City of Baltimore
Community Health Assessment (2010-2015)
Baltimore City Health Department
www.baltimorehealth.org

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Introduction and background

Since 2009, the Baltimore City Health Department (BCHD) has conducted a comprehensive process for assessing the health of the community it serves, setting goals on how to improve health, and convening partnerships to help the city reach these goals. BCHD utilized a three-pronged approach to create a comprehensive assessment of the city's health status and targets. Each of these approaches has been grounded in community-level feedback and guidance and recognizes that the health status of our city's residents is inter-connected with other major social determinants. The three phases, which together make up the Community Health Assessment, are as follows:

- The Community Health Survey: The CDC's Behavioral Risk Factor Surveillance System (BRFSS) survey does not have adequate response rates from Baltimore City to provide any city level data. To fill this gap, the BCHD conducted the city's first community health survey in 2009 (results published in 2010) in order to gain city-specific information on the incidence and prevalence of a variety of health conditions and behaviors. It will be repeated every 2-3 years.

- Neighborhood Health Profiles (NHPs): Resident socio-demographic, health, and economic status vary widely in Baltimore City, and statistics aggregated at the city level do not reflect the true health status of the city. In 2008, the BCHD published NHPs, which provide health status information by community statistical area (CSA), which is a geographical areas based on a cluster of recognizable city neighborhoods. CSAs were developed by the City's Planning Department. The 2011 profiles added data on social determinants of health. The NHPs enable comparisons of health determinants and outcomes, revealing health disparities and showing where there is the greatest need. The NHPs will be updated and published every 3 – 5 years.

- Healthy Baltimore 2015 (HB 2015) is Baltimore City's comprehensive health policy agenda. Published in 2011, it articulates priority areas, where the health department and its partners can have the greatest impact on reducing morbidity and mortality and improving the quality of life of city residents. The priority areas highlight how improving where residents live, work and play can have a greater health impact than direct medical care. HB 2015 utilized data from a wide variety of sources to measure social, economic and health indicators that can be tracked over time to show progress towards each indicator's goal.

The overall vision for the community health assessment and health policy agenda is to be a city where all residents realize their full health potential.

Overview of the Healthy People 2020 Framework (www.healthypeople.gov) **and Baltimore City's Community Health Assessment**

Baltimore's Community Health Assessment is modeled on the U.S. Department of Health and Human Services' (HHS) Healthy People 2020 framework, which envisions a society where all people live long, healthy lives. Healthy People 2020's mission is to:

- Identify nationwide health improvement priorities;
- Increase public awareness and understanding of the determinants of health, disease, and disability, and opportunities for progress;

- Provide measureable objectives and goals that are applicable at the national, state, and local levels,
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge; and
- Identify critical research, evaluation and data collection needs.

Its overarching goals are to:

- Attain high-quality, longer lives free of preventable disease, disability, injury and premature death;
- Achieve health equity, eliminate disparities, and improve the health of all groups;
- Create social and physical environments that promote good health for all; and
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

BCHD's community health assessment shares many of the same goals and reflects the following key features of the national framework:

- <u>Importance of a determinants approach to health</u>: Healthy People 2020 recognizes that health and health behaviors are determined by factors at multiple levels, from the personal to the environmental and policy levels. All three pieces of Baltimore City's community health assessment take into account distal factors that affect health outcomes - from environmental determinants like housing and neighborhood characteristics, to issues of access to health care and individual behaviors.

- <u>Focus on health disparities</u>: Underlying Healthy People 2020's determinants approach is a continued focus on health equity and eliminating disparities. The BCHD community health assessment aims to provide information on health determinants and outcomes broken down by race/ethnicity, socioeconomic stats, sex, age and geographical location. According to what information is available, Healthy Baltimore 2015's benchmarks are also disaggregated by demographics so that the city can measure its progress in reducing disparities as well as in improving overall health outcomes.

- <u>Measureable objectives</u>: For over 30 years, Healthy People 2020 has established national benchmarks and monitored progress over time in a wide variety of health areas. Baltimore's community health assessment also recognizes that the purpose of compiling and disseminating health assessment data is to use it, and HB 2015 sets city-wide objectives in a subset of priority health areas and targets to measure progress over time.

- <u>Collaboration</u>: Healthy People 2020 was developed through a collaborative process, and its focus on ecological factors of health requires action from partners across sectors and not just through traditional health actors.   Similarly, HB 2015's priorities are those of the entire city, and not just those of the health department. Achieving its goals requires collaboration between city agencies, state and federal levels of government, health care providers, community-based organizations, academic institutions, and city residents. The information contained in the community health assessment is meant to empower and motivate these actors to action.

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<u>Mapping between Healthy People 2020 and Baltimore City Community Health Assessment documents</u>

Healthy People 2020 uses four foundation health measures to monitor progress towards its goals over promoting health, preventing disease and disability, eliminating disparities, and improving quality of life. Table A outlines these foundation health measures and where this data can be found in Baltimore City's community health assessment (if applicable). Please see http://www.healthypeople.gov/2020/about/tracking.aspx for complete definitions of the foundational health measures.

Table A

Healthy People 2020 Foundational Health Measure	CHA document in which this health measure is found and what health measure is included
General health status • Life expectancy • YPLL • Physically and mentally unhealthy days • Self-assessed health status • Limitation of activity • Chronic disease prevalence	• Neighborhood Health Profiles (NHP) • NHP • HB 2015 • Community health survey • N/A • CHS: Obesity and diabetes self-reported, asthma Neighborhood profiles and HB 2015: Rate of premature deaths from cardiovascular disease
Health-related quality of life and well-being	• Comm. Health survey: self-reported data on overall health by race, gender, age, and SDoH; percentage of respondents who reported feeling socially isolated • HB 2015: Percent of adolescents expressing feelings of sadness or hopelessness.
Determinants of health • Social and physical determinants • Access to health • Individual behaviors • Genetics / biology	Social and physical determinants • Comm. Health survey: Self-reported measures on neighborhoods and homes (dangerousness, roaches, CO detectors); Food and energy security. • NHP: Socio-economic characteristics, education, built and social environment, housing, food environment. • HB 2015: Supermarket access; juvenile homicide and non-fatal shooting victims; school readiness; neighborhoods (vacant building and liquor outlet density). Access to health • Comm. Health survey: Access to health care (insurance, obtaining adequate medical and mental health care). • HB 2015: Access to quality health care, unmet mental health care needs; early detection of

	cancer.
	Individual behaviors • Comm. Health survey: Food and diet; physical activity; smoking; substance abuse; condom use; maternal and child health. • HB 2015: Smoking; physical activity; drug use and alcohol abuse; teen birth rate. **Genetics / biology** • Limited demographic information – age, sex, HIV status - contained in all three documents.
Disparities • Race/ ethnicity, Gender, Geography	Comm. Health survey: Provides results stratified by age, sex, race, SES factors (education, income, and other various). NHP: Geography HB 2015: Baseline and targets usually stratified by race, occasionally also by sex and SES factors, depending on the information available.

Summary of Baltimore City demographics and general health issues

The 2011 Neighborhood Health Profile for Baltimore City contains city-wide demographic and socio-economic information (unless otherwise noted, this document contains citations and a description of all data sources). According to the 2010 US Census, Baltimore City had a total population of 616,802, making it the largest city in Maryland. 21.6% of the population is under the age of 18; 66.5% is between 18 and 64, and 11.8% of the population is aged 65 and above. 53.3% of Baltimore City's population is female. Baltimore City is a majority black city, with African-Americans making up 63.3% of the population (compared to 29.4% for Maryland). Non-Hispanic whites represent 29.7% of the city's population (vs. 63.7% for Maryland), and Hispanics / Latinos and Asians make up 4.2% and 2.4% of the population respectively (vs. 8.2% and 5.5% for Maryland).

Baltimore City is Maryland's poorest county, with a median household income of $37,395 compared to a state median of about $72,419.[1]   About 22.4% of people in Baltimore live below poverty level, compared to 9% statewide.[2] Baltimore City's health outcomes are similarly worse when compared to the rest of the state. For example, Baltimore City's life expectancy is 71.8 compared to that of Maryland's (78.7), and the infant mortality rate in 2010 was 12.2 per 1000 live births, compared to a statewide proportion of 6.7 / 1000.[3]

The top five causes of death in Baltimore City are the following: Heart disease (25.8% of all deaths), cancer (all types – 23.1%), stroke (5.2%), HIV/AIDS (3.9%) and chronic lower respiratory disease (3.9%). While heart disease and cancer mirror trends in the rest of the state and

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[1] http://quickfacts.census.gov/qfd/states/24000.html
[2] Ibid.
[3] Maryland State Health Improvement Process 2012 update, available at:
http://dhmh.maryland.gov/ship/PDFs/Maryland%20SHIP%202012%20Update%2039%20measures.pdf

country, the top five causes of death for those under age 75 include homicide, HIV/AIDS and drug-induced deaths, which show particular challenges that Baltimore City faces.

Sub-population health issues

While Baltimore City generally has worse health outcomes than the rest of the state, there is wide internal variability. Figure 1 below the range of life expectancy found in Baltimore City. In the neighborhoods with the shortest life expectancy, residents can expect to die more than 20 years earlier than in the neighborhoods with the longest life expectancy. Upton / Druid Heights is 94.3% black or African-American with a median income of $13,388, while Greater Roland Park / Poplar Hill is 79.5% white with a median income of $90,492.

Figure 1
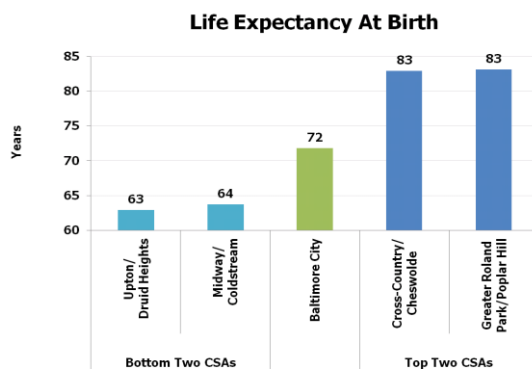
These statistics highlight the importance of collecting information on sub-populations to reveal health disparities.   Towards this end, the Community Health Survey reports results according to different demographic and socio-economic subgroups. Each of the 55 neighborhood profiles (http://www.baltimorehealth.org/neighborhoodmap.html) provides neighborhood-specific information and comparison to city-wide data on demographics, socio-economic characteristics like income and education, built and social environment indicators, and health outcomes. Finally, Healthy Baltimore 2015's indicators and targets are disaggregated by race and age whenever possible, and reporting against this framework will highlight progress made or not made within sub-groups.

A few key findings on sub-population health from the CHS and NHPs include the following (see survey and profiles for more details):

- General health status: A total of 20% of all respondents reporting being in "fair" or "poor" health. However, those with less than a B.A. were 3 times more likely to report being in "fair" or "poor" health, and those in the lowest income quintile were 4 times more likely than those in the highest income group to report being in "poor" or "fair" health.

  For chronic health conditions, those in the lowest income group were 2.4 times more likely to report being obese and 3.7 times more likely to report having diabetes than those in the highest. Additionally, blacks were 85% more likely to report having diabetes than whites. Using information from the Neighborhood Health Profiles shows the difference in percent of premature deaths due to heart disease in the bottom and top 2 ranked CSAs. Demographic and socio-economic information can be found in each NHP.

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Figure 2

Percent of Premature Deaths Due to Heart Disease
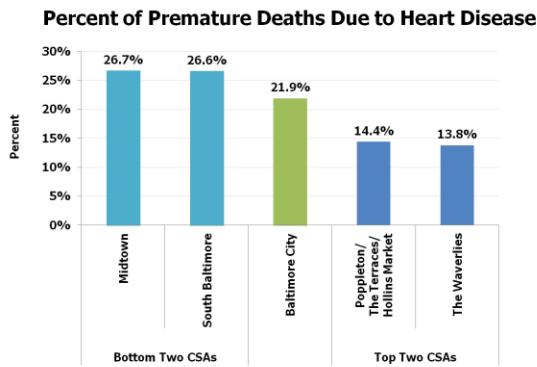
- <u>Health behaviors</u>: Those with less than a BA were 3 times more likely than those with a BA or higher to reporting eating "very unhealthy" in the last week. Those in the lowest income group were also 2.4 times more likely than those in the highest income group to report being current smokers.

- <u>Social and environmental factors</u>: Those in the lowest income group were 14 times more likely than those in the highest income group to report their neighborhood being "very dangerous", and black respondents were 3 times more likely to report their neighborhoods as "very dangerous." Blacks were also 2 times more likely to report concerns about having enough food. The NHPs show disparities in the built environment that likely affect health outcomes:
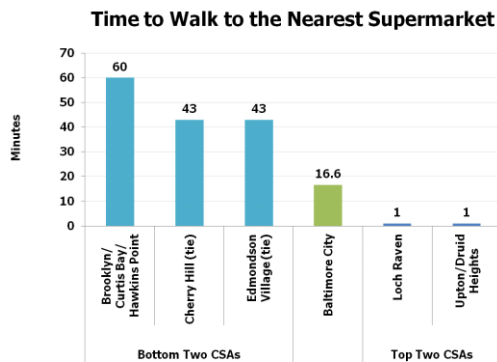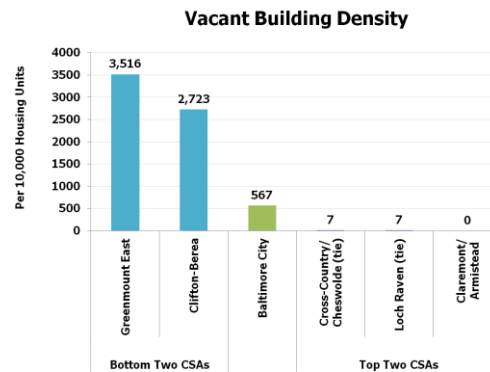
Figure 3   Figure 4

Time to Walk to the Nearest Supermarket

Vacant Building Density

- <u>Access to health</u>: Blacks were 2 times more likely than Whites to report being uninsured, and 4 times more likely to report having had unmet mental health needs.

<u>Priority Areas and Indicators</u>

The Healthy Baltimore Priority Areas were also based on Healthy People 2020. Priority areas were selected on the basis of two main criteria: whether or not they were major drivers of preventable disease, disability and death in Baltimore City; and if these areas had related evidence-based interventions that could lead to their improvement and data sources that enabled measurement of progress. The selected priority areas went through an internal vetting process, with assistant commissioners and program directors drawing on the partnerships and

coalitions with whom they already worked. BCHD also convened stakeholders by drawing on a number of content experts from the Johns Hopkins School of Public Health who reviewed Healthy Baltimore 2015 for consistency with the latest public health research and alignment with national priorities.

Maryland's State Health Improvement Plan (SHIP) for 2011-2014 (available online here) is also a subset of the national health agenda's objectives. SHIP objectives and targets were selected to reflect areas in which Maryland has poorer health outcomes than its neighbors. The final plan also incorporates public comments made on a draft version. There is substantial overlap between the objectives and indicators included in SHIP and Healthy Baltimore 2015. Indeed, the health areas in which the state is weak are also largely those where its most populous city faces challenges and disparities.

Annex 1 of this report is a crosswalk of the priority areas and indicators contained in the National Prevention Strategy, Healthy People 2020, SHIP and HB 2015. While there are many similarities between all of the frameworks, HB 2015 does sometimes differ. This generally occurs when BCHD seeks to either 1) measure an illness or condition in a particular population (for example, decrease rates of Gonorrhea and Chlamydia in adolescents vs. Reduce Chlamydia infections), or 2) use a different, city-specific data source (e.g., decrease inequities in supermarket access vs. increase access to healthy foods). Additionally, HB 2015 disaggregates baselines and targets by race or SES whenever possible, which is in line with the community health assessment's focus on health disparities.

Process and partnerships

The Community Health Survey is modeled on national surveys like the Centers for Disease Control and Prevention's Behavior Risk Factor Surveillance System (BRFSS). The sampling strategy involves targeting both cell phone and landline users, which is consistent with the BFRSS methodology used by the CDC.

The BCHD will be conducting its next Community Health Survey in the spring of 2013. The questionnaire is based on that used in 2009 in order to maximize comparability of results over time. However, some questions have been added and modified to target current issues, such as the impact of the new healthcare laws on the care available to Baltimore City residents.

The Community Health Survey is being planned with technical assistance from Johns Hopkins Bloomberg School of Public Health, which was involved in the survey's first iteration. Survey results will be fed back to the communities directly and also be made available through the BCHD website.

The Neighborhood Health Profiles were originally compiled in 2008 and revised in 2011. They were developed by the BCHD's Offices of Epidemiology and Planning in partnership with the Johns Hopkins Bloomberg School of Public Health. The Neighborhood Health Profiles use a variety of data sources, including from the Maryland Vital Statistics Administration at the Department of Health and Human Hygiene, the US Census, the Baltimore Neighborhood Indicators Alliance, and the Maryland Department of the Environment.

There are a total of 55 profiles for each of the Community Statistical Areas (CSAs) in Baltimore City. Developed by the City's Planning Department, CSAs are geographical areas that are based on recognizable city neighborhoods. Each CSA profile is divided into four sections: The first section provides an overview of demographic information; the second section outlines health

outcomes; the third section provides information on maternal and child health, and the last section summarizes how each neighborhood compares to the city as a whole across major health indicators.

The profiles will be updated and revised every three to five years, and additional indicators will be added when possible. Community members provide feedback on the profiles at neighborhood health meetings, which will be considered during the subsequent revision. In the years between full revisions, shorter reports that update the indicators most relevant to the communities will be published.

Healthy Baltimore 2015, the city's health policy agenda, was developed in partnership with a variety of partners:

- City agencies (Health Services Cost Review Commission, Baltimore City Police Department, Baltimore City Liquor Board, Mayor's Office of Information Technology);

- Maryland's Department of Health and Mental Hygiene;

- Academic institutions (Morgan State University's School of Community Health and Policy, Johns Hopkins University's Bloomberg School of Public Health);

- Health care systems and providers (Union Memorial Hospital, St. Agnes Hospital, Johns Hopkins Hospital, Bon Secours Hospital, Good Samaritan Hospital, University of Maryland Medical Center, Mercy Medical Center, Sinai Hospital, Harbor Hospital, and Maryland General Hospital); and

- Non-profit organizations (Maryland Health Care Access, Baltimore Substance Abuse Systems, and Baltimore Mental Health Systems).

These partners helped provide data to and feedback on Healthy Baltimore 2015.

Dissemination of community health assessment and Healthy Baltimore 2015

After Healthy Baltimore 2015 was published in May 2011, BCHD sought to widely disseminate the city's community health assessment and health policy agenda. BCHD's dissemination strategy targeted three main audiences, with the expectation that each would be involved in implementing efforts to meet health goals: health stakeholders, government agencies, and residents.

Health Improvement Planning Council (HIPC)

In order to improve coordination and collaboration between the city's large and diverse group of health stakeholders, the BCHD formalized its relationship with them through the Health Improvement Planning Council (HIPC).

HIPC is a senior advisory body to the BCHD. It is composed of 32 members who represent a wide range of health stakeholders, including: community groups, non-governmental organizations, academic institutions, healthcare systems and hospitals, insurance companies, and private foundations. The body is charged with helping the BCHD address the city's most pressing health challenges by:

- Prioritizing Healthy Baltimore areas;
- Identifying and developing strategies to improve health outcomes; and
- Guiding the implementation of interventions.

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In addition to providing strategic direction on how to reach Healthy Baltimore 2015 goals, the HIPC is also responsible for reporting against the SHIP objectives on a quarterly basis to ensure alignment. The HIPC emphasized the importance of ensuring community engagement throughout the assessment, planning and implementation process.

Cross-Agency Health Taskforce (CAHT)

When HB 2015 was launched, Baltimore City's mayor, Stephanie Rawlings-Blake charged each government agency to help improve where Baltimore residents live, work, learn and play in order to make health impacts. In response, the BCHD established CAHT, which is a group made up of representatives from all city agencies, and presented the community health assessment to them. CAHT holds that each agency should promote health through policies, programs, standard operating procedures, and practices that reflect the agency mission and builds from existing organizational infrastructure. The group meets on a monthly basis and works together to promote cross-sector efforts supporting Healthy Baltimore 2015's priority areas.

Neighborhood Health Initiative (NHI)

The goal of the Neighborhood Health Initiative is to strengthen the relationship between the BCHD, other city agencies, and the community to realize neighborhood health improvements and HB2015 goals. To accomplish this, the Neighborhood Health Initiative first focused on presenting residents with neighborhood-specific health and social determinant data and prioritizing top health concerns based on their feedback, and assessing community capacity and readiness.

Between January and May 2012, one community meeting was held in each of the city's fourteen council districts. BCHD staff facilitated the meetings, with each district's City Council representative and staff from other city agencies, like the Departments of Transportation and Parks and Recreation. The aim of this first phase of meetings was to share the data contained in each district's neighborhood health profiles, identify the residents' priorities through facilitated discussion and a ranking exercise, and also learn about best practices in each neighborhood. BCHD explained it wanted to improve collaboration in order to better use existing resources and ensure community engagement as new opportunities emerged.

When asked about their health concerns residents' discussions often revolved around environmental factors like being employed, having access to affordable and high quality food, liquor outlet density, and feeling safe in their neighborhoods. The emphasis on their daily, lived experiences rather than specific diseases reinforced the importance of addressing social determinants of health with a cross-sector approach. For example, when discussing what their community needed to address childhood obesity, participants mentioned conventional public health programming like behavior change interventions, as well as distal factors like having recreational centers that helped children fill their free time with healthy, physical activities.

From June to October 2012, a second phase of meetings was held in 11 of the 14 council districts. Additional time was spent narrowing down health priorities from ten to three (see next section), identifying resources that were already working in the neighborhoods, and discussing ways community work on health issues could be supported. People interested in being closely involved in the Healthy Baltimore 2015 agenda were also identified as potential health champions.

Prioritization of health areas and health improvement planning and implementation

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Ranking results

The HIPC and CAHT members and all of the neighborhood residents attending the community meetings were asked to rank the Healthy Baltimore 2015 areas in order of importance. The BCHD originally considered employing the Hanlon prioritization method, which compares different health problems in a relative framework, as equally as possible. After considering the large number of participants and the limited time allotment, however, Dr. Carlos Castillo-Salgado, the BCHD's senior advisor from the Johns Hopkins Bloomberg School of Public Health, ultimately recommended using a simpler nominal ranking method.

For HIPC and the neighborhood health meetings, a list of 34 health concerns was drawn out of HB 2015's ten health priority areas (some areas encompassed several distinct health issues). In the HIPC meeting, Dr. Castillo-Salgado facilitated a prioritization process to come up with a council-wide list of ranked health concerns. In the neighborhood meetings, each participant was asked to rank their top ten health concerns privately on an individual form, and the results were later compiled and shared back with residents during the second community meeting. For CAHT, members ranked their top three overall health priority areas, while also considering the potential impact their agency could have. The results for HIPC, CAHT and each council district (first and second rounds of ranking) are contained in Annex 2.

After the prioritization exercise helped narrow down the health areas that were most important to each group, planning on how to address these health concerns and implementation will happen through each body. These efforts will be collectively captured in a Community Health Improvement Plan (CHIP), which is currently in the process of being documented.

Health Improvement Planning Council (HIPC)

The HIPC's top three health concerns were 1) Adults dying too young from heart disease; 2) Adults getting the medical care they've needed in the past year; and 3) Babies dying before their first birthday. The first priority area – heart disease – is also linked to efforts in smoking cessation, physical activity, and improved diet. In 2013, the HIPC will meet on a quarterly basis and begin focusing on health improvement planning and implementation by: 1) sharing what the organization that represent already do in the top health priority areas and identify potential partnerships across the city to improve existing efforts; and 2) developing new evidence-based strategies on how to tackle the health areas and make commitments on behalf of their organization toward these strategies. Additionally, the HIPC will guide implementation efforts coming out of CAHT and the Neighborhood Health Initiative, no matter the health area. It will also review and approve the Community Health Improvement Plan, and monitor its implementation progress.

Cross-Agency Health Taskforce (CAHT)

The CAHT's number one priority area was, "Redesigning communities to combat obesity." Since it is a new body, and for most agencies, a truly different way of working together across sectors, the CAHT decided to further hone in on promoting physical activity city-wide. What this means for each individual agency varies by that agency's mission, however a Health in All Policies approach suggests the need to consider the role that each agency can play in making our the built and social environment in our communities more supportive of physical activity. Currently, each agency has committed to a series of activities around promoting physical activity within their respective arenas. As the task force gains experience in using a Health in All Policies approach, its mandate will grow to cover other aspects of combating obesity, like improving access to healthy food.

Neighborhood Health Initiative (NHI)

Each council district came up with its own top three concerns. Some of the issues most commonly prioritized included adults dying too young from heart disease, vacant buildings in the neighborhood, and HIV/AIDs. Going forward, the NHI will move from assessment and prioritization to planning and implementation in the following ways:

- Building community capacity: One of NHI's goals is to identify community champions that can take the lead in assessing their own community's needs and implementing local initiatives, are willing to work collaboratively with other neighborhoods towards common goals for larger communities of people, as well as form a core group of contacts that will work more closely with the health department on developing new funding opportunities and programming.

  The BCHD is currently preparing a workshop for community representatives designed to strengthen the ability of community residents and Community Health Workers to better communicate health needs and improve access to care and case management.

- Facilitating ongoing feedback and communication between BCHD and communities: The NHI is currently developing and implementing a communications strategy. The first component is an interactive e-newsletter to be piloted in the spring of 2013 that will highlight neighborhood projects that impact health. The goal is to connect communities across the city, spotlight best practices, link residents to capacity-building training and resource opportunities, and inform on local and regional health intervention trends and developments.

- Driving local, place-based interventions that are in line with the community's stated priorities, and capacity and readiness: NHI is helping start interventions in a variety of ways.

  - Leveraging existing resources: For example, in areas that prioritized cardio-vascular health concerns, NHI is collaborating with the Parks and Recreation Department to provide bicycle programming, nutrition education, and youth engagement.

  - Connecting communities with new programs and resources that become available, no matter the health area: The Delmarva Foundation is piloting a CMS special innovation project to provide nutritional counseling to older adults at two sites in Baltimore City. The Neighborhood Health Initiative connected them to interested groups in the Oliver and Poppleton communities.

  - Guiding neighborhood-based health interventions through representation and collaboration with local partners: BCHD serves on the West Baltimore Primary Care Access Collaborative (WBPCAC) steering committee, which was recently designated as one of Maryland's Health Enterprise Zones (HEZ) by the Maryland Department of Health and Mental Hygiene (DHMH) and the Community Health Resources Commission. As a HEZ, WBPCAC will carry out clinic and community-based interventions to reduce cardiovascular disease and associated disparities in West Baltimore.

    BCHD also collaborates with the Urban Health Institute's Community Health Initiative to guide and develop their Community Health Assessment that aims to improve the health and well-being of residents of all ages who live in East Baltimore through sustainable health partnerships and specific health interventions.

- <u>Working with HIPC and CAHT to ensure that the community perspective is represented and health prioritizations in neighborhoods are considered</u>: For example, the NHI helped connect residents and community groups to the Departments of Planning and Health's policy efforts to reduce corner store and liquor outlet density in areas that prioritized them as concerns, such as Park Heights and Frankford. Additionally, Plans are underway for a CAHT intervention in Park Heights that will incorporate community feedback and solicit community participation through NHI contacts.

Summary of assets and resources

The Community Health Assessment and Improvement Plan will draw on existing resources as much as possible. During the second group of community meetings, residents were asked to talk about what was already working well in their neighborhoods. The groups and things most commonly cited were neighborhood associations, churches and the faith community, and hospitals or clinics. Other assets that were mentioned included schools and academic institutions, libraries, community gardens and farms, bike lanes, parks and other open spaces that encouraged exercise, and senior centers. City-wide maps and / or lists of these resources are contained in Annex 3. Interestingly, none of the neighborhood meetings mentioned city agencies, including the health department, as assets. Residents often requested that the health department offer more outreach activities, like nutrition education and exercise classes, in their neighborhoods. Since the BCHD currently does not have the resources available to offer more outreach, it is important for it to consider other ways to improve its community presence. Some suggestions included providing:

- A web-based clearinghouse of health resources that provide both content information and existing programs or resources by neighborhood and health topic;
- Build local capacity by providing trainings on how to apply for grant funds and conduct monitoring and evaluation;
- Help improve existing programs sponsored by other groups more accessible for a range of audiences, including youth and those with literacy issues;
- Coordinate efforts with other city agencies and institutions to either provide services in their neighborhoods or to make changes at the community level (for example, improving public transportation or improving street lighting).