19.5%
Female	35.3%

Source: Center for Disease Control and Prevention's Youth Risk Behavior Surveillance System Survey (YRBSS), 2007

HIGHLIGHTING WORK UNDERWAY: EXPANDED SCHOOL MENTAL HEALTH (ESMH) IN BALTIMORE CITY PUBLIC SCHOOLS



Baltimore is recognized as a leader in the state of Maryland and in the nation for its ability to provide expanded school mental health (ESMH) services to its public school students. Since 1987, ESMH services have complemented and supplemented the services provided by school social workers, psychologists and guidance counselors employed by the Baltimore City Public School System (BCPSS). ESMH services are intended to address barriers to learning, enable students to make better use of educational programs in their schools, and provide an alternative to mental health services provided within the structure of the Special Education system. Through partnerships between BCPSS and community-based mental health programs, a greater range of mental health services, including assessment and treatment, have been made available to students identified as experiencing or being at risk for emotional or behavioral difficulties.

Technical Note: Shown here is data from the 2007 Centers for Disease Control and Prevention's 2007 Youth Risk Behavior Surveillance System Survey, which was also highlighted in the original Healthy Baltimore 2015 Report. Iterations of the YRBSS survey since have not had a high enough response rate from Baltimore City to report city-level data. The Baltimore City Health Department is working closely with the CDC and the Maryland Department of Health and Mental Hygiene to increase the sampling from Baltimore City for the 2013 survey so that this data can once again be reported.

7. REDUCE DRUG USE AND ALCOHOL ABUSE

Photo credit: BCHD Photo File

PREVENTION.

TREATMENT.

RECOVERY.

Drug and alcohol abuse cause substantial costs in lost productivity, family and community disruption, crime, homelessness, and healthcare utilization. Intervening early with comprehensive programs that include prevention, treatment and recovery support services provides individuals with the best chance for healthy and productive futures.

Behavioral Health System Baltimore (BHSB) is a new non-profit organization focused on advancing behavior health for individuals, families and communities in Baltimore City. It is being formed by a merging of Baltimore Substance Abuse Systems (BSAS) and Baltimore Mental Health Sytems (BMHS), thus fostering an efficient, collaborative and holistic behavior health system that will help Baltimore City residents address mental health and substance abuse issues.

[Goal 7A]: Decrease rate of alcohol and drug-related hospital admissions by 10%

AT-A-GLANCE

- Hospitalization rates for drug and alcohol related disorders have decreased by 31% from 2009 to 2012.

CLOSING THE GAP

- There was an 87% reduction in disparities between White and Black residents in the rates of alcohol and/or drug related hospitalizations between 2009 and 2012.

Photo credit: Alcohol - Wiki credit: Kotivalo, August 2012

TABLE 7.1: RATES OF HOSPITALIZATION DISCHARGE FOR PRIMARY AND SECONDARY DIAGNOSES OF ALCOHOL-RELATED AND DRUG-RELATED DISORDERS BY RACE, 2009, 2010 AND 2012

Rate per 100,000 population	*2009*	*2010*	*2012*	*% Change 2009-12*
TOTAL ALCOHOL AND/OR DRUG-RELATED				
All Races	**992.6**	**878.3**	**685.0**	**-31.0%**
White	912.4	925.0	695.6	-23.8%
Black	1,091.5	1,007.6	719.2	-34.1%
ALCOHOL-RELATED (W/O DRUG)				
All Races	**463.9**	**408.9**	**396.4**	**-14.6%**
White	452.6	501.3	405.9	-10.3%
Black	491.0	412.3	407.9	-16.9%
DRUG-RELATED (W/O ALCOHOL)				
All Races	**564.6**	**502.4**	**323.5**	**-42.7%**
White	499.1	461.3	323.8	-35.1%
Black	673.3	580.1	349.4	-45.2%

Source: HSCRC hospital discharge data; Categorized as primary or secondary discharge diagnoses

Technical Note: Calculations in this report were done using newly standardized definitions and methods to increase ease of comparison over the years. Therefore, some numbers will differ from what was reported in the original Healthy Baltimore 2015 report.

[Goal 7B]: Decrease rate of alcohol and drug-related emergency department visits by 15%

TABLE 7.2: RATES OF EMERGENCY DEPARTMENT DISCHARGE FOR ALCOHOL AND DRUGS BY RACE, 2009, 2010 AND 2011				
Rate per 100,000 population	*2009*	*2010*	*2012*	*% Change 2009-12*
TOTAL ALCOHOL AND/OR DRUG-RELATED				
All Races	**1,095.5**	**1,436.0**	**2,017.6**	**84.2%**
White	909.5	1,587.8	1,879.7	106.7%
Black	1,229.2	1,591.0	2,143.6	74.4%
ALCOHOL-RELATED (W/O DRUG)				
All Races	**744.4**	**978.3**	**1,388.8**	**86.6%**
White	607.6	1,066.0	1,287.9	112.0%
Black	828.5	1,026.6	1,452.2	75.3%
DRUG-RELATED (W/O ALCOHOL)				
All Races	**378.2**	**498.7**	**682.6**	**80.5%**
White	330.9	559.4	634.9	91.9%
Black	428.2	531.9	753.7	76.0%

Source: HSCRC hospital discharge data; Categorized as primary or secondary discharge diagnoses

AT-A-GLANCE

- Emergency department visits have increased substantially between 2009 and 2012 for drug and alcohol related disorders.

CLOSING THE GAP

- There was a 17% reduction in the disparity between White and Black residents in the rates of alcohol and/or drug related emergency department visits between 2009 and 2012.

HIGHLIGHTING WORK UNDERWAY: THE STAYING ALIVE PROGRAM

Since 2004, the Baltimore City Health Department's Staying Alive Drug Overdose Prevention and Response Program has taught more than 5,000 injection drug users, drug treatment clients and providers, prison inmates, and corrections officers about how to prevent drug overdoses. More than 240 reversals — lives saved — have been documented.

One survey of injection drug users found that approximately 50 percent personally experience at least one non-fatal overdose, and 70 percent witness at least one overdose during their injection career. Drug overdose is now the second-leading cause of accidental death in America, according to The Drug Policy Alliance.

The Staying Alive Program trains individuals to recognize an opiate/heroin overdose and respond by calling 911, applying rescue breathing, and administering the drug Naloxone (also known as Narcan). Naloxone is an opioid antagonist that effectively reverses life-threatening symptoms of patients who have overdosed on heroin or other opioids. Naloxone is safe; patients experience few side effects and there are no negative effects on people who are free of opioids. Emergency medical technicians have long used Naloxone as an intramuscular or intravenous injection. Naloxone can also be administered intra-nasally, reducing the risk of disease transmission by accidental needle sticks. The Staying Alive program also links drug users to substance abuse treatment and other services.

Since launching the Staying Alive program, the number of Baltimore City residents who died of drug overdose associated with use of heroin and other opioids has decreased significantly. More information can be obtained from http://baltimorehealth.org/stayingalive.html, or by calling 443-829-9480.

Technical Note: Calculations in this report were done using newly standardized definitions and methods to increase ease of comparison over the years. Therefore, some numbers will differ from what was reported in the original Healthy Baltimore 2015 report.

[Goal 7C]: Decrease percent of high school students reporting alcohol and/or drug use in the last 30 days by 20%

AT-A-GLANCE

- In 2007, at least 10% of high school students reported consuming 5 or more drinks in a day, and approximately 20% had used marijuana one or more times
- The next update of data is anticipated to be available from the Center for Disease Control and Prevention's 2013 Youth Risk Behavior Surveillance System Survey.

TABLE 7.3: PERCENT OF HIGH SCHOOL YOUTH REPORTING ALCOHOL OR DRUG USE IN THE LAST 30 DAYS, BY GENDER, 2007

	All	*Male*	*Female*
5 or more consecutive drinks within a couple of house at least 1 day	10.8%	13.4%	8.7%
Used marijuana one or more times	21.4%	25.7%	17.6%

Source: Center for Disease Control and Prevention's Youth Risk Behavior Surveillance System Survey (YRBSS), 2007

HIGHLIGHTING WORK UNDERWAY: THE ADOLESCENT CLUB HOUSE AND OTHER SUPPORT SYSTEMS FOR ADOLESCENTS

Behavioral Health Systems Baltimore, formerly Baltimore Substance Abuse Systems, Inc., (BSAS), offers resources and support to substance abuse treatment programs; many address the needs of adolescents. For more information, please visit www.bsasinc.org

The Adolescent Club House provides recovery support for adolescents aged 12-17, who have either completed or are currently engaged in substance abuse treatment. By combining a recovery-support model with evidence-based programs that are designed to attract young people, the Clubhouse provides opportunities for socializing with others in recovery, while offering assistance with education employment and other needed services.

School-Based Treatment provides direct services to students and educational services for staff within the school environment. Counselors facilitate trainings for teachers on substance use prevention and education.

Community Prevention Schools are partnerships between a school and the community it serves to foster a safe and drug-free environment for youth. Community Prevention Schools provide age- and developmentally-appropriate violence and substance use prevention programs; train members of the community on substance use prevention; train staff to identify youths in crisis and to make appropriate referrals; and sponsor activities to further communicate the school's commitment and community's commitment against violence and substance use.

The Sixth Grade Expanded School Behavioral Health Initiative (ESBHI) is a behavioral health intervention funded by BSAS in collaboration with the Baltimore Mental Health Systems, Inc. (BMHS) and the Baltimore City Public School System (BCPS). The Sixth Grade (ESBHI) provides support to sixth grade students who are at high risk for school dropout. The Sixth Grade ESBHI will be implemented in 35 public schools in Baltimore City.

Technical Note: Shown here is data from the Centers for Disease Control and Prevention's 2007 Youth Risk Behavior Surveillance System Survey, which was also highlighted in the original Healthy Baltimore 2015 Report. Iterations of the YRBSS survey since have not had a high enough response rate from Baltimore City to report city-level data. The Baltimore City Health Department is working closely with the CDC and the Maryland Department of Health and Mental Hygiene to increase the sampling from Baltimore City for the 2013 survey so that this data can once again be reported.

8. ENCOURAGE EARLY DETECTION OF CANCER

Photo credit: Bill Branson / National Cancer Institute

Cancer results in a substantial mortality and morbidity burden in Baltimore City. There are ways to detect certain types of cancers (including colon and breast cancer) using relatively non-invasive tests; early detection of both breast and colon cancers has been associated with better outcomes. BCHD supports efforts in screening for both of these types of cancer in Baltimore City residents; increasing the number of people screened are important indicators in this priority area.

PROMOTE EARLY CANCER TREATMENT.

[Goal 8A]: Increase percent of adults 50 and older who have had a colon cancer screening in the last 10 years by 15%

AT-A-GLANCE

- There was no significant change in the total number of residents >50 years of age who had ever had a sigmoidoscopy or colonoscopy between 2008 and 2010.

CLOSING THE GAP

- The percent of individuals 50 and older who had ever had a sigmoidoscopy or colonoscopy increased in those individuals with at least a high school diploma or higher level of education between 2008 and 2010.

TABLE 8.1: PROPORTION OF RESIDENTS (≥50 YEARS) WHO HAVE EVER HAD A SIGMOIDOSCOPY OR COLONOSCOPY BY EDUCATIONAL ATTAINMENT AND BY INCOME, 2008 & 2010

	2008	*2010*	*% Change 2008-10*
Total	**66.2%**	**66.6%**	**0.6%**
EDUCATIONAL ATTAINMENT			
HS Diploma or equivalent	60.6%	63.6%	5.0%
Some college	72.9%	76.7%	5.2%
Bachelor's Degree and above	70.8%	72.5%	2.4%
HOUSEHOLD INCOME			
Under $15,000	52.9%	^	^
$75,000 and over	78.7%	77.2%	-1.9%

Source: Maryland Behavioral Risk Factor Surveillance System, 2008 & 2010
^Answers to this question not available for Maryland in the 2011 survey

[Goal 8B]: Increase percent of women who receive breast cancer screening based on the most recent guidelines by 10%

AT-A-GLANCE

- There was a 13.7% increase in the total number of women greater than or equal to 40 years of age who reported having had a mammogram within the prior 2 years between 2008 and 2010.

CLOSING THE GAP

- Breast cancer screening increased from 2008 and 2010, in particular in women with a Bachelor's Degree or higher.

TABLE 8.2: PROPORTION OF WOMEN ≥40 YEARS OF AGE WHO HAVE HAD A MAMMOGRAM WITHIN THE PRIOR 2 YEARS

	2008	*2010*	*% Change 2008-10*
Total	**71.4%**	**81.2%**	**13.7%**
EDUCATIONAL ATTAINMENT			
HS Diploma or equivalent	71.4%	75.2%	5.3%
Some college	77.6%	85.3%	9.9%
Bachelor's Degree and above	66.0%	88.1%	33.5%
HOUSEHOLD INCOME			
Under $15,000	^	^	^
$75,000 and over	^	93.8%	^

Source: Maryland Behavioral Risk Factor Surveillance System, 2008 & 2010
^Answers to this question not available for Maryland in the 2011 survey

Technical Note: The original Healthy Baltimore 2015 report showed data from the Maryland Cancer Surveys. In order to show trends data through 2010, this report shows data from the Maryland Behavior Risk Factor Surveillance System.

9. PROMOTE HEALTHY CHILDREN AND ADOLESCENTS

Photo credit: BCHD Photo File

The leading indicators within this priority area highlight pivotal stages of development for children in Baltimore City. These include delaying pregnancy until later in life, reducing mortality in babies under 1 year of age, decreasing youth violence, and improving readiness of children to start school. By improving the health of our children and adolescents in these and other ways, we can improve their future quality of life and the future of Baltimore City as a whole.

START HEALTHY, STAY HEALTHY.

[Goal 9A]: Decrease teen birth rate by 20%

AT-A-GLANCE

- Teen birth rates declined from 2009 to 2011, reflecting a national trend.

CLOSING THE GAP

- A 37% reduction in the disparity in birth rates between Black and White 15-19 year olds from 2009 to 2011 has been realized.

TABLE 9.1: TEEN BIRTH RATES (15-19) BY MATERNAL RACE, 2009 AND 2011

Age-Specific Teen Birth Rate (per 1,000 Population)	*2009*	*2011*	*% Change 2009-11*
ALL			
15-19	**64.9**	**49.7**	**-23.5%**
15-17	42.6	32.9	-22.7%
18-19	88.2	65.8	-25.4%
WHITE			
15-19	**30.1**	**28.3**	**-6.0%**
15-17	21.6	21.2	-1.8%
18-19	35.7	32.7	-8.5%
BLACK			
15-19	**82.3**	**61.2**	**-25.7%**
15-17	50.9	38.2	-24.9%
18-19	120.7	86.9	-28.0%

Source: Maryland Vital Statistics Birth Files, 2009 and 2011

HIGHLIGHTING WORK UNDERWAY: B'MORE FOR HEALTHY BABIES TEEN PREGNANCY PREVENTION INITIATIVE

Although the rate of teen births has declined, Baltimore City continues to have one of the highest rates of teen births compared to other cities in the United States. In 2010, the Baltimore City Health Department, in partnership with the Family League of Baltimore, established the Teen Pregnancy Prevention Initiative*. This multi-level initiative aims to reduce teen births in Baltimore City by ensuring that adolescents and young adults have age-appropriate and evidence-based health education, access to appropriate clinical services, and opportunities to engage their communities. The initiative addresses factors through four key strategies:

- **The Teen Pregnancy Prevention Taskforce**, a multiagency coalition committed to implementing strategies to reduce unintended pregnancies
- **Provider Engagement and Outreach**, a strategy to expand access to long-acting reversible contraceptives for adolescents and young adults
- **Youth Advisory Council**, a youth group that provides programmatic steering to the Teen Pregnancy Prevention Initiative messages and participates in leadership, skill-building and outreach activities for youth throughout the city
- **Know What U Want: U Choose**, a social marketing campaign that provides youth with family planning education to empower them to plan for their futures. More information is available at www.knowwhatuwant.org

Through generous funding from the David & Barbara B. Hirschhorn Foundation, the Aaron & Lillie Strans Foundation, the Abell Foundation, the Rosenberg Foundation, and the Blausten Philanthropic Group.

Calculations in this report were done using newly standardized definitions and methods to increase ease of comparison over the years. Therefore, some numbers will differ from what was reported in the original Healthy Baltimore 2015 report.

[Goal 9B]: Decrease rate of infant mortality by 10%

TABLE 9.2: INFANT MORTALITY RATES BY RACE, BALTIMORE CITY 2009 AND 2012			
	2009	*2012*	*% Change 2009-11*
All Races	**13.5**	**9.7**	**-28.1%**
White	3.5	3.4	-2.9%
Black	18.6	12.6	-32.3%

Source: Data from the Vital Statistics Administration

HIGHLIGHTING WORK UNDERWAY: B'MORE FOR HEALTHY BABIES

Baltimore babies die at unacceptably high rates. There is also an extremely high rate of babies born pre-term and underweight – key factors contributing to infant mortality. In response to this public health crisis, in 2009, through support from CareFirst, leaders from the corporate, nonprofit, and government sectors came together to launch an innovative initiative to prevent infant deaths and promote family health. Known as B'more for Healthy Babies (BHB), the initiative is built on the realization that reducing infant deaths will only happen when everyone in the community is involved: leaders of key city agencies; physicians, nurses and social workers; community groups and teachers; and family members and pregnant women themselves.

B'more for Healthy Babies focuses on Baltimore's high rate of fetal mortality and poor maternal health. BHB is conducting a perinatal periods of risk analysis (PPOR), in which high fetal and infant mortality rates are identified at different perinatal development stages, to determine where the largest disparities exist. PPOR will allow BHB to prioritize actions based on evidence based methods and will inform BCHD's strategic direction. BHB has several initiatives running concurrently and in partnership with one another to address the diverse needs of new moms and moms-to-be:

- Safe Sleep
- Home Visiting
- Baby Basics
- B'more Fit
- Family Planning
- Teen Pregnancy Prevention
- Smoking
- Literacy
- Substance Exposed Pregnancies
- Housing
- Prenatal Care
- Fetal Infant Mortality Review

AT-A-GLANCE

- The infant mortality rate declined by 28% among all races from 2009 to 2012, with a more dramatic 32.3% decline among Black infants.

CLOSING THE GAP

- Between 2009 and 2012, there was a 39% reduction in the disparity in infant mortality between Black and White babies.

SUCCESS!

Baltimore saw the lowest number of deaths due to infant unsafe sleep in almost a decade (see chart at left). In 2012, we launched a new safe sleep campaign featuring Baltimore Ravens wide receiver Laquan Williams. The campaign was viewed 891,693 times on our facebook page. Of those who viewed the advertisements, 753 users visited B'more for Healthy Babies' page and 373 took action (by liking the page or engaging with a post).

More information is available at www.healthybabiesbaltimore.com. Baltimore residents can also sign up for text message reminders and information at the website above.

[Goal 9C]: Decrease rate of juvenile homicide and non-fatal shooting victims by 30%

AT-A-GLANCE

- Homicides and non-fatal shootings declined from 2009 to 2012 among juveniles. In 2012, the rate of non-fatal shooting victims among juveniles was less than half of what it was in 2009.

TABLE 9.3: RATES OF JUVENILE (0-17) HOMICIDE AND NON-FATAL SHOOTING VICTIMS

Rates per 100,000	*2009*	*2012*	*% Change 2009-12*
Homicide	11.2	8.2	-26.8%
Non-fatal shootings	39.2	12.7	-67.6%

Source: City Police Department; U.S. Census Bureau 2009 and 2012 population estimates

PARTNERSHIP FOR PROGRESS

Baltimore's first Mayor's Summit on Violence Reduction was held in April 2013. Mayor Rawlings-Blake convened her Deputy Chief for Public Safety, Health Commissioner, Police Commissioner, and Public Schools CEO, a selection of partners, elected officials, advocates and other stakeholders to gather input on ongoing and innovative approaches to address youth violence in Baltimore City.

HIGHLIGHTING WORK UNDERWAY: THE OFFICE OF YOUTH VIOLENCE PREVENTION

The Office of Youth Violence Prevention is dedicated to combating the epidemic of violence among our city's young people through innovative public health programming and policy initiatives. The office houses two programs exclusively within BCHD: Operation Safe Kids and Safe Streets.

Operation Safe Kids (OSK) provides intensive community-based case management and monitoring to high-risk youth with the goal of preventing them from becoming victims or perpetrators of violent crime. The Baltimore City Health Department team works closely with Department of Juvenile Services (DJS) case managers and other state and city agencies to reduce youth violence in the city by ensuring these young people have the tools they need to become productive adults. In addition to case management activities, OSK provides employment counseling, education coordination, parent support groups, extracurricular activities, transition services for re-entry youth, and the Operation Safe Kids Court.

The Operation Safe Kids Court (OSK Court) program, a problem-solving court model, targets juvenile justice system youth who are under DJS supervision and at-risk of out-of-home placement. OSK Court's intensive community-based program provides accountability and immediate response to the highest risk youth who continue to exhibit delinquent behavior within DJS's Violence Prevention Initiative. This is achieved through intensive monitoring, case management and regular court review hearings on a separate docket within the Baltimore City Juvenile Court.

Safe Streets is a community mobilization and outreach program designed to combat shootings and homicides. This intervention targets high-risk youth aged 14 to 25 through outreach and service connection, and the community as a whole through a media campaign and community mobilization.

The intervention, modeled after a program called Ceasefire Chicago, is based on five core components:

- Community coalition building
- Street outreach to at risk youth
- Public education
- Clergy involvement
- Law enforcement collaboration

SUCCESS!

The Safe Streets program in the Cherry Hill neighborhood was associated with:

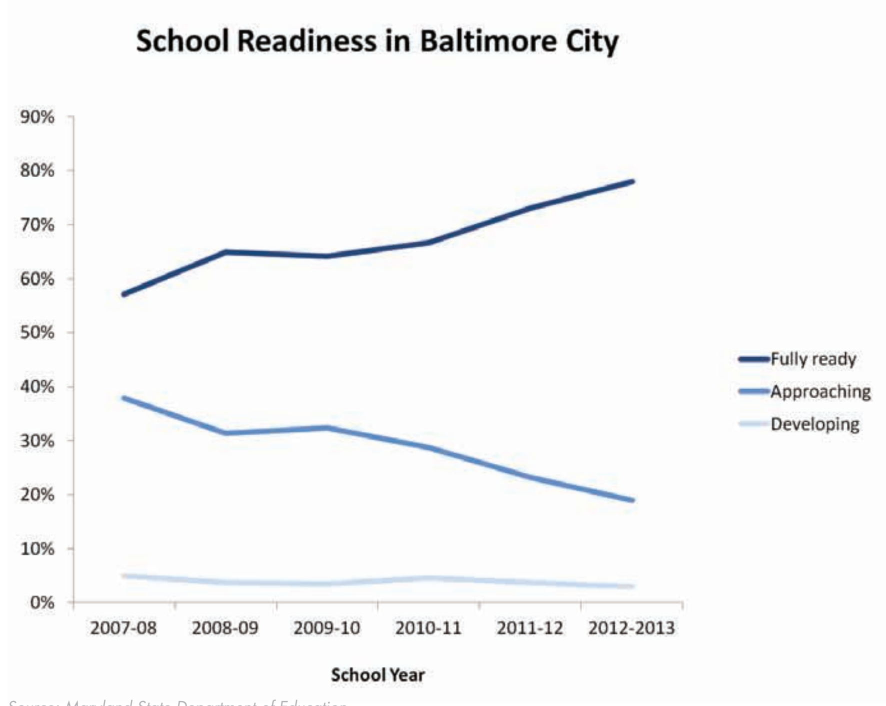
- 56% reduction in homicide incidence
- 34% reduction in non-fatal shooting incidence

Source: Webster et al., Journal of Urban Health, 2012

[Goal 9D]: Increase percent of school readiness by 15%

TABLE 9.4: SCHOOL READINESS			
	2010-11 SY	*2012-13 SY*	*% Change**
% of kindergartners "fully ready" to learn	67%	78%	16.4%

Source: Maryland State Department of Education
Maryland Model for School Readiness - Annual School Readiness Report, 2011, 2013



Source: Maryland State Department of Education
Maryland Model for School Readiness - Annual School Readiness Report, 2008-2012

According to the Maryland State Department of Education, the time from birth to age 5 offers children their greatest opportunity for learning. Since most brain development happens during this period, and the brain depends on the experiences a child receives these years of stimulation are the most important in a child's life.

Educational attainment is one of the strongest social determents of health; therefore policies that improve educational outcomes have the potential to substantially improve health.

Children's school readiness – their ability to successfully perform kindergarten work – hinges on their birth-to-five learning experiences. Maryland was first in the nation to create a tool for assessing children's school readiness: the Maryland Model for School Readiness, or MMSR, developed by the Maryland State Department of Education. The MMSR evaluates what each kindergartener knows and is able to do in the seven Domains of Learning: Social & Personal Development, Language & Literacy, Mathematical Thinking, Scientific Thinking, Social Studies, the Arts, and Physical Development.

AT-A-GLANCE

- Kindergartners' school readiness increased by nearly 16% between the 2010-11 and 2012-13 school years.
- Since 2007-08, school readiness among kindergartners has increased by 37%.

10. CREATE HEALTH PROMOTING NEIGHBORHOODS

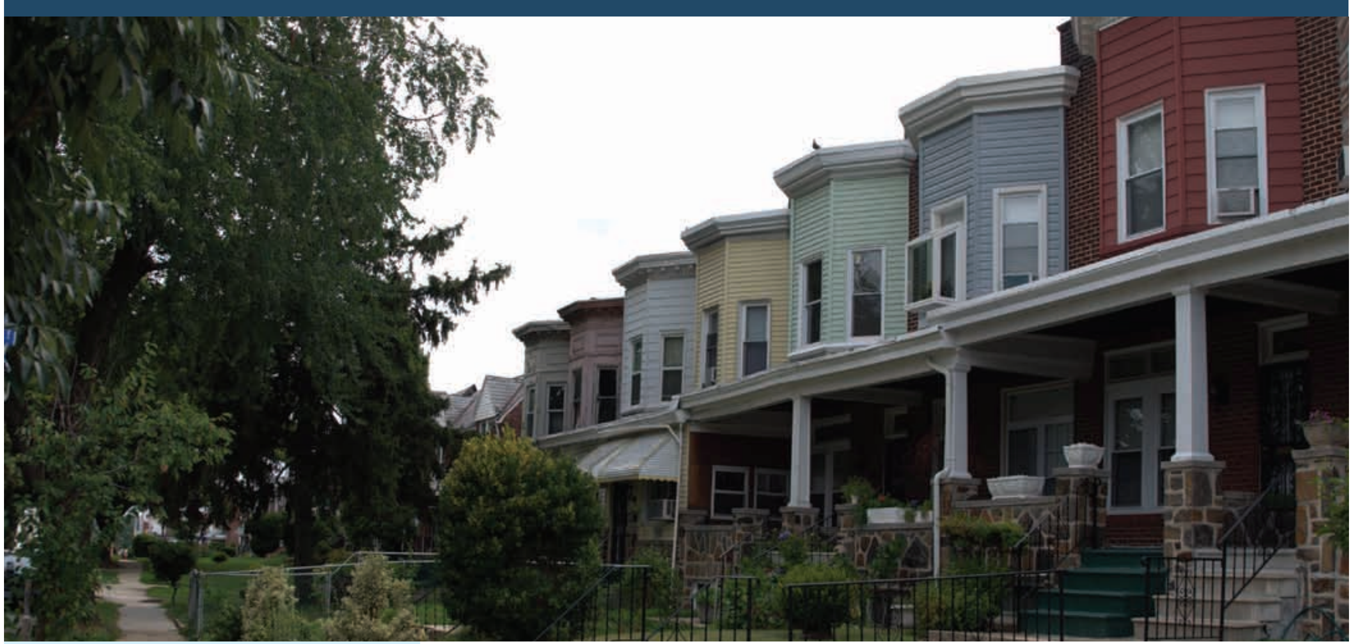


Photo credit: Edmondson Avenue - Credit: Baltimore Heritage, July 2010.

PROMOTE THE BUILT ENVIRON-MENT.

Healthy neighborhoods are created when we are deliberate in the ways in which we create public policy to right injustices. Where we live, and by extension what is present in our physical surroundings, is a critical factor in determining our health. Indeed, life expectancy can be predetermined by where one lives at birth. The leading indicators in this priority area explore how neighborhood level factors such as vacant building density and liquor outlet density influence community health.

[Goal 10A]: Decrease density of vacant buildings by 20%

TABLE 10.1: VACANT BUILDING DENSITY			
	2009	*2013*	*% Change*
# of Vacant Buildings per 10,000 Households	716.5	658.4	-8.1%

Sources: Mayor's Office of Information Technology; U.S. Census Bureau (2009, 2012 estimates). # of vacant buildings accessed September 24, 2013.

AT-A-GLANCE

- Vacant building density declined from 2009 to 2013 by 8.1%.

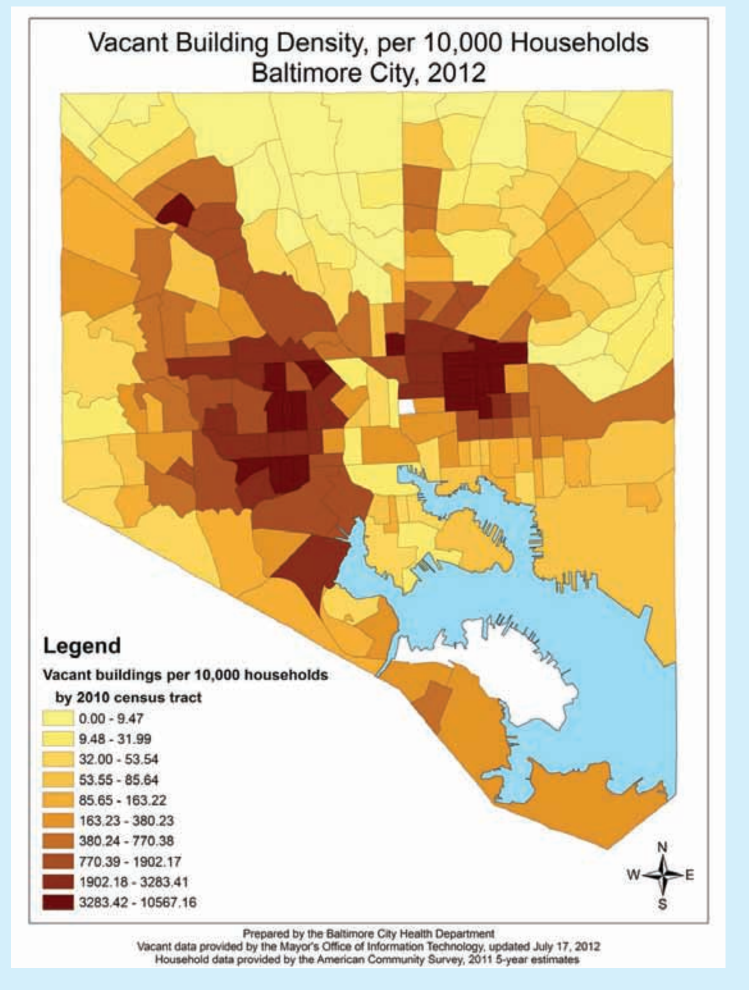
HIGHLIGHTING WORK UNDERWAY: VACANTS TO VALUES

The "Vacants to Value Program" is a City initiative, led by the Baltimore City Housing Department, to encourage the demolition or renovation and sale of vacant properties by:

1. Streamlining the disposition of city-owned properties
2. Streamlining code enforcement in stronger markets
3. Facilitating investment in emerging markets
4. Targeting home buying incentives
5. Supporting large-scale redevelopment in distressed areas
6. Demolishing and maintaining severely distressed blocks

On January 1, 2013, Baltimore launched a Clinton Global Initiative America commitment to address 3,000 vacant residential buildings in the city over 3 years, using the strategies that comprise the Vacants to Value program.

More information is available from: www.baltimorehousing.org/vacants_to_value.aspx



[Goal 10B]: Decrease liquor outlets density by 15%

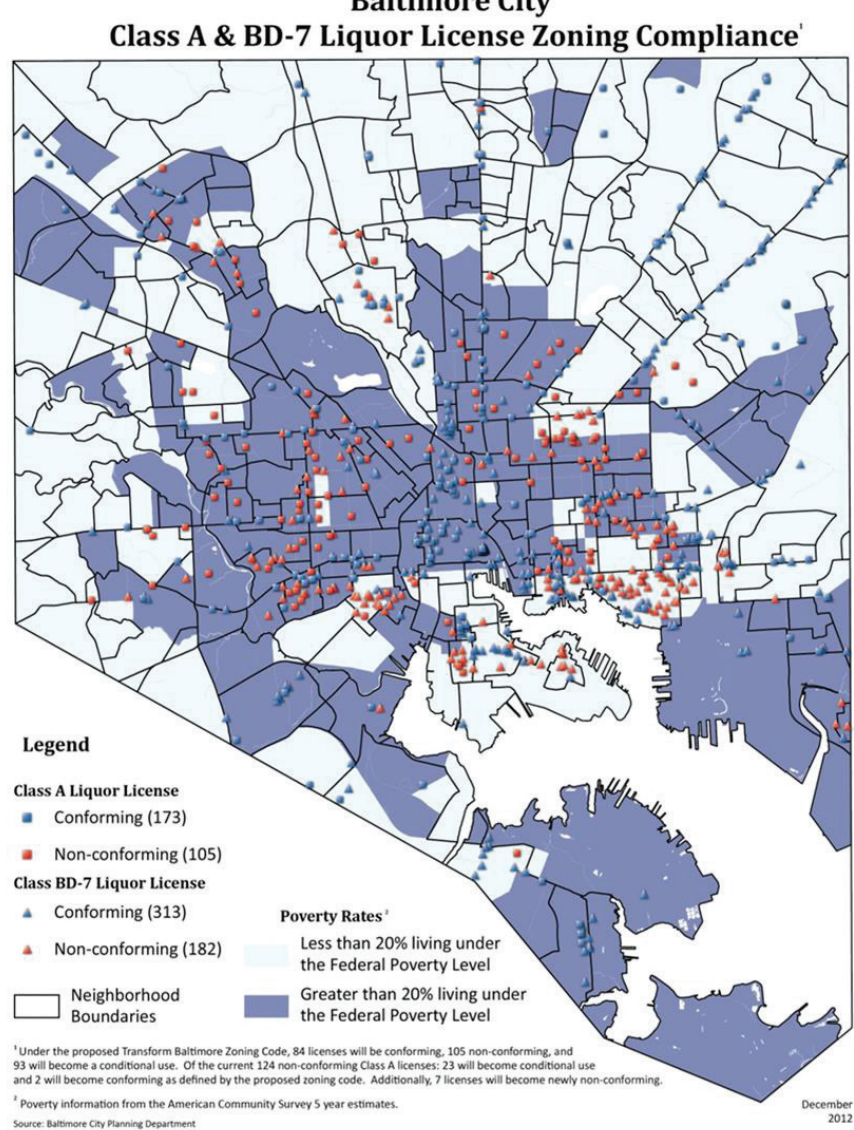
"Alcohol outlet density" refers to the number of businesses that sell alcohol in a geographical area, such as a neighborhood. Across the United States, higher alcohol outlet density has consistently been found to be associated with higher rates of violent crime, such as homicide, aggravated assault, rape, and robbery. In addition to violence, higher alcohol outlet density is associated with a variety of health risks. In Baltimore, liquor stores are over-concentrated in African-American neighborhoods and low income communities — neighborhoods generally associated with poorer health outcomes overall, including shorter life expectancies.

AT-A-GLANCE

- In Baltimore City, the areas with the highest poverty levels (neighborhoods in which greater than 20% of residents are living below the Federal Poverty Level) are the areas with the highest density of liquor outlets.

TABLE 10.2: ALCOHOL OUTLET DENSITY PER 10,000 RESIDENTS	
	2009
Class A, A2, and BD-7 (off -premise consumption and taverns)	12.5

Sources: Mayor's Office of Information Technology; Baltimore City Liquor License Board; U.S. Census Bureau (2009 population estimates).



Technical Note: Shown here is data from the Baltimore City Liquor Board, reflecting the density of liquor outlets per 10,000 residents in 2009. BCHD is now working with the liquor board to analyze updated liquor license data by type; future versions of Healthy Baltimore 2015 Update Reports will include this updated data.

Photo credit: Karl Merton Ferron / courtesy Baltimore Sun

HIGHLIGHTING WORK UNDERWAY:
POLICY STRATEGIES TRANSFORM BALTIMORE

Better Health through Zoning

Zoning influences a city's character, by directing the location of industrial, commercial, and residential areas, the size of buildings, and the design of the built environment. Zoning's purpose is to protect public 'health, safety and welfare', which in the past simply meant separating healthy and unhealthy uses. Today, this encompasses much more – from public safety to mental health to food access. Transform Baltimore, the new proposed zoning code introduced to the Baltimore City Council in April 2013, has the potential to positively impact the lives of city residents through many different applications.

One such application is a three-pronged approach to reducing alcohol outlet density. This evidence-based approach is supported by the U.S. Task Force on Community Preventive Services. The three components are:

- Amortizing approximately 100 non-conforming off-premises alchohol outlets (class A licenses)
- Clarifying definitions for taverns (class BD 7 licenses) to enable greater enforcement
- Creating a 300-foot limitation between new liquor stores and existing stores

As of production of this report, the proposal had been passed by the City Planning Commission and introduced to the City Council, with public hearings and a vote scheduled for Fall 2013.

Coalition Building for Health

Transform Baltimore, and the alcohol outlet density reduction specifically, have been widely supported by community stakeholders and institutions. Coalition-building for health, a key component of *Healthy Baltimore 2015* and the neighborhood health initiative has fostered powerful partnerships between faith community leaders, positive youth development organizations, anchor institutions, and community-based organizations.

HEALTHY BALTIMORE 2015, INTERIM STATUS REPORT:

TECHNICAL NOTES

DEMOGRAPHICS AND STRATIFICATION:

Denominators were obtained from the United States Census Bureau. 1-Year American Community Survey estimates were used for 2009 and 2012 data. The American Community Survey (ACS), administered to a representative sample by the US Census Bureau, replaced the long form of the decennial census. Annual data is updated through monthly samples across the United States. Five years of samples are required for small-area data (e.g. census tracts); one year and three year estimates are available for larger areas (e.g. county-level). The 2010 Census was the short form and for this report provided the information for the neighborhood population, age, gender, race and ethnicity, family poverty rate, and single-parent household.

Proportions for age-adjustment were based on 10-year age groups and the 2000 projected breakdowns of US population distributions (from: Klein RJ, Schoenborn CA. Age-adjustment using the 2000 projected US population. Healthy People Statistical Notes, no. 20, Hyattsville, Maryland: National Center for Health Statistics. January 2001).

MORTALITY DATA

Mortality data was obtained from the Maryland Department of Health and Mental Hygiene's Vital Statistics Administration. The VSA compiles information from death certificates across Maryland. Data specific to residents of Baltimore City was utilized in this report. Cause-specific mortality was identified by the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) code. Codes representing each condition were selected from reports published by the Centers for Disease Control and Prevention's National Center for Health Statistics.

Age-adjusted mortality represents the number of deaths per 10,000 people per year assuming that each neighborhood had the same age structure (number of people in each age group). Age adjustment is done so that a neighborhood with a proportionally large number of elderly people (who are more likely to die because of their age) does not show a higher mortality rate simply because of the older age of its residents.

HOSPITALIZATION AND EMERGENCY DEPARTMENT DATA

Information on hospital admissions and emergency department visits was obtained from the Maryland Health Services Cost Review Commission. The HSCRC aggregates data from all Maryland hospitals; information from those hospitals located within Baltimore City were used in this report. Cause specific hospitalization and ED visits for Baltimore City residents were identified by International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM) code. Codes representing each condition were selected from reports published by the Centers for Disease Control and Prevention's National Center for Health Statistics.

JUVENILE HOMICIDES AND NON-FATAL SHOOTINGS

Data for juvenile homicides and non-fatal shooting victims are from the Baltimore City Police Department.

TECHINICAL NOTES (CONTINUED):

BEHAVIORAL RISK FACTORS

Information on behaviors and behavioral risk factors was obtained from the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System. Data was accessed via the online access system (www.marylandbrfss.org). Information was queried at the level of Baltimore City, although for some questions the response rate within the Baltimore City population was not high enough for BRFSS to report results. Of note, significant changes were made in the analytic methods for BRFSS surveys in 2010 and beyond. Therefore, BRFSS data prior to 2010 cannot be compared directly with subsequent surveys.

The Centers for Disease Control and Prevention also administers a Youth Risk Factor Behavioral Surveillance System Survey, reflecting a representative sample of students in grades 9-12 in specified jurisdictions. 2007 was the most recent year in which Baltimore City had a sufficient response rate to allow for analysis and reporting at the city level.

ALCOHOL & DRUG ABUSE TREATMENT

Drug and alcohol abuse treatment information was obtained from the Baltimore Substance Abuse Systems (BSAS)'s Outlook and Outcomes 2011 Report (http://www.bsasinc.org/site/wp-content/uploads/2012/06/BSAS-Outlook-and-Outcomes-FY2011-11-19-2012-revision.pdf).

BIRTH OUTCOMES

The birth rate is defined as the number of live births per 1,000 persons. The teen birth rate is the number of live births to females per 1,000 females in the population in the same age range. Smoking during pregnancy was as reported on the birth certificate, compiled by the Vital Statistics Administration; of note, changes were made to this question on the Maryland Birth Certificate starting in 2010 which resulted in an increased likelihood that smokers accurately reported their smoking status. The infant mortality rate is calculated as the number of infant deaths (babies less than 1 year of age) per 1,000 live births in a given time period.

EDUCATION

Kindergarten readiness data are from Baltimore City Public Schools for school years 2007-2008 through 2012-2013. School readiness was computed based on the Maryland Model for School Readiness Working Sampling System (WSS). Each year, teachers use seven domains of learning to assess students' readiness. The seven domains include: language and literacy, physical development, social studies, scientific thinking, mathematical thinking, the Arts, and social/personal development. School absenteeism and reading level data are from the Baltimore City School System. Adult educational attainment data are from the American Community Survey. Maryland School Assessments are scored using a tiered system: 1) "Proficient" is a realistic and rigorous level of achievement indicating proficiency in meeting the needs of students, 2) "Advanced" is a highly challenging and exemplary level of achievement indicating outstanding accomplishment in meeting the needs of students.

MENTAL HEALTH

The Network of Care for Behavioral Health, provided by Baltimore Mental Health Systems, is a resource for individuals, families and agencies concerned with behavioral health. The directory of clinics providing outpatient mental health services for the non-insured was accessed from http://baltimorecity.md.networkofcare.org/mh/services/subcategory.aspx?tax=RM-6500&cid=21531.

The directory of schools offering expanded school mental health services (ESMH) comes from the Expanded School Mental Health Services: Provider Agency and School Assignment Directory, SY 2012-2013, compiled by Baltimore Mental Health Systems, Inc.

1001 E. Fayette Street
Baltimore, MD 21202
(410) 396-4398
http://www.baltimorehealth.org

Visit us on Facebook: http://www.facebook.com/BaltimoreHealth
Follow us on Twitter: http://twitter.com/BMore_Healthy