

HEALTHY BALTIMORE 2015

INTERIM STATUS REPORT

May 2016



Stephanie Rawlings-Blake, Mayor
Leana Wen, M.D., M.Sc., 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, Health Services Cost Review Commission, Center for HIV Surveillance, Virtual Data Unit, Epidemiology and Evaluation), Baltimore City Mayor's Office of Information Technology, Baltimore City Liquor Board, the Maryland State Department of Education and the Johns Hopkins Bloomberg School of Public Health (Office of Public Health Practice and Training, Department of Epidemiology, Center for a Livable Future). Thank you also Jack Out of the Box Designs for the graphic design of this report.

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Suggested citation:

Baltimore City Health Department. Healthy Baltimore 2015 Interim Status Report, May 2016.

This report can be accessed electronically at <http://health.baltimorecity.gov/>.

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LETTER FROM THE MAYOR

Dear fellow Baltimore City resident:

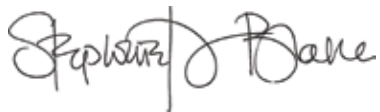
Since the initial Healthy Baltimore 2015 report was published in May 2011, my administration – along with support from numerous city and state agencies – has maintained a commitment to improving the health and quality of life within our communities. The well-being and positive growth of our city is dependent on the mental and physical welfare of our residents. The Healthy Baltimore 2015 report offered a plan on how we as a city would achieve long, healthy, productive lives for all citizens. Since the report’s publication, I have redoubled efforts to foster greater collaboration among our agencies to promote health through programming and policy.

This Interim Report will serve as a touchstone for our current efforts, and a baseline for our future efforts, as we recommit ourselves to the challenges we continue to face.

The continued collaboration among city agencies and neighborhoods, educational institutions and charitable organizations, the health industry and our business community will be key to our goal of transforming Baltimore City into a national model for community health. We aim to be a city that is celebrated for superior medical care and health-informed policymaking that promotes community awareness and citizens’ participation in protecting their own health.

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 of Baltimore

LETTER FROM THE HEALTH COMMISSIONER

Dear Baltimore City resident:

As the Commissioner of the nation's oldest health department, one that has been at the forefront of innovation in public health since 1793, I am pleased to share this Healthy Baltimore 2015 Report. Though we have made much progress toward the goals set out in 2011 in the initial Healthy Baltimore 2015 report, much work remains to be done. The results in this report will help guide our work as we move towards a healthier Baltimore.

Since Healthy Baltimore 2015 was initially published, we have seen improvements in a number of areas: access to health insurance coverage, levels of smoking in adults, rates of sexually transmitted diseases in adolescents, levels of poor mental health in adults, teen births, infant mortality, school readiness, and liquor store density. New HIV diagnoses have fallen by half, thanks in large part to the efforts of the Health Department's dedicated outreach and intervention teams.

Although the challenges we face are rooted in decades of poverty, violence, and substance abuse; we are lucky to have committed partners across the city to help us address these challenges. Devoted civic and faith leaders, engaged community organizations, a strong philanthropic community, and nearly 1,000 employees in our health department are committed to working together to serve our residents. We understand that every single issue is tied to health, be it economics, unemployment, school readiness, housing, homelessness, drugs, or mental health. Because the leaders in our city understand this, we can ensure wellness and health in the policies that impact where we live, learn, work, and play.

This report will serve as a tool to continue the conversation regarding the health and well-being of our community, the impact of the social determinants of health, and health equity. I am honored to work with Mayor Stephanie Rawlings-Blake and the citizens of Baltimore to show how public health can be a powerful social justice tool that ties into all policies.

Building on this foundation, we now look ahead to Healthy Baltimore 2020, our strategic blueprint for health across the city. With your help, we can continue our work to reduce health disparities and improve the health and well-being of all Baltimore residents.

Sincerely,



Leana Wen,
M.D., M.Sc.
*Baltimore City Health
Commissioner*

IMPORTANT NOTE REGARDING DATA ON RACE AND HOSPITAL VISITS IN THIS REPORT

Hospital admissions and emergency department (ED) visit data are not reported by race in this report for the years 2013 and 2014. This is because the agency that collects these data (Maryland Health Services Cost Review Commission (HSCRC)) changed the way race data were collected from hospitals starting in Fiscal Year (FY) 2013. Prior to FY2013, the HSCRC collected race data from hospitals by using one variable. After FY2013, the HSCRC collected race data from hospitals by using eight variables. Not all hospitals in Baltimore City properly implemented the change in the method to collect race data, and, as a result, race data from calendar years 2013 and 2014 are not valid or reliable. Because of the inaccuracies in the 2013 and 2014 data, hospital admissions and ED visit data are not reported stratified by race for these two years in this report. For more information on hospital admissions and ED visit data, please see the technical notes section of this report.

1. PROMOTE ACCESS TO QUALITY HEALTH CARE FOR ALL



Source: Pixabay

IMPROVE HEALTH FOR ALL.

Improving the health of all Baltimore City residents requires access to high quality and affordable health care for all. Key indicators of access to quality health care include the rates of diabetes, hypertension and asthma as well as the rate of insured individuals who have their medical needs met.

- Diabetes and hypertension contribute to heart disease, the leading cause of death in Baltimore City.
- Asthma is one of the health conditions that accounts for the greatest loss of productivity – through missed work or school absenteeism.
- Management of diabetes, hypertension and asthma ideally takes place in outpatient (ambulatory) settings. When these are managed in hospitals and emergency departments, the cost of care significantly increases, for both 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							
Age-adjusted Rate per 100,000 population	2009	2010*	2011	2012	2013	2014	% Change
DIABETES TYPE I							
All Races	98.5	96.9	97.9	91.7	100.0	101.7	5.0%
White	49.7	65.2	53.5	55.3	+	+	+
Black	129.9	119	101.6	116	+	+	+
DIABETES TYPE II							
All Races	270.5	274.7	196	232.3	210.0	215.2	-21.7%
White	106.6	156.8	95.8	117.1	+	+	+
Black	371.1	351.2	228.7	303.6	+	+	+
HYPERTENSION							
All Races	274.8	254.3	119.7	217.5	193.6	182.4	-28.3%
White	58.4	68.5	20.5	58	+	+	+
Black	403.9	362.7	157.3	308.1	+	+	+

Source: BCHD analysis of HSCRC hospital discharge data; primary diagnosis only. + Indicates that HSCRC data on race in 2013-2014 were not reported - see important note on page 4, *indicates year of comparison for percent change calculation (i.e., 2010 vs. 2014).

TABLE 1.2: RATES OF HOSPITALIZATION DISCHARGE FOR ASTHMA BY RACE AND AGE							
Age-specific Rate per 100,000 population	2009	2010*	2011	2012	2013	2014	% Change
ALL RACES							
Total	426.3	405.8	397.0	380.8	353.0	311.7	-23.2%
Less than 5 years	671.7	780.0	680.4	665.5	688.9	655.1	-16.0%
5-17 years	356.6	378.8	339.8	428.6	384.4	392.6	3.6%
18-44 years	248.6	221.5	200.2	190.7	171.3	146.4	-33.9%
45-64 years	674.7	625.5	669.6	585.0	533.1	453.8	-27.4%
65 years+	477.2	410.6	427.1	386.9	370.0	297.2	-27.6%
WHITE							
Total	184.6	156.7	186.6	148.1	+	+	+
Less than 5 years	312.1	318.1	238.6	214.6	+	+	+
5-17 years	120.1	158.6	99.1	120.8	+	+	+
18-44 years	89.3	61.7	66.2	60.4	+	+	+
45-64 years	310.2	249.5	372.0	263.8	+	+	+
65 years+	289.2	255.3	296.6	239.2	+	+	+
BLACK							
Total	575.3	551.8	526.6	517.5	+	+	+
Less than 5 years	854.7	951.5	849.0	855.9	+	+	+
5-17 years	459.2	446.5	408.7	522.9	+	+	+
18-44 years	367.8	350.4	310.2	291.9	+	+	+
45-64 years	883.7	815.8	825.4	751.3	+	+	+
65 years+	594.9	510.5	521.8	517.5	+	+	+

Source: BCHD analysis of HSCRC hospital discharge data; primary diagnosis only. + Indicates that HSCRC data on race in 2013-2014 were not reported - see important note on page 4, *indicates year of comparison for percent change calculation (i.e., 2010 vs. 2014).

AT-A-GLANCE

- The rates of hospitalization for Diabetes Type II and hypertension have decreased by more than 20% between 2010 and 2014.
- There was a slight increase (5%) in the rate of hospitalization for Diabetes Type I between 2010 and 2014.
- Overall, rates of asthma hospitalization have decreased by 23.2% between 2010 and 2014. There have been steady decreases in asthma hospitalizations for all age groups except 5-17 year olds who had a 3.6% increase in asthma hospitalizations.

HIGHLIGHTING WORK UNDERWAY: COMMUNITY ASTHMA PROGRAM



Source: Pixabay

The Community Asthma Program (CAP) enrolls Baltimore City children ages 1 to 18 who have trouble managing their asthma. Home visits from trained community health workers help families improve asthma control by reviewing medications prescribed by the doctor, showing proper medication technique, helping obtain an asthma action plan from the family doctor, showing families where asthma triggers are in their homes, giving supplies to reduce asthma triggers in the home, and connecting families to other services that might help.

SUCCESS!

Carlos and Juan (names changed to protect privacy), ages 7 and 3 respectively, were both diagnosed with asthma and were referred to CAP by the Esperanza Center. Neither parent was fluent in English and they were struggling with managing Carlos' asthma. In the 6 months prior to our first visit, Carlos' asthma symptoms had necessitated both an emergency room visit and in-patient hospitalization; Juan had been to the emergency room twice.

At the time of our first visit, Carlos was waking up nightly with asthma symptoms. During the environmental assessment of the home by our bilingual Community Health Worker (CHW), she discovered that the family's furnace had not been working over the winter, and the air conditioner was also non-functional. In addition, the family was living with a significant mouse infestation. All of these issues had the potential to negatively impact both boys' asthma. Initially, the family was hesitant to request a housing inspection, since they did not feel confident speaking or understanding English, and believed that their landlord would penalize them.

With the support of the CHW, the family made the 311 call, and the CHW agreed to attend the inspection to facilitate communication. As a result, the landlord has been mandated to complete work in the house including fixing the HVAC system and remediating any structural issues related to the mouse infestation. The CHW is also working with the family on the implementation of integrated pest management strategies.

While the CHW is still working with the family, Carlos' symptoms have decreased significantly and neither child has been back to the emergency room. The parents have also gained knowledge about the potential asthma triggers in their home and how to manage them.

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

AT-A-GLANCE

- For Diabetes (both Type I and Type II) and hypertension, emergency department visits have steadily increased over time. Since 2010, emergency department visits for Diabetes Type I have more than doubled.
- Emergency department visits for asthma have increased by 20.6% between 2010 and 2014. This rate is highest among 65+ year olds, with an increase of 72.2%. Children less than 5 years old were the only age group with a decrease in their asthma emergency department visits (reduction of 4%).
- Over the past 10 years, and even more so after the passing of the Affordable Care Act (“Obamacare”), there has been a national trend of increasing emergency department visits for chronic conditions. Emergency department visits have also been increasing over time across the state of Maryland.

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

Age-adjusted Rate per 100,000 population	2009	2010*	2011	2012	2013	2014	% Change
DIABETES TYPE I							
All Races	18.3	20	29.8	36.3	36.2	43.1	115.5%
White	9.7	9.9	17.6	21.5	+	+	+
Black	24	24.2	38.2	45.3	+	+	+
DIABETES TYPE II							
All Races	221	279.2	307.5	359.1	360.5	394.1	41.2%
White	89.1	125.9	114.1	150.5	+	+	+
Black	303.3	369.7	353.9	482.9	+	+	+
HYPERTENSION							
All Races	261.7	344.5	441.3	439.1	467.8	518.2	50.4%
White	55	86.7	102.6	117.1	+	+	+
Black	385.6	490.4	548.9	621.9	+	+	+

Source: BCHD analysis of HSCRC emergency department discharge data; primary diagnosis only. + Indicates that HSCRC data on race in 2013-2014 were not reported - see important note on page 4, * indicates year of comparison for percent change calculation (i.e., 2010 vs. 2014).

TABLE 1.4: RATES OF EMERGENCY DEPARTMENT DISCHARGE FOR ASTHMA BY RACE AND AGE

Age-specific Rate per 100,000 population	2009	2010*	2011	2012	2013	2014	% Change
ALL RACES							
Total	1,281.9	1,455.0	1,705.9	1,837.2	1,672.5	1,755.2	20.6%
Less than 5 years	3,257.0	4,259.8	4,920.8	4,651.7	3,769.7	4,089.1	-4.0%
5-17 years	2,199.4	2,483.6	2,922.9	3,096.6	2,837.5	3,050.7	22.8%
18-44 years	1,145.5	1,244.6	1,479.6	1,700.8	1,548.9	1,582.3	27.1%
45-64 years	869.6	1,034.2	1,176.8	1,286.8	1,308.3	1,350.6	30.6%
65 years+	221.5	214.3	282.9	312.5	311.2	368.9	72.2%
WHITE							
Total	303.3	369.4	460.2	499.1	+	+	+
Less than 5 years	788.4	1,533.6	1,442.7	1,250.3	+	+	+
5-17 years	443.1	660.9	786.5	773.0	+	+	+
18-44 years	292.2	364.3	454.5	492.4	+	+	+
45-64 years	273.7	240.7	393.9	460.0	+	+	+
65 years+	48.8	56.3	82.6	115.9	+	+	+
BLACK							
Total	1,867.8	2,068.6	2,394.3	2,593.4	+	+	+
Less than 5 years	4,651.6	5,489.9	6,360.1	6,200.0	+	+	+
5-17 years	2,933.0	3,011.9	3,494.8	3,803.6	+	+	+
18-44 years	1,773.2	1,945.7	2,294.1	2,645.1	+	+	+
45-64 years	1,198.9	1,417.9	1,556.3	1,685.0	+	+	+
65 years+	331.9	309.4	402.1	437.1	+	+	+

Source: BCHD analysis of HSCRC ED discharge data; primary and secondary diagnoses only. + Indicates that HSCRC data on race in 2013-2014 were not reported - see important note on page 4, *Indicates year of comparison for percent change calculation (i.e., 2010 vs. 2014).

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

Ensuring that individuals have their medical needs met is one of the focuses for redesigning the health care delivery system. One aspect of improving access to health care is increasing health insurance coverage.

AT-A-GLANCE

- There have been notable improvements in health insurance coverage between 2009 and 2014. There was more than a 40% overall decrease in the number of residents without health insurance between 2009 and 2014.
- Implementation of the Affordable Care Act (“Obamacare”) led to this dramatic improvement in health insurance coverage among Baltimore City residents.

TABLE 1.5: PERCENT OF BALTIMORE RESIDENTS THAT DO NOT HAVE HEALTH INSURANCE BY DEMOGRAPHICS							
	2009*	2010	2011	2012	2013	2014	% Change
Total	15.2%	14.5%	13.5%	12.3%	10.7%	8.5%	-44.1%
AGE GROUP							
Under 18 years	7.8%	5.3%	5.1%	5.4%	4.0%	3.8%	-51.3%
18 to 64 years	20.3%	19.9%	18.4%	16.6%	14.6%	11.4%	-43.8%
65 years and older	0.7%	0.3%	0.8%	1.1%	0.9%	0.8%	14.3%
SEX							
Male	18.9%	18.0%	16.7%	15.5%	12.5%	10.0%	-47.1%
Female	12.0%	11.4%	10.7%	9.6%	9.1%	7.1%	-40.8%
RACE							
White Alone	13.7%	12.7%	11.6%	10.1%	10.1%	7.5%	-45.3%
Black/African-American Alone	15.5%	14.4%	13.7%	12.6%	10.5%	8.5%	-45.2%
ETHNICITY							
Hispanic or Latino (of any race)	37.4%	45.3%	35.9%	36.1%	25.5%	26.4%	-29.4%
HOUSEHOLD INCOME							
Under \$25,000	17.5%	14.0%	15.6%	14.6%	11.5%	7.8%	-55.4%
\$100,000 and over	7.1%	9.6%	7.9%	8.6%	7.3%	3.4%	-52.1%

Sources: U.S. Census Bureau American Community Survey (S2701: Health Insurance Coverage Status, 2009, 2010, 2011, 2012, 2013, 2014 1-year estimates). * Indicates year of comparison for percent change calculation (i.e., 2009 vs. 2014).



Source: Pixabay

HIGHLIGHTING WORK UNDERWAY: LEAD SOLUTIONS

Responding to situations where children are exposed to lead can sometimes be challenging and require collaboration between many different people; however, sometimes the solution is simple! One such case involved a property that tested positive for lead using a tool to detect for lead paint. The front porch railing tested positive for lead, and the family noted that this was where their child liked to climb and play.

In discussing the dangers of this railing with lead paint hazards with the property owner, he was able to under-

stand the importance of eliminating the exposure. By simply removing the whole component - the entire railing, the lead hazards to the child would be eliminated from this source. While the owner was preparing to hire a lead abatement contractor and temporarily relocate the family, interim controls were put in place. An interim control temporarily places a barrier between the lead hazard and the child. In addition, all chipping, peeling paint was stabilized and repainted. After the work was completed a lead specific clean was conducted and this family was able to return to a safe and healthy home.

2. BE TOBACCO FREE



Source: Pixabay

**REDUCE
PREVENTABLE
DEATHS.**

Tobacco use is a significant contributor to chronic lung disease, cancer, heart attacks and stroke for both men and women. A large proportion of death and disease can be prevented by decreasing tobacco use.

KEY FACT

There are no safe tobacco products and there is no safe exposure level for adults, children or pregnant women.

KEY FACT

Exposure to Secondhand smoke is harmful to non-smokers, children, and infants.

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

TABLE 2.1: PERCENT OF BALTIMORE RESIDENTS WHO CURRENTLY SMOKE CIGARETTES BY DEMOGRAPHICS

	2009	2010	2011*	2012	2013	2014	% Change‡
Total	26.8%	25.5%	23.8%	21.2%	22.7%	23.1%	-2.9%
SEX							
Male	29.6%	32.8%	23.6%	27.6%	28.6%	25.8%	9.3%
Female	24.8%	21.0%	24.8%	16.3%	17.7%	20.7%	-16.5%
RACE							
White, Non-Hispanic	26.4%	16.6%	22.9%	18.8%	14.1%	17.4%	-24.0%
Black, Non-Hispanic	28.5%	30.8%	23.7%	25.2%	27.7%	28.1%	18.6%
HOUSEHOLD INCOME							
Under \$15,000	39.4%	43.3%	31.2%	43.0%	48.2%	40.9%	31.1%
\$75,000 and over	6.8%	11.8%	5.4%	12.3%	8.9%	12.5%	131.5%

Source: CDC Behavioral Risk Factor Surveillance System, 2009-2014. ‡ Indicates that, due to a change in CDC methodology, 2009-2010 data are not comparable to data from 2011 and beyond. * indicates year of comparison for percent change calculation (i.e., 2011 vs. 2014).

AT-A-GLANCE

- Similar to previous years, nearly one quarter of Baltimore City residents reported they were current smokers in 2014.
- Since 2011, there have been notable reductions in smoking among female residents and white, non-Hispanic residents.
- Nearly 41% of Baltimore City residents with lower household incomes (under \$15,000) reported smoking, compared to 23.1% for Baltimore City overall in 2014.

Maryland's  SmokingStopsHere.com

1-800 QUIT NOW

A tobacco-free life is just a phone call away

Maryland Quitline: 1-800-QUIT-NOW

Live counselors 24/7

Special counseling services for teens ages 13-17 years
Intensive support program for pregnant women
Enhanced online support offered through Web Coach®

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

AT-A-GLANCE

- The percent of Baltimore City high school students who reported smoking in the past month has not changed significantly between 2007 and 2013. It remains slightly under 12%.
- Compared to female high school youth, male high school youth are slightly more likely to report smoking tobacco in the last month.

TABLE 2.2: PERCENT OF HIGH SCHOOL YOUTH WHO REPORTED SMOKING TOBACCO PRODUCTS AT LEAST 1 DAY DURING THE PREVIOUS 30 DAYS BY SEX			
	2007*	2013	% Change
Total	11.7%	11.8%	0.9%
SEX			
Male	13.8%	12.4%	-10.1%
Female	10.0%	10.9%	9.0%

Source: Maryland Youth Risk Behavior Survey, 2007, 2013, estimates are not available for 2008-2012. * Indicates year of comparison for percent change calculation (i.e., 2007 vs. 2013).

HIGHLIGHTING WORK UNDERWAY: BEATING TOBACCO TOGETHER



Based on the increase of tobacco and cigar use among youth in Baltimore, the Baltimore City Health Department along with other city organizations have stepped up their efforts to cut down on the number of minors using tobacco. Residents can now report stores selling cigarettes and other tobacco products to minors by calling 311. This has been linked with a larger public health campaign calling for residents to report stores selling tobacco to kids.

The Tobacco-Free Baltimore program launched a youth-developed teen smoking prevention campaign. The youth created a photonovella called "We Can Beat This Together" highlighting the impact of secondhand smoke on children and their families. This project was developed in partnership with fourth grade students at KIPP Harmony Academy and SOURCE (Student Outreach Resource Center) graduate students at the Johns Hopkins Bloomberg School of Public Health.

[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 BY RACE AND BY EDUCATIONAL ATTAINMENT							
Rate per 1,000 live births	2009	2010*	2011	2012	2013	2014	% Change
MATERNAL RACE							
All	94.8	115.8	107.3	103.8	112.2	104.3	-9.9%
Black	97.0	117.1	116.6	109.4	123.3	125.7	7.3%
White	121.4	120.6	96.0	100.1	101.5	73.6	-39.0%
EDUCATIONAL ATTAINMENT FOR AGES 20 YEARS AND OLDER							
HIGH SCHOOL (HS) OR LESS							
All	148.8	192.9	182.3	182.9	183.6	176.9	-8.3%
Black	134.6	179.7	178.8	167.8	174.1	182.5	1.6%
White	199.8	239.8	200.2	240.1	223.9	167.0	-30.4%
MORE THAN HIGH SCHOOL							
All	24.4	45.1	45.1	40.3	53.7	43.3	-4.0%
Black	29.7	51.1	52.5	53.1	71.0	60.7	18.8%
White	21.0	42.4	40.0	31.0	41.4	30.9	-27.1%

Source: BCHD analysis of Maryland VSA Birth Files; due to variability in analysis methods, data from 2009 is not comparable to data from 2010 and beyond. * Indicates year of comparison for percent change calculation (i.e., 2010 vs. 2014).

AT-A-GLANCE

- Rates of smoking during pregnancy have decreased by 39.0% among white women between 2010 and 2014. However, the rate of smoking during pregnancy among black women increased by 7.3% over the same time period.
- Though women with a high school diploma or less have reduced their rates of smoking during pregnancy, their rates still remain much higher than those of women with more than a high school education (176.9 per 1,000 live births vs. 43.3 per 1,000 live births, respectively in 2014).

3. REDESIGN COMMUNITIES TO PREVENT OBESITY



Source: Pixabay

HEALTHY
FOOD.

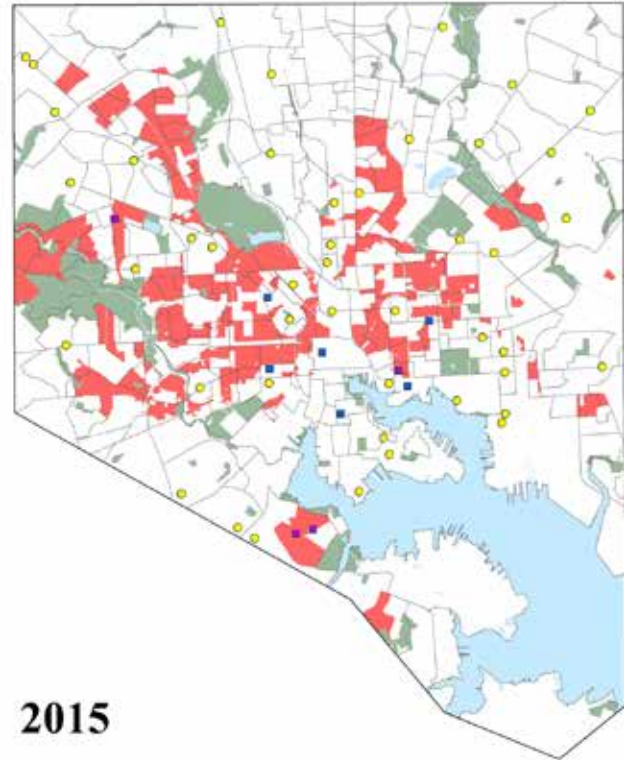
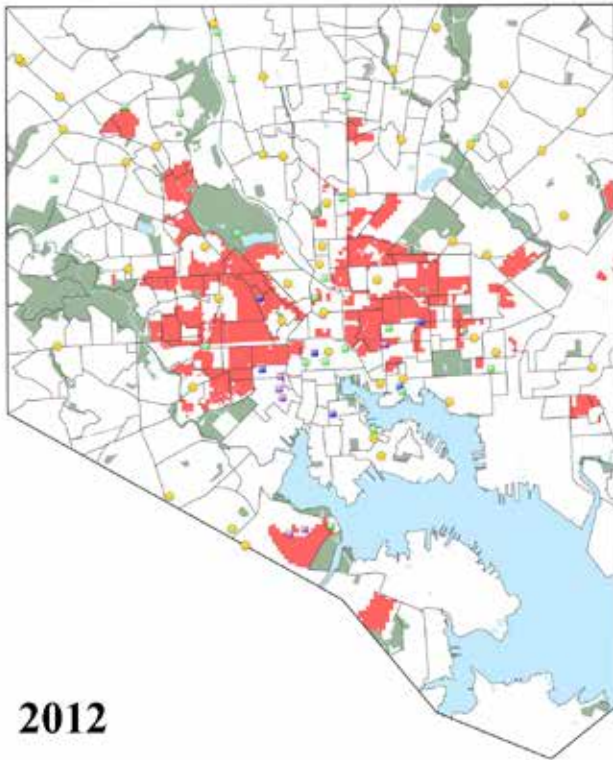
HEALTHY
RESIDENTS.

Obesity continues to be a serious public health issue in Baltimore City. Obesity is linked to many serious health problems such as high blood pressure, diabetes and cardiovascular disease. Obesity can be prevented and reduced by addressing these 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 represent areas with little or no access to healthy foods. Four factors determine whether or not an area is considered a food desert: distance to supermarkets, household income, vehicle availability and supply of healthy food. One way to prevent obesity is by redesigning communities to increase access to healthy and fresh food. This includes improving public transportation and other creative strategies that reduce the impact of food deserts.



Baltimore City Food Environment

- | | | |
|---|--|---|
| ■ Food Desert | Alternative Healthy Food Retail | |
| ● Supermarkets | ■ Public Markets | ■ Virtual Supermarket |
| Neighborhood Boundaries | ■ Farmers Markets (2012 only) | |
| ■ Major Parks | | |

A Food Desert is an area where: 1) The distance to a supermarket or supermarket alternative is more than 1/4 mile; 2) the median household income is at or below 185% of the Federal Poverty Level; 3) over 30% of households have no vehicle available; and 4) the average Healthy Food Availability Index score for all food stores is low.



**Due to differences in methods, the two above maps are not directly comparable. They should not be used to make conclusions regarding changes in food deserts over time.*

AT-A-GLANCE

- As of 2015, 25% of Baltimore City residents live in food deserts. Among school-aged children, about 30% live in food deserts.

HIGHLIGHTING WORK UNDERWAY: VIRTUAL SUPERMARKETS



The Baltimarket Virtual Supermarket Program is an innovative approach to food desert elimination that uses online grocery ordering and delivery to bring food to neighborhoods with low vehicle ownership and inadequate access to healthy foods. It enables residents to order groceries at their local library, senior/disabled housing, public housing, or from any computer and pick up their order at their community site for no delivery cost. In the six year history of the program, it has served over 700 customers, who placed over 6,000 orders for affordable groceries, totaling over \$220,000.

SUCCESS!

To combat the issue of food deserts in Baltimore, the Baltimore City Council passed new legislation in 2015 to give grocery stores tax breaks for being built in or making improvements in areas that would otherwise be food deserts. It is our hope that these breaks will provide incentive for grocery stores to be built in and thrive in areas where they are most needed.

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

AT-A-GLANCE

- In 2013, only 16.7% of Baltimore City residents were getting the recommended amount of weekly physical activity.
- Between 2011 and 2013, there was a 22.6% decrease in the percent of females who met the weekly physical activity recommendations.

TABLE 3.1: PERCENT OF RESIDENTS WHO MEET PHYSICAL ACTIVITY RECOMMENDATIONS BY SEX

	2009	2010	2011*	2012	2013	2014	% Change‡
Total	29.4%	31.2%	17.5%	16.5%	16.7%	x	-4.6%
SEX							
Male	28.4%	41.7%	19.1%	24.3%	21.0%	x	9.9%
Female	30.1%	25.5%	16.4%	10.8%	12.7%	x	-22.6%

Source: CDC Behavioral Risk Factor Surveillance System, 2009-2013. x indicates that data were not collected in 2014 by the CDC, ‡ indicates that, due to a change in CDC methodology, 2009-2010 data are not comparable to data from 2011 and beyond, The 2011 data in this table have been updated from incorrect values published in the 2013 Interim report. * indicates year of comparison for percent change calculation (i.e., 2011 vs. 2013).

RECOMMENDED PHYSICAL ACTIVITY

According to the Centers for Disease Control and Prevention, two types of physical activity are needed each week to improve your health: aerobic activities and muscle-strengthening activities.

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

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

AT-A-GLANCE

- Approximately one in three Baltimore City residents is obese.
- Overall, the level of obesity hasn't significantly changed since 2011, though there has been a slight increase in obesity in those with a lower household income (under \$15,000).

TABLE 3.2: PERCENT OF RESIDENTS WHO ARE OBESE BY HOUSEHOLD INCOME							
	2009	2010	2011*	2012	2013	2014	% Change‡
Total	34.0%	30.9%	36.1%	30.8%	35.8%	35.9%	-0.6%
HOUSEHOLD INCOME							
Under \$15,000	37.5%	28.7%	44.8%	27.3%	47.2%	49.7%	10.9%
\$75,000 and over	26.3%	22.7%	22.2%	20.9%	23.1%	22.9%	3.2%

Source: CDC Behavioral Risk Factor Surveillance System, 2009-2014. ‡ Indicates that, due to a change in CDC methodology, 2009-2010 data are not comparable to data from 2011 and beyond, * indicates year of comparison for percent change calculation (i.e., 2011 vs. 2014).

KEY FACT

Sugar-sweetened beverages such as regular soda and fruit drinks contain added sugar and calories but few, if any, essential nutrients.

KEY FACT

Consumption of sugar-sweetened beverages on a daily basis is associated with many negative health outcomes, such as obesity, diabetes and cardiovascular disease.

HIGHLIGHTING WORK UNDERWAY: WARNING LABELS FOR SUGAR-SWEETENED BEVERAGES

Among high school students in Baltimore, 1 in 3 are overweight or obese, and about 1 in 4 drink a regular soda every day. Legislation supported by BCHD has been introduced to the City Council that would require retailers to post warning labels stating the fact that sugar-sweetened beverages lead to tooth decay, diabetes, and obesity. The legislation is based on scientific evidence that warning labels influence consumer behavior and ensures that consumers can make informed choices about their purchase. This is particularly important in Baltimore City with the rising rates of obesity among children and with beverage companies' practices of disproportionate marketing in communities of color and low-income communities.

HIGHLIGHTING WORK UNDERWAY: BALTIMARKET HEALTHY STORES

The Baltimarket Healthy Stores program was launched in 2015 in order to increase supply of and demand for healthy foods in west Baltimore. The program has three elements: corner store, Youth Neighborhood Food Advocate, and grocery store-based nutrition education. In corner stores, the program provides owners with technical assistance, customer education, marketing, start-up incentives and infrastructure to enable small stores to stock and sell healthier foods. The Youth Neighborhood Food Advocates Program engages young people in conversations around health disparities, teaches practical nutrition information, and develops young people as community leaders. The in-store nutrition education program educates and demonstrates healthy eating and cooking in west Baltimore grocery stores.



Source: Pixabay

4. PROMOTE HEART HEALTH



Source: Pixabay

Cardiovascular disease (CVD) is the leading cause of death across the nation. The major risk factors for CVD are smoking, high cholesterol, high blood pressure, physical inactivity, overweight/obesity, and diabetes. Other factors that contribute to CVD are 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.

**REDUCE
PREMATURE
DEATH
FROM
HEART
DISEASE.**

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



Source: Pixabay

TABLE 4.1: PREMATURE DEATH RATES DUE TO CARDIOVASCULAR DISEASE BY RACE

Age-adjusted Rate per 100,000 population	2009*	2010	2011	2012	2013	2014	% Change
PREMATURE (<75 YEARS) DEATHS							
All Races	165.3	154.2	151.2	152.3	158.4	145.0	-12.3%
Black	190.2	176.5	171.4	175.2	180.6	174.2	-8.4%
White	143.6	123.7	143.5	119.4	131.6	107.8	-24.9%

Source: BCHD analysis of Maryland Vital Statistics data. * Indicates year of comparison for percent change calculation (i.e., 2009 vs. 2014).

AT-A-GLANCE

- Premature deaths (deaths before age 75) from cardiovascular disease have decreased by 12.3% between 2009 and 2014.
- In 2014, the CVD premature death rate among black residents was about 1.6 times the same rate among white residents.

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

TABLE 4.2: PERCENT OF BALTIMORE RESIDENTS WITH HIGH BLOOD PRESSURE WHO REPORT TO BE CURRENTLY TAKING MEDICINE FOR HIGH BLOOD PRESSURE BY SEX

	2009	2010	2011 *	2012	2013	2014	% Change‡
Total	82.5%	x	84.3%	x	84.8%	x	0.6%
SEX							
Male	77.7%	x	83.4%	x	75.2%	x	-9.8%
Female	86.3%	x	84.9%	x	92.0%	x	8.4%

Source: CDC Behavioral Risk Factor Surveillance System, 2009, 2011, 2013. x indicates that data were not collected in 2010, 2012 or 2014 by the CDC, ‡ indicates that, due to a change in CDC methodology, 2009-2010 data are not comparable to data from 2011 and beyond, * indicates year of comparison for percent change calculation (i.e., 2011 vs. 2013).

AT-A-GLANCE

- Of residents with high blood pressure, 84.8% of them reported that they were taking blood pressure medication in 2013.
- Among women with high blood pressure, there has been a modest increase in reported blood pressure medication usage between 2011 and 2013. In contrast, among men with high blood pressure, there was a decrease in reported blood pressure medication usage.

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



Source: Pixabay

KNOW YOUR STATUS.

GET TREATMENT.

Baltimore City is disproportionately affected by HIV and other Sexually Transmitted Infections (STIs) including Chlamydia, Gonorrhea and Syphilis. 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 SEX AND RACE							
Rate per 100,000 population	2009*	2010	2011	2012	2013	2014	% Change
Total	22.3	25.9	38.2	39.1	34.8	31.1	39.4%
SEX							
Male	39.5	51.0	69.5	72.9	62.6	55.4	40.3%
Female	7.0	3.7	10.3	9.1	10.0	9.4	34.7%
RACE							
Black	30.9	36.6	52.6	55.8	46.2	41.4	34.1%
White	6.1	5.4	13.1	9.8	11.4	9.8	60.5%

Source: Baltimore City Bureau of HIV/STD Services; U.S. Census Bureau 2010 Summary File. * Indicates year of comparison for percent change calculation (i.e., 2009 vs. 2014).

AT-A-GLANCE

- Syphilis rates have increased by more than 30% in both males and females between 2009 and 2014.
- Syphilis rates are much higher for males compared to females and for black residents compared to white residents.
- The rise in Syphilis rates observed in Baltimore reflects a larger pattern of increasing Syphilis rates across Maryland and the whole country. The Maryland Department of Health and Mental Hygiene noted a 40% increase in Syphilis cases across the state between 2010 and 2011. Additionally, according to the Centers for Disease Control and Prevention, Syphilis cases across the United States have more than doubled between 2005 and 2013.

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

AT-A-GLANCE

- New HIV diagnoses in Baltimore have declined by half between 2009 and 2014.

TABLE 5.2: REPORTED NEW HIV DIAGNOSES IN ADULTS/ADOLESCENTS (≥ 13 YEARS) BY SEX AND BY RACE							
	2009*	2010	2011	2012	2013	2014	% Change
All (Count)	633	623	439	469	385	315	-50.2%
SEX PROPORTIONS							
Male	65.9%	66.1%	73.1%	70.6%	71.2%	73.0%	10.8%
Female	34.1%	33.9%	26.9%	29.4%	28.8%	27.0%	-20.9%
RACE PROPORTIONS							
Non-Hispanic Black	84.5%	84.8%	80.2%	84.4%	83.6%	88.3%	4.4%
Non-Hispanic White	9.3%	7.5%	11.6%	9.8%	10.1%	7.9%	-14.7%

Source: Maryland DHMH Center for HIV Epidemiology, Surveillance, and Evaluation: Baltimore City HIV Epidemiological Profile. * Indicates year of comparison for percent change calculation (i.e., 2009 vs. 2014).

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



Source: Pixabay

AT-A-GLANCE

- Both Chlamydia and Gonorrhea rates among adolescents have decreased considerably between 2009 and 2014.
- In 2014, about 1 in 30 adolescents in Baltimore City were infected with Chlamydia.

TABLE 5.3: RATES OF YOUTH (10-19 YEARS) WITH GONORRHEA OR CHLAMYDIA BY RACE

Rate per 100,000 population ages 10-19	2009*	2010	2011	2012	2013	2014	% Change
GONORRHEA							
All	1,234.3	1,258.0	905.7	744.1	744.1	745.4	-39.6%
Black	1,329.8	1,425.8	1,079.0	872.0	880.4	868.6	-34.7%
White	141.5	168.4	70.2	63.2	77.2	126.3	-10.7%
CHLAMYDIA							
All	4,778.9	5,132.5	4,534.6	4,221.7	3,976.2	3,498.0	-26.8%
Black	5,589.1	6,068.5	5,319.4	4,435.7	4,338.0	3,619.2	-35.2%
White	449.9	491.2	442.1	385.9	259.6	378.9	-15.8%

Source: Baltimore City Bureau of HIV/STD Services; U.S. Census Bureau 2010 Summary File. * Indicates year of comparison for percent change calculation (i.e., 2009 vs. 2014).

6. RECOGNIZE AND TREAT MENTAL HEALTH CARE NEEDS



Source: Bing images

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. 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%

AT-A-GLANCE

- About 1 in 6 Baltimore City residents reported their mental health was not good for 8 or more days over the past month in 2014.

TABLE 6.1: PERCENT OF BALTIMORE RESIDENTS WHO REPORTED THEIR MENTAL HEALTH WAS "NOT GOOD" 8 OR MORE DAYS OUT OF THE PAST 30 BY DEMOGRAPHICS							
	2009	2010	2011*	2012	2013	2014	% Change‡
Total	19.1%	13.5%	20.9%	15.5%	17.3%	16.9%	-19.1%
RACE							
White, Non-Hispanic	21.8%	12.4%	15.1%	14.5%	10.2%	16.9%	11.9%
Black, Non-Hispanic	17.1%	13.8%	19.5%	16.4%	20.6%	18.0%	-7.7%
EDUCATIONAL ATTAINMENT							
Less than a Bachelor's Degree	21.3%	17.8%	23.8%	16.0%	18.4%	17.3%	-27.3%
Bachelor's Degree and above	14.1%	7.8%	12.4%	11.0%	7.4%	9.3%	-25.0%

Source: CDC Behavioral Risk Factor Surveillance System, 2009-2014. ‡ indicates that, due to a change in CDC methodology, 2009-2010 data are not comparable to data from 2011 and beyond, *indicates year of comparison for percent change calculation (i.e., 2011 vs. 2014).

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



Source: Pixabay

AT-A-GLANCE

- Between 2007 and 2013, there was a slight increase in the percent of high school students feeling sad or hopeless on a near daily basis for two or more consecutive weeks.

TABLE 6.2: PERCENT OF HIGH SCHOOL STUDENTS FEELING SAD OR HOPELESS, NEARLY DAILY FOR 2 OR MORE CONSECUTIVE WEEKS BY SEX

	2007*	2013	% Change
Total	27.7%	29.4%	6.1%
SEX			
Male	19.5%	25.7%	31.8%
Female	35.3%	32.1%	-9.1%

Source: Maryland Youth Risk Behavior Survey, 2007, 2013, estimates are not available for 2008-2012. * Indicates year of comparison for percent change calculation (i.e., 2007 vs. 2013).

7. REDUCE DRUG USE AND ALCOHOL ABUSE



Source: Pixabay

Drug and alcohol abuse lead to substantial costs due to lost productivity, family and community disruption, crime, homelessness, and healthcare utilization. Comprehensive programs that include prevention, treatment and recovery support services provide individuals with the best chance for healthy and productive futures.

Behavioral Health System Baltimore (BHSB) is a non-profit organization focused on advancing behavioral health for individuals, families and communities in Baltimore City. It fosters an efficient, collaborative and holistic behavioral health system that will help Baltimore City residents address mental health and substance abuse issues.

PREVENTION.
TREATMENT.
RECOVERY.

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

AT-A-GLANCE

- Alcohol and drug related hospitalizations decreased by nearly 40% between 2010 and 2014.

TABLE 7.1: RATES OF HOSPITALIZATION DISCHARGE FOR PRIMARY AND SECONDARY DIAGNOSES OF ALCOHOL-RELATED AND DRUG-RELATED DISORDERS BY RACE							
<i>Rate per 100,000 population</i>	2009	2010*	2011	2012	2013	2014	% Change
TOTAL ALCOHOL AND/OR DRUG-RELATED							
All Races	992.6	878.3	821.5	685	636.7	528.7	-39.8%
White	912.4	925	720.5	695.6	+	+	+
Black	1091.5	1007.6	712.9	719.2	+	+	+
ALCOHOL-RELATED							
All Races	463.9	408.9	352.8	396.4	365.4	300.3	-26.6%
White	452.6	501.3	337.4	405.9	+	+	+
Black	491	412.3	300.8	407.9	+	+	+
DRUG-RELATED							
All Races	564.6	502.4	306.6	323.5	304.9	261.4	-48.0%
White	499.1	461.3	233.5	323.8	+	+	+
Black	673.3	580.1	283.6	349.4	+	+	+

Source: BCHD analysis of HSCRC ED discharge data; primary and secondary diagnoses only. + Indicates that HSCRC data on race in 2013-2014 were not reported - see important note on page 4, *Indicates year of comparison for percent change calculation (i.e., 2010 vs. 2014).

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



Source: Pixabay

AT-A-GLANCE

- There have been significant increases in both drug and alcohol related emergency department visits between 2010 and 2014.
- There were more than 1.5 times as many drug related emergency room visits in 2014 than in 2010.

TABLE 7.2: RATES OF EMERGENCY DEPARTMENT DISCHARGE FOR PRIMARY AND SECONDARY DIAGNOSES OF ALCOHOL-RELATED AND DRUG-RELATED DISORDERS BY RACE

Rate per 100,000 population	2009	2010*	2011	2012	2013	2014	% Change
TOTAL ALCOHOL AND/OR DRUG-RELATED							
All Races	1095.5	1436.0	1748.3	2017.6	2089.4	2053.5	43.0%
White	909.5	1587.8	1520.5	1879.7	+	+	+
Black	1229.2	1590.1	1538.1	2143.6	+	+	+
ALCOHOL-RELATED							
All Races	744.4	978.3	1211.6	1388.8	1407.3	1308.8	33.8%
White	607.6	1066	1134.3	1287.9	+	+	+
Black	828.5	1026.6	1044.4	1452.2	+	+	+
DRUG-RELATED							
All Races	378.2	498.7	416.3	682.6	738.1	791.4	58.7%
White	330.9	559.4	270.9	634.9	+	+	+
Black	428.2	531.9	399.1	753.7	+	+	+

Source: BCHD analysis of HSCRC ED discharge data; primary and secondary diagnoses only. + Indicates that HSCRC data on race in 2013-2014 were not reported - see important note on page 4, *Indicates year of comparison for percent change calculation (i.e., 2010 vs. 2014).

**YOU CAN
STOP
OVERDOSE
DEATH**

GET NALOXONE SAVE A LIFE

**GET ALL THE INFO
DONTDIE.ORG**

Staying Alive Program: Since 2004, the Baltimore City Health Department's Staying Alive Drug Overdose Prevention and Response Program has taught more than 16,000 injection drug users, drug treatment clients and providers, prison inmates, and corrections officers about how to prevent drug overdoses. The Staying Alive training program teaches individuals how to recognize an opiate/heroin overdose and respond by calling 911 and administering rescue breathing and the drug Naloxone (also known as Narcan). More than 350 reversals (lives saved) have been documented.

Don't Die Campaign: In July 2015, the Baltimore City Health Department created a new anti-overdose campaign to address heroin and opioid addiction. The campaign aims to create awareness about stopping drug overdoses by using Naloxone. Visit www.dontdie.org for more information.

Baltimore Mayor's Heroin Treatment & Prevention Task Force: In July 2015, the Mayor's Heroin Treatment and Prevention Task Force identified 10 steps to address the city's epidemic of heroin and opioid addiction. Some of these steps include the creation of 24/7 treatment facilities for substance users, a public education campaign to encourage treatment and combat stigma, and a Citywide Heroin Overdose Plan focused on ensuring the widespread dissemination of Naloxone.

[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 2013, about 1 in 8 high school students reported alcohol use in the past 30 days.
- In 2013, about 1 in 4 high school students reported marijuana use in the past 30 days.
- There was a slight increase in both alcohol and marijuana use reported by high school students between 2007 and 2013.
- Female high school students experience slightly greater increases in drug and alcohol use than male high school students.

TABLE 7.3: PERCENT OF BALTIMORE HIGH SCHOOL YOUTH REPORTING ALCOHOL OR DRUG USE IN THE LAST 30 DAYS BY DRUG AND SEX			
	2007*	2013	% Change
ALCOHOL			
Total	10.8%	12.4%	14.8%
Male	13.4%	13.4%	0.0%
Female	8.7%	10.3%	18.4%
MARIJUANA			
Total	21.4%	24.7%	15.4%
Male	25.7%	26.5%	3.1%
Female	17.6%	22.0%	25.0%

Source: Maryland Youth Risk Behavior Survey, 2007, 2013, estimates are not available for 2008-2012. * Indicates year of comparison for percent change calculation (i.e., 2007 vs. 2013).

HIGHLIGHTING WORK UNDERWAY: BANNING SYNTHETIC DRUGS

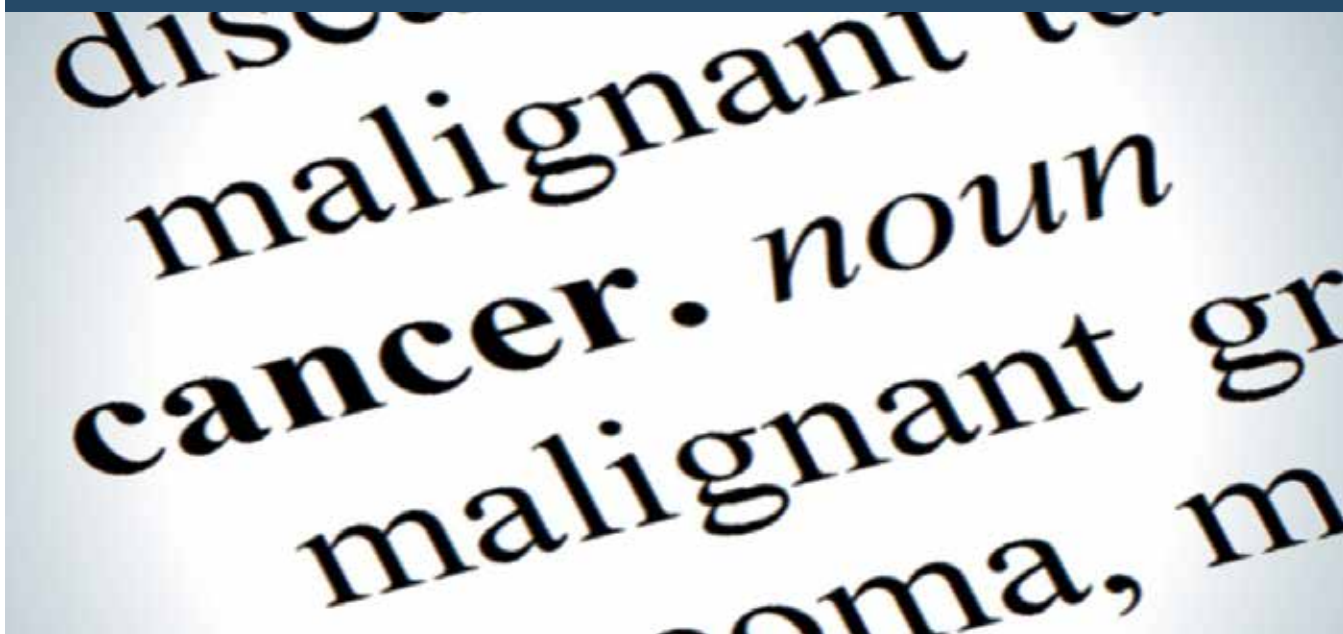


Source: Bing images

The Baltimore City Health Department advocated for several policy initiatives to reduce the harmful effects of tobacco and alcohol. These include prohibiting the indoor use of e-cigarettes and hookahs, creating buffer zones around schools, an increase in the state-wide tobacco tax, and increased enforcement funding and capacity. In 2016, BCHD's advocacy resulted in a statewide ban of powdered alcohol and a citywide ban of the sales of synthetic drugs.

In February 2016, Mayor Stephanie Rawlings-Blake signed a new city law that bans synthetic drugs from being sold in Baltimore City. Synthetic drugs, often called "K2," "spice," or "bath salts" are chemically-laced substances marketed as being similar to marijuana and cocaine. Because the chemical composition of these drugs often changes and is unknown, using them can lead to unexpected and serious adverse effects. The new law imposes hefty fines for retailers selling these synthetic drugs and can even lead to the revocation of a retailer's license.

8. ENCOURAGE EARLY DETECTION OF CANCER



Source: Google images

Cancer is the second leading cause of death in Maryland, with Baltimore City having the highest cancer mortality rate among all Maryland jurisdictions. Fortunately, there are ways to detect certain types of cancers (including colon and breast cancer) early using relatively non-invasive tests. Early detection of both breast and colon cancers has been associated with better health outcomes. The Baltimore City Health Department supports efforts in screening for both of these types of cancer in Baltimore City residents. Important indicators in this priority area are increasing the number of people screened for colon and breast cancer.

PROMOTE
EARLY
CANCER
DETECTION
AND
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

- In 2014, 70.8% of Baltimore City residents aged 50 years and older had ever had a sigmoidoscopy or colonoscopy, a slight increase from previous years.

TABLE 8.1: PERCENT OF BALTIMORE RESIDENTS 50+ YEARS OF AGE WHO HAVE EVER HAD A SIGMOIDOSCOPY/COLONOSCOPY BY DEMOGRAPHICS							
	2009	2010	2011	2012*	2013	2014	% Change‡
Total	x	66.6%	x	68.8%	x	70.8%	2.9%
EDUCATIONAL ATTAINMENT							
HS Diploma or equivalent	x	63.6%	x	77.1%	x	63.7%	-17.4%
Some college	x	76.7%	x	73.2%	x	81.1%	10.8%
Bachelor's Degree and above	x	72.5%	x	72.2%	x	83.3%	15.4%
HOUSEHOLD INCOME							
Under \$15,000	x	^	x	44.9%	x	51.2%	14.0%
\$75,000 and over	x	77.2%	x	65.9%	x	74.7%	13.4%

Source: CDC Behavioral Risk Factor Surveillance System, 2010, 2012, 2014. x indicates that data were not collected in 2009, 2011 or 2013 by the CDC, ^ indicates insufficient data, ‡ indicates that, due to a change in CDC methodology, 2009-2010 data are not comparable to data from 2011 and beyond, * indicates year of comparison for percent change calculation (i.e., 2012 vs. 2014).

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

AT-A-GLANCE

- In 2014, 82.5% of women aged 50 years and older reported having had a mammogram within the last two years.

TABLE 8.2: PROPORTION OF WOMEN 50+ YEARS OF AGE WHO HAVE HAD A MAMMOGRAM WITHIN THE PRIOR 2 YEARS BY DEMOGRAPHICS							
	2009	2010	2011	2012*	2013	2014	% Change‡
Total	x	84.4%	x	85.3%	x	82.5%	-3.3%
EDUCATIONAL ATTAINMENT							
HS Diploma or equivalent	x	80.0%	x	87.6%	x	89.8%	2.5%
Some college	x	91.6%	x	88.9%	x	86.6%	-2.6%
Bachelor's Degree and above	x	90.3%	x	78.1%	x	90.8%	16.3%
HOUSEHOLD INCOME							
Under \$15,000	x	^	x	79.8%	x	65.6%	-17.8%
\$75,000 and over	x	^	x	71.4%	x	93.7%	31.2%

Source: CDC Behavioral Risk Factor Surveillance System, 2010, 2012, 2014. x indicates that data were not collected in 2009, 2011 or 2013 by the CDC, ^ indicates insufficient data, ‡ indicates that, due to a change in guidelines for mammography screenings, 2009-2010 data are not comparable to data from 2011 and beyond, *indicates year of comparison for percent change calculation (i.e., 2012 vs. 2014).

9. PROMOTE HEALTHY CHILDREN AND ADOLESCENTS



Source: Bing images

By improving the health of our children and adolescents, we can improve their future quality of life and the future of Baltimore City as a whole. The leading indicators within this priority area highlight important 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.

**START
HEALTHY,
STAY
HEALTHY.**

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

AT-A-GLANCE

- Teen birth rates have decreased among all races and ages, with a 23.1% overall decrease between 2010 and 2014.

TABLE 9.1: TEEN BIRTH RATES, 15-19 YEARS OLD, BY MATERNAL AGE CATEGORY AND MATERNAL RACE							
Age-specific Teen Birth Rate (per 1,000 females in age group)	2009	2010*	2011	2012	2013	2014	% Change‡
ALL							
15-19	64.4	53.3	50.7	46.9	43.4	41.0	-23.1%
15-17	42.4	37.7	32.9	28.3	24.6	26.5	-29.7%
18-19	87.2	68.7	68.7	65.5	62.7	56.9	-17.2%
WHITE							
15-19	28.0	30.8	27.6	25.9	23.4	25.1	-18.5%
15-17	19.5	26.8	20.9	22.3	16.3	26.1	-2.6%
18-19	34.7	33.2	31.7	28.0	27.6	24.5	-26.2%
BLACK							
15-19	79.4	62.0	59.9	55.4	51.1	48.0	-22.6%
15-17	49.0	40.6	36.0	30.2	26.8	26.8	-34.0%
18-19	116.5	87.4	88.8	86.1	82.4	77.5	-11.3%

Source: DHMH Vital Statistics Administration Annual Reports, 2009-2014: General Fertility Rates and Birth Rates by Age of Mother, Race, and Hispanic Origin of Mother, Region, and Political Subdivision. ‡ Indicates that, due to a change in analysis methodology, 2009 data are not comparable to data from 2010 and beyond, *indicates year of comparison for percent change calculation (i.e., 2010 vs. 2014).

HIGHLIGHTING WORK UNDERWAY: BALTIMORE YOUTH HEALTH & WELLNESS STRATEGY

Communities across Baltimore want their children and teens to be as healthy and happy as possible. As a City we can do much more to improve the health and wellbeing of all children and youth. The Youth Health and Wellness Strategy describes how we can improve young people's access to health, mental health and drug treatment services. Our goal is to reduce school absences caused by health problems – whether physical, emotional, or social. This five-year plan seeks to make sure that all young people ages 6-19 have equal opportunities to connect with the people and services they need to be healthy and successful. For more information, please visit <http://www.baltimoreyouthhealthandwellness.com/>

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

AT-A-GLANCE

- There has been a decrease in the overall infant mortality rate of 23% between 2009 and 2014.
- Infant mortality rates among black infants have decreased by 30.8%.
- Between 2009 and 2014, mortality rates among white infants in Baltimore City more than doubled. However, the number of white infant deaths is low enough such that small changes in the number of deaths can lead to great fluctuations in the white infant mortality rate from year to year. Since 2007, the rate has fluctuated between 1.8 and 7.3 per 1,000 live births. For more information on historic trends, see: <http://healthybabiesbaltimore.com/about-bhb/infant-mortality-statistics-and-research>.

TABLE 9.2: INFANT MORTALITY RATES BY RACE

Rate per 1,000 live births	2009*	2010	2011	2012	2013	2014	% Change
All Races	13.5	11.0	10.5	9.7	10.3	10.4	-23.0%
White	3.5	3.6	3.1	3.4	6.8	7.1	102.9%
Black	18.5	14.7	14.5	12.6	12.5	12.8	-30.8%

Source: DHMH Vital Statistics Administration Annual Reports, 2009-2014: Infant Deaths and Infant Mortality Rates by Race, Hispanic Origin, Region and Political Subdivision. *Indicates year of comparison for percent change calculation (i.e., 2009 vs. 2014).

HIGHLIGHTING WORK UNDERWAY: B'MORE FOR HEALTHY BABIES

In 2009, Baltimore had one of the worst rates of infant mortality in the country—127 babies died before their first birthdays in that year alone. Black babies were five times more likely to die than white babies. The city struggled to address the two leading causes of infant mortality—babies born too soon and too small, and babies dying in their sleep. In response to this public health crisis, leaders from the corporate, nonprofit, academic, and government sectors came together to launch B'more for Healthy Babies (BHB). This groundbreaking initiative, led by the Baltimore City Health Department with Family League of Baltimore and HealthCare Access Maryland, works to improve policies and services that support mothers, babies, and families. BHB has several initiatives 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 Cessation
- Family Literacy
- Substance Exposed Pregnancies Prevention
- Prenatal Care
- Fetal-Infant Mortality Review
- Child Fatality Review

BHB has made history by bringing infant mortality in Baltimore to its lowest point ever. Sleep-related infant deaths have been reduced by more than 50%. The gap between black and white infant deaths is also closing. BHB is currently conducting a perinatal periods of risk analysis (PPOR), in which fetal and infant mortality rates are identified at different perinatal development stages, to determine which factors are driving the largest disparities. The PPOR analysis allows BHB to prioritize actions based on the evidence and will inform the Baltimore City Health Department's (BCHD's) strategic direction, grounding our work in local data.

In 2010, BCHD, in partnership with the Family League of Baltimore, established the Teen Pregnancy Prevention Initiative (TPPI), a multi-agency task force committed to reducing unintended teen pregnancies. This citywide initiative ensures that young people have access to age-appropriate and evidence-based sexual health education, access to effective family planning and youth-friendly services and opportunities for young people to engage their communities and grow as civic leaders. All of TPPI's efforts are unified by Know What U Want U Choose campaign. Developed by TPPI's Youth advisory Council, the campaign distributes key sexual health information relevant to young people in Baltimore through clinics, social media and guerilla marketing. TPPI's efforts have paid off with notable declines in teen birth rates between 2009-2014 in Baltimore City.

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

AT-A-GLANCE

- The rate of juvenile homicides increased by nearly 50% between 2009 and 2015.
- The rate of non-fatal shootings has fluctuated between 2009 and 2015.

TABLE 9.3: RATES OF JUVENILE (0-17 YEARS OF AGE) HOMICIDE AND NON-FATAL SHOOTING VICTIMS								
Rate per 100,000 children under 18	2009*	2010	2011	2012	2013	2014	2015	% Change
Homicide	11.2	9.0	11.2	8.2	7.6	11.4	16.7	49.1%
Non-fatal shooting victims	39.2	25.6	21.7	13.5	17.5	9.9	39.5	0.8%

Source: Baltimore City Police Department; U.S. Census Bureau American Community Survey [B09001: Population Under 18 Years by Age, 2009, 2010, 2011, 2012, 2013, 2014 1-year estimates]. *Indicates year of comparison for percent change calculation (i.e., 2009 vs. 2015).

HIGHLIGHTING WORK UNDERWAY: SAFE STREETS



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. One program housed exclusively within BCHD is Safe Streets.

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. In 2015, Safe Streets workers had 11,000 contacts with key individuals and mediated 692 conflicts. Seventy-seven percent of interactions were deemed to be “likely” or “very likely” to result in gun violence. Three of the four sites went more than a year without a fatal shooting.

Currently the Safe Streets program is operating five sites: Cherry Hill, McElderry Park, Mondawmin, Park Heights, and Sandtown. For more information on the Safe Streets program, please visit <http://health.baltimorecity.gov/safestreets>

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

AT-A-GLANCE

- In 2014, a new assessment tool was used to evaluate Kindergarten readiness, the Kindergarten Readiness Assessment (KRA). The KRA uses substantially higher standards than the assessment tool used in previous years, the Maryland Model for School Readiness (MMSR). Because of this change in assessment tools, data from before school year (SY) 2014-2015 cannot be compared to data from SY 2014-2015 and after.
- There was a 14.0% increase in school readiness between SY 2010-2011 and SY 2013-2014 - the last year of the MMSR.

TABLE 9.4: PERCENT OF BALTIMORE KINDERGARTNERS "FULLY READY" FOR SCHOOL

	2010-11 SY	2011-12 SY	2012-13 SY	2013-14 SY	2014-15 SY	% Change
% of kindergartners "fully ready" to learn	66.6%	73.1%	77.6%	75.9%	48.2%	‡‡

Source: Maryland State Department of Education (Maryland Model for School Readiness/Kindergarten Readiness Assessment - Annual School Readiness Report). ‡‡ Indicates that due to a change in the readiness assessment tool, data from before SY 2014-2015 cannot be compared to data from SY 2014-2015 and after.



Source: Pixabay

10. CREATE HEALTH PROMOTING NEIGHBORHOODS



Source: Pixabay

**PROMOTE
THE BUILT
ENVIRON-
MENT.**

Health starts - long before illness - in our homes, neighborhoods, schools and jobs. Where we live and how our physical surroundings are built and organized are important factors in determining our health. The leading indicators in this priority area include vacant building density and liquor outlet density.

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

AT-A-GLANCE

- In 2015, there were about 7 vacant buildings per 100 households.
- There has not been a significant decline in vacant building density between 2009 and 2015.

TABLE 10.1: VACANT BUILDING DENSITY PER 10,000 HOUSEHOLDS						
	2009*	2012	2013	2014	2015	% Change
Vacants	716.5	652.4	659.2	688.7	703.9	-1.8%

Sources: Mayor's Office of Information Technology, last updated August 25, 2015; U.S. Census Bureau American Community Survey (S1101: Households and Families, 2009, 2012, 2013, 2014 1-year estimates). *Indicates year of comparison for percent change calculation (i.e., 2009 vs. 2015).

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

AT-A-GLANCE

- The number of liquor outlets per 10,000 residents has decreased by almost 15% between 2009 and 2015.

TABLE 10.2: LIQUOR OUTLET DENSITY PER 10,000 RESIDENTS BY CLASS OF LIQUOR LICENSE								
	2009*	2010	2011	2012	2013	2014	2015	% Change
Class A and A2 (off sale package goods)	4.6	3.0	3.3	3.9	3.8	3.7	3.7	-19.0%
Class A, A2, and BD-7 (off sale package goods and taverns)	12.5	7.7	8.5	10.9	11.0	10.5	10.7	-14.5%

Sources: Mayor's Office of Information Technology, last updated July 22, 2015; Baltimore City Liquor License Board; U.S. Census Bureau American Community Survey (B01003: Total Population, 2009, 2010, 2011, 2012, 2013, 2014 1-year estimates). * Indicates year of comparison for percent change calculation (i.e. 2009 vs. 2015).

TECHNICAL NOTES

PERCENT CHANGE CALCULATIONS

Percent change calculations were made using the following formula: $(\text{most recent data available} - \text{comparison year data}) / (\text{comparison year data}) \times 100$. The comparison year was the 'baseline' year used in the initial Healthy Baltimore Report (either 2007, 2008, 2009 or 2010), except in cases where data collection methods or analysis had changed since the initial report. For indicators that had a change in the data collection or analysis methodology, the comparison year was the first year which used the new data collection or analysis methods. Please note that some data from 2009-2013 have slightly changed between the current report and the 2013 Interim Report. This is due to a minor change in calculation methods or updated data. Percent change calculations were made using exact data with no rounding. The estimates in this report, though, are presented as rounded to the nearest tenth or, in the case of percentages, nearest tenth of a percent. As such, replicating percent change calculations using these rounded estimates may lead to minor discrepancies with the percent change values published in this report.

DEMOGRAPHICS AND STRATIFICATION

Denominators were obtained from the United States Census Bureau. 1-Year American Community Survey estimates were used for 2009, 2010, 2011, 2012, 2013, and 2014 data. 2014 1-year estimates were used as the denominator for 2015 data. Unless otherwise noted here, direct age-adjustment was conducted with 10-year age groups and the 2000 US standard population (from: Klein RJ, Schoenborn CA. Age-adjustment using the 2000 projected U.S. population. Healthy People Statistical Notes, no. 20, Hyattsville, Maryland: National Center for Health Statistics. January 2001). Direct age-adjustment using the 2000 US standard population for premature mortality due to cardiovascular disease employed the following age categories as these are the categories used by the US Census for providing age-by-race denominator data: < 5, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74 years.

ACCESS TO HEALTH INSURANCE

Insurance coverage rates were obtained from the United States Census Bureau, American Community Survey, Report S2701: Health Insurance Coverage Status. 1-Year estimates were used for 2009, 2010, 2011, 2012, 2013, and 2014.

HOSPITALIZATION AND EMERGENCY DEPARTMENT DATA

Information on hospital admissions and emergency department (ED) 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 was used in this report (HSCRC). Baltimore City residents were identified by residence ZIP code. Since some ZIP codes cross city lines, we excluded residents of ZIP codes where less than 10% of the ZIP code population lives within Baltimore City limits. 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. See important note on page 4 of the report explaining why data by race were not reported for calendar years 2013 and 2014.

MORTALITY DATA

Mortality data specific to residents of Baltimore City were obtained from the Maryland Department of Health and Mental Hygiene's Vital Statistics Administration. Cause-specific mortality was identified by the International Statistical Classification of Diseases and Related Health Problems, 10th Revision Clinical Modification (ICD-10-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. Premature mortality measures the rate of deaths in people under 75 years of age. Many of these deaths are considered preventable. For the purposes of this report, premature mortality rates were age-adjusted (as described above).

BEHAVIORAL RISK FACTORS

Information on behaviors and behavioral risk factors was obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS). Data was accessed via the online access system (www.marylandbrfss.org). Information was queried at the level of Baltimore City. BRFSS questions on high blood pressure medication adherence, colorectal cancer screening, and breast cancer screening are asked on a biennial basis. All other questions are asked annually.

Of note, significant changes were made in the analytic methods for BRFSS surveys in 2011 and beyond. Therefore, BRFSS data prior to 2011 cannot be compared directly with subsequent surveys. For more information, please reference the September 2012 Maryland Department of Health and Mental Hygiene Virtual Data Unit Report here: <http://www.marylandbrfss.org/pdf/BRFSS-Special-Report-9-12.pdf>. For the purposes of this report, changes in adult behavioral risk factors are measured between 2011 data and the most recently available data.

The Centers for Disease Control and Prevention also administers a Youth Risk Behavior Survey, reflecting a representative sample of students in grades 9-12 in specified jurisdictions. 2007 and 2013 data are available for Baltimore City; these are the only years in which Baltimore City had a sufficient response rate to allow for analysis and reporting.

TECHINICAL NOTES (CONTINUED)

ALCOHOL & DRUG ABUSE TREATMENT

Drug and alcohol abuse treatment information was obtained from the Maryland Health Services Cost Review Commission. Please see above for more information on HSCRC methodology. Cases in which tobacco was the only substance were excluded from the analysis.

BIRTH OUTCOMES

Smoking during pregnancy was as reported on the birth certificate, compiled by the Maryland Department of Health and Mental Hygiene's 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. Teen birth rate is defined as the number of live births to females aged 15-19 years old per 1,000 females in the population in the same age range. 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 2010-2011 through 2014-2015. School readiness was computed based on the Maryland Model for School Readiness Working Sampling System (MMSR WSS) through school year 2013-2014, and on the stricter Kindergarten Readiness Assessment (KRA) in school year 2014-2015. As a result, data from school year 2014-2015 are not comparable to previous school years. For the purposes of this report, changes in school readiness are measured between school year 2010-2011 and school year 2013-2014.

JUVENILE HOMICIDES AND NON-FATAL SHOOTINGS

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

MENTAL HEALTH

Mental health data are from the Maryland Behavioral Risk Factor Surveillance System (BRFSS). Please see above for BRFSS methodology. For the percent of Baltimore residents who reported their mental health was "not good" for 8 or more days out of the past 30, data were aggregated from responses "8-29 days" and "30 days".

BUILT ENVIRONMENT

Data on vacant buildings and alcohol outlets are from Baltimore City's Open Baltimore website: <https://data.baltimorecity.gov/>. The most recent dataset for vacant buildings is dated August 25, 2015; the most recent dataset for liquor licenses is dated July 22, 2015. Baltimore City has four classes of liquor license:

- Class "A" – Off Sale package goods, no on-premises consumption (e.g., liquor stores)
- Class "B" – Restaurants and other businesses whose primary source of income is not from alcohol sales (e.g., hotels)
- Class "C" – Non-profit private clubs (e.g., American Legion posts)
- Class "D" – Taverns, whose primary source of income comes from on-premises consumption

For the purposes of this report, facilities with class "A" and class "BD7" – taverns open 7 days a week – licenses were included in the analysis.



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