RWJF Culture of Health
Sentinel Community Snapshot:

Baltimore, Maryland
Table of Contents

Introduction

DISCRIMINATORY HOUSING PRACTICES

RACIAL DIVISIONS AND INSTITUTIONAL DISTRUST

SOCIAL AND ECONOMIC DISPARITIES

NEIGHBORHOOD CRIME, SAFETY HAZARDS, AND SUBSTANCE ABUSE

HEALTH DISPARITIES AS A LEGACY OF RACIAL SEGREGATION

Collaborating Across Sectors for a Healthier, Safer Baltimore

CHILD AND ADOLESCENT HEALTH AND WELL-BEING

OPIOID OVERDOSE PREVENTION

NEIGHBORHOOD HEALTH AND SAFETY

ROBUST HEALTH POLICY INFRASTRUCTURE

Making a Sustained Impact on Health and Well-Being in Baltimore

ABOUT THIS REPORT
The Sentinel Communities project, conducted by RTI International in collaboration with the RAND Corporation, is sponsored by the Robert Wood Johnson Foundation. The project will monitor activities in each of 30 diverse communities around the country for at least 5 years. This Snapshot is the first in a series of planned reports about this Sentinel Community. Using data compiled in early 2016, it provides an initial overview of the community’s history, challenges, and approaches to building a Culture of Health. Visit cultureofhealth.org to see the full list of communities and links to other reports and information about the project.
Introduction

Baltimore, located on the Chesapeake Bay, is Maryland’s largest city. Baltimore’s port, established in 1706, supported the development of a local manufacturing and shipping industry. During World War II and in the post-war period, the city experienced strong economic and population growth, powered by a robust manufacturing sector. By 1950, more than 950,000 people lived in Baltimore, and approximately one-third of employed residents worked in manufacturing.

As employment in Baltimore’s manufacturing sector declined from its 1950s peak, the city experienced a large migration of white residents to the suburbs, which reshaped its racial composition. Between 1950 and 2000, the city’s white population decreased by 500,000, but its black population increased by 195,000. Today, Baltimore’s 622,000 population is 63% black, 28% white, 5% Hispanic, and 3% Asian. The city’s economy has shifted increasingly toward professional and service-sector jobs. Many of Baltimore’s largest employers are academic institutions and large health systems, including Johns Hopkins University and the University of Maryland. As these sectors have expanded, so have the number of professional and service-sector jobs they provide for Baltimore’s residents. However, this economic transition has not equally benefited all of the city’s residents, nearly one-quarter of whom live in poverty.

Insurance coverage and access to quality health care have increased in Baltimore, even among its poorest residents, as a result of Maryland’s progressive health care policies. For instance, Maryland is leading an ambitious statewide initiative in which all insurers pay...
hospitals the same reimbursement rates, as a way to constrain hospital spending growth, increase health care quality, and improve population health. In addition, Maryland expanded Medicaid under the Affordable Care Act (ACA), which helped reduce Baltimore's uninsured rate by 56% between 2013 and 2016.6

Some of the changes in Baltimore's demographics and employer base have occurred against a backdrop of racism. The city has been profoundly shaped by structural discrimination against black residents, particularly in housing. In the early 1900s, Baltimore became the first U.S. city to implement a neighborhood segregation law that barred black residents from living in white neighborhoods.8 Although the Supreme Court overturned that law in 1917, other forms of segregation persisted, and many of the city's neighborhoods remain racially divided.7 As a result of neighborhood segregation, black residents live primarily in East and West Baltimore, while white residents live primarily in the northern and southern parts of the city (Figure 1). Poverty is significantly higher in East and West Baltimore than in the city's northern and southern neighborhoods.8

Government agencies, community organizations, and local residents are engaged in a large number of cross-sector collaborations to address these challenges and improve the health and well-being of all who call Baltimore home. Their efforts focus on many issues, including child and adolescent health and well-being, opioid overdose prevention, and neighborhood health and safety. For example, the city's juvenile justice system and the Mayor's Office of Employment Development are partnering to provide case management services to young people at high risk for being victims or perpetrators of violent crime. In addition, a broad, cross-sector initiative seeks to improve infant health outcomes through home visiting, providing parenting education, reducing substance-exposed pregnancies, and reducing teen pregnancy.

Despite these investments, many of Baltimore's black residents still experience significant disparities in health, income, and educational attainment compared with the city's white residents. Some of the disparities have been linked to historical racial segregation that has led to many black residents living in unsafe neighborhoods with limited economic opportunities. For example, lead paint and vacant properties in predominantly black neighborhoods create health and safety issues for residents, such as lead poisoning in children and violent crime. These economic and social disadvantages have serious consequences on black residents' health and well-being, including higher rates of obesity, diabetes, and other chronic illnesses, in addition to substance abuse and homicide.

DISCRIMINATORY HOUSING PRACTICES
Baltimore's racially divided neighborhoods can be traced to the discriminatory housing policies of a century ago. In 1911, the city government implemented a law that effectively prohibited black residents from purchasing homes in predominantly white neighborhoods. After the Supreme Court struck down this law in 1917, neighborhood segregation was maintained in other ways. In 1925, white neighborhoods in Baltimore began using racially restrictive covenants—contracts that prohibited rent or sale of property to black residents—to prevent racial integration.9 During the same period, the Federal Housing Administration refused to insure mortgages for black potential home buyers on a national level, shutting most out of the real estate market and forcing many to rely on predatory lending schemes to purchase property in black neighborhoods.9

The practice of forced displacement has also contributed to neighborhood segregation in Baltimore.10 For example, during the 1950s, the Baltimore city government approved a plan to expand Johns Hopkins University's medical campus. Resulting development, which included hotels, offices, and housing for Hopkins employees and medical students, displaced 1,000 black families in East Baltimore.10 Further, from the 1950s to the 1970s, city officials relocated 25,000 families—most of them black—to make way for government-funded building projects, such as new highways and schools.12 More recent controversy has surrounded East Baltimore Development Inc., an initiative aimed at revitalizing East Baltimore, which catalyzed the demolition of many homes in Middle East, a predominantly black neighborhood.13, 14 The project has attempted to mitigate displacement by providing some benefits to evicted residents.
For instance, it established the first public school in the community in nearly 30 years, which it opened to evicted residents first, for whom it covered all transportation expenses.18

Racial Divisions and Institutional Distrust
With Baltimore’s history of racial discrimination, the black community has a fraught relationship with local institutions, including law enforcement and health systems. Distrust of the city’s police department stems from concerns about police brutality and high arrest rates for petty crimes in predominantly black neighborhoods.16,17 In response to these tensions, the department has undertaken policing reforms, which include creating a Professional Standards and Accountability Bureau in 2013 to investigate police misconduct, reducing the number of arrests for minor drug offenses, and developing a class to familiarize officers with Baltimore’s communities and history.17,18 The Baltimore Police Department is also increasing foot patrols and assigning specific officers to designated geographic areas as a way to build relationships between them and community members.19 Finally, the police department is attempting to increase positive police interactions with young people through initiatives such as a “Police Explorer’s Program,” intended to encourage high school students to pursue careers as police officers.19

Leaders of local health systems also recognize the need to regain the black community’s trust, particularly given their history of providing substandard care to black patients and regarding them primarily as research subjects.20 For example, in 1951, Johns Hopkins physicians took tissue samples from a cervical cancer patient named Henrietta Lacks without her knowledge. For decades, scientists extensively used cells from these samples for biomedical research without her family’s knowledge or consent.20

More recent public health activities also have contributed to this distrust. In a 1990s study conducted by the Kennedy Krieger Institute to examine the effectiveness of different lead abatement methods, low-income, predominantly black children and their parents were given subsidies to move into homes where lead paint, common in low-income housing in Baltimore, had only been partially removed.21 Children exposed to lead can develop lead poisoning, which produces lifelong negative effects on physical health, learning, and behavior.22

Another source of tension is the Baltimore City Health Department’s (BCHD’s) efforts to make long-acting reversible contraceptive methods—first Norplant and later Nexplanon, both hormonal implants inserted in the upper arm—available to public school students without parental consent.23 In the early 1990s, BCHD provided Norplant to several school-based health clinics with the goal of reducing high teen pregnancy rates. Community members—in particular, black clergy—expressed concerns about providing Norplant to students without parental knowledge, Norplant’s potential side effects, and whether the Norplant distribution program unfairly focused on black students.24 The program was eventually discontinued, and Norplant was withdrawn from the U.S. market in 2002.22,23 BCHD recently began offering Nexplanon in school clinics, a program that faces many of the same criticisms as the earlier Norplant program.23

Social and Economic Disparities
The consequences of segregation and discrimination also are evident in the social and economic disparities between the city’s black and white residents. Although approximately half of Baltimore’s white residents have at least a 4-year college degree, just 14% of the city’s black residents do (Figure 2).25 As a result, most black residents are not eligible for local white-collar jobs, and they are almost three times more likely to be unemployed than white residents (19% vs. 7%).26,27 At $62,034, the median income for Baltimore’s white residents is almost twice the income for black residents ($33,801), while the poverty rate for black residents (28%) is nearly twice the rate for white residents (15%). Black children are much more likely to live in poverty (41%) than white children (13%).

Neighborhood Crime, Safety Hazards, and Substance Abuse
Crime, trash, vacant properties, lead paint, and aging infrastructure are key challenges in Baltimore’s low-income neighborhoods, which create health and safety issues for residents.28,29,30 For example, vacant properties are associated with increases in violent crimes.29 The year 2015 marked the highest number of murders per capita in Baltimore, and more than 50% of the victims were aged 18 to 30.23 A high proportion of mostly male residents from Baltimore’s black neighborhoods are in prison. In 2010, blacks made up only 64% of Baltimore residents, but...
HEALTH DISPARITIES AS A LEGACY OF RACIAL SEGREGATION

In Baltimore, poverty and health outcomes are inextricably tied to race. The social and economic disadvantages that black residents face are a direct consequence of decades of segregation in unsafe neighborhoods with limited economic opportunities. These disadvantages lead to worse health outcomes for Baltimore’s black residents compared with its white residents.

More than one-quarter of black residents (27%) report being in fair or poor health, nearly twice the level (15%) reported by white residents (Figure 3). Among black residents, approximately 38% are obese compared with 19% of white residents. At 19%, the rate of black residents diagnosed with diabetes is more than twice as high as that for their white counterparts (7%). Black children are also diagnosed with asthma at three times the rate of white children.

Rates of death from homicide are six times higher for black residents, they experience significantly higher rates of death from HIV/AIDS and diabetes, and infant mortality is higher as well (in 2015, 9 per 1,000 live births for black residents vs. 5 per 1,000 live births for white residents).

The uninsured rate is similar among both groups (approximately 15% for whites and blacks before ACA Medicaid expansion), and the rate of unmet health care needs is only slightly higher for black residents (17% vs. 15%) (Figure 3).

Collaborating Across Sectors for a Healthier, Safer Baltimore

To address the city’s significant inequities in health and well-being, a number of agencies and organizations—including BCHD—are partnering on cross-sector initiatives that target top public health priorities, including youth wellness and substance abuse prevention. Additional cross-sector collaborations in Baltimore are focused on improving neighborhood health and safety.

CHILD AND ADOLESCENT HEALTH AND WELL-BEING

Baltimore’s infant mortality rate exceeds U.S. averages, with 10 deaths per 1,000 live births in 2014, compared with 5 deaths per 1,000 live births at the national level. The B’More for Healthy Babies initiative was launched in 2009 in an effort to reduce this rate. A broad citywide effort, the initiative seeks to improve infant health outcomes through interventions such as evidence-based home visiting, providing education on parenting and safe sleep practices for infants, reducing substance exposed pregnancies, and reducing teen pregnancy. Partner organizations include BCHD, the nonprofit Family League of Baltimore, health care providers, home visiting organizations, local and state government agencies, community organizations, and churches. Funding comes from public sources, private foundations, and a health insurance company. B’More for Healthy Babies reports that infant mortality rates in Baltimore have decreased by nearly 38% between 2009 and 2015.

To curb youth violence, BCHD leads a cluster of cross-sector initiatives through its Office of Youth Violence Prevention. The Operation Safe Kids program, for example, brings together the city’s juvenile justice system and the Mayor’s Office of Employment Development to provide case
management services to young people at high risk for being victims or perpetrators of violent crime.67

Another program, Safe Streets, uses street outreach workers to build relationships with at-risk youth and to mediate conflicts before they escalate to violence. The program, launched in 2007, has been implemented in four high-crime Baltimore neighborhoods by community organizations.68 A 2012 evaluation—the most recent available—found that this program reduced homicides and non-fatal shootings in these neighborhoods and adjacent communities.69

A third youth violence prevention initiative, the Centers for Disease Control and Prevention–funded Dating Matters, seeks to teach middle school children about healthy relationships to prevent teen dating violence. BCHD has partnered with 10 Baltimore schools to operate the program over a 5-year period ending in 2016.90

**OPIOID OVERDOSE PREVENTION**

To reduce the harm associated with use of heroin and other opiates,70 BCHD has led cross-sector initiatives such as Staying Alive, implemented in 2004.71 Through Staying Alive, BCHD partners with two nonprofit organizations to train individuals to administer naloxone, a drug that reverses the effects of opioid overdose.72 BCHD reports that in 2015 approximately 8,000 individuals received naloxone training.73

BCHD also collaborated with the city’s police department and Behavioral Health System Baltimore to implement a pilot program which trains new police recruits to use naloxone. In the 4 months during which officers carried naloxone in 2015, they administered it on 15 occasions.74 In the same year, Baltimore became the first jurisdiction in Maryland to expand access to naloxone through local pharmacies using a standing order.75

**NEIGHBORHOOD HEALTH AND SAFETY**

Several cross-sector initiatives directly address neighborhood-level environmental problems with the goal of improving residents’ health and safety. Initiatives to reduce environmental problems include the Clean Water Schools and Communities Project, the Vacants to Value Program, and the Green and Healthy Homes Initiative.

The Clean Water Schools and Communities Project seeks to reduce the amount of litter around five schools in neighborhoods with severe trash problems. Managed by the Baltimore Community Foundation, the initiative includes community groups in affected neighborhoods, local government, an environmental nonprofit focused on clean water, and a coalition focused on improving Baltimore’s waterfront.76

The Vacants to Value Program, implemented in 2010, is a mayoral initiative to rehabilitate vacant properties in low-income neighborhoods. As part of this program, Baltimore Mayor’s Office partners with real-estate developers to make the vacant properties livable and provides financial incentives to potential homeowners.77 A recent evaluation suggests that Vacants to Value is “making a difference in select city neighborhoods,” but notes that the city has “overstated” the program’s impacts.78

Finally, the Green and Healthy Homes Initiative (GHHI), founded in 2008 as a program of the Coalition to End Childhood Lead Poisoning, provides free services for low-income households, such as lead removal, weatherization, and mitigation of other safety hazards. GHHI also provides legal services, education on home safety issues, and home inspections to identify hazards.99 GHHI’s partners include Baltimore government agencies, federal government agencies, private foundations, and universities.99

**ROBUST HEALTH POLICY INFRASTRUCTURE**

Progressive health care policies at the state level, including Maryland’s unique hospital payment system and its acceptance of the ACA’s Medicaid expansion, have helped increase insurance coverage and access to quality care at the local level. Since 1977, all health insurers—including Medicare, Medicaid, and private insurers—have reimbursed hospitals in Baltimore and throughout Maryland according to identical, prespecified rates. In the rest of the United States, most hospital reimbursement policies require that different insurers pay different prices for the same care.

In January 2014, Maryland implemented an updated version of its hospital payment model.91 This objectives of this updated approach, known as the All-Payer Model or “global budgeting,” are to constrain per capita hospital spending growth in Maryland, reduce hospital readmission rates among Maryland’s Medicare beneficiaries, decrease rates of hospital-acquired conditions, and monitor population health.

Maryland also has implemented policies to increase health insurance coverage among low-income adults. Before the ACA’s passage, Maryland was one of a handful of states that offered publicly funded health insurance coverage to adults not otherwise eligible for Medicaid.92 In January 2014, Maryland implemented the ACA’s Medicaid expansion, which helped reduce Baltimore’s uninsured rate by an estimated rate of 56% between 2013 and 2016.8

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**Making a Sustained Impact on Health and Well-Being in Baltimore**

A number of agencies and organizations in Baltimore are partnering on cross-sector initiatives to address the city’s significant inequities in health and well-being. Additional surveillance, information gathering, analysis, and reporting will identify changes in health equity over time in Baltimore, examine the impact of the city’s many cross-sector initiatives on overall population health and health equity, and describe how public health priorities and initiatives evolve.

The following questions could provide insights into the degree to which meaningful change is taking place and can be sustained:

- How have key indicators of health equity in Baltimore changed over time? Which key indicators have changed most significantly, and
which ones have not?

- Have barriers and facilitators been identified that increased health equity in Baltimore? Which ones contribute most significantly?

- Which new cross-sector partnerships have emerged that show improvements in the health and well-being of Baltimore’s residents? Which cross-sector partnerships are led by universities, and what are the health and well-being impacts of these university-led initiatives?

- Baltimore elected a new mayor in fall 2016. To what extent have public health priorities shifted under a new mayoral administration, and how are current health and well-being initiatives be sustained or changed?

- What are the interrelationships among various initiatives to improve public health and well-being in Baltimore? Is there coordination across initiatives?
References

35. Author's comparison of Prison Policy Initiative report with demographics from Baltimore City Health Department Neighborhood Health Profiles (http://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports)


