

**Philadelphia Comprehensive School Health Initiative
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2. Memoranda of Agreement

- A. List of Community Planning Committee
- B. Michael Smith, PATHS/PRISM
- C. Joan M. Reeves, City of Philadelphia, Children and Families Cabinet
- D. Estelle B. Richman, City of Philadelphia, Department of Public Health
- E. David A. Ricci, The Germantown Hospital and Medical Center
- F. Judy L. Brody, Northwest Region, School District of Philadelphia
- G. Emanuel V. Freeman, Germantown Settlement
- H. Deitra E. Spence, Robert Fulton Elementary School
- I. John S. Hackman, John B. Kelly Elementary School
- J. Carol A. Mullin, Anna Lane Lingelbach School
- K. Samuel J. Gotlieb, Clarence E. Pickett Middle School
- L. Barbara Daly, John Wister School

3. Staff Resumes

- A. Gina L. Blyther, Program Officer
- B. Stephen R. Cox, Director
- C. Elizabeth L. Useem, Senior Fellow
- D. Michael Smith, Executive Director

4. Tax Exempt Certificate

5. Financial Statements for LEF

PATHS/PRISM, 1994 Annual Report
PATHS/PRISM, 1993 Annual Report

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Community Assessment Report

Introduction

The School District of Philadelphia and the Mayor's Cabinet on Families and Children have been working to implement comprehensive school health programs at a number of sites across Philadelphia over the past five years. There is a growing support for building a district-wide comprehensive school health program. The recently appointed Superintendent of Schools David Hornbeck places particular emphasis on the importance of building connections between schools and social and health services in three of the goals set forth in "Children Achieving" -- his vision for school reform in Philadelphia.

Philadelphia's Community Assessment combines city-wide data with neighborhood specific data. As PATHS/PRISM began the community assessment process, we discovered that a comprehensive assessment of community health needs had already been conducted in the Northwest Region of Philadelphia. In addition, we learned that the City of Philadelphia is establishing a number of Family Centers across the City and the School District is establishing one community school in each of six regions. Therefore we have elected to compile city-wide statistical data but to use the qualitative needs assessment carried out in the Northwest Region as the basis for fulfilling the requirements of the Community Assessment.

The following is a list of written data sources which we used to compile our Community Assessment:

Philadelphia Department of Public Health, *Vital Statistics Report*, 1991;

School District of Philadelphia, *Board Budget Review of the Division of School Health Services*, January 18, 1994;

PCCY, *Our Village Our Children: A Report to Philadelphia about its Children*, 1993;

School District of Philadelphia, *Youth Risk Behavior Survey*, 1993;

City of Philadelphia, Department of Public Health, *AIDS Surveillance Quarterly Update: September 30, 1994*.

Partners for a Healthy Community: Health Assessment for Northwest Philadelphia and Adjoining Suburbs is the primary source of our Community Assessment Protocol qualitative data. We have attached a complete copy of this report. While this assessment examines the health needs of the entire community not just those of school-aged children, it places a particular

emphasis on the needs of young children and adolescents. This assessment involved over 800 residents of Northwest Philadelphia as well as representatives of city-wide agencies in an eight-month study process. The report describes the processes and methodologies that were used to conduct this study as follows:

"The Community Picture: The project involved the compilation and analysis of census data, vital statistics, communicable disease rates, crime rates, hospital discharge and household survey data. That analysis provide a view of the health status of the community, and of resources and their use by the varied populations within it.

Interviews with Professionals and Community Leaders: Seventy-five people were interviewed in depth for the assessment. They included physicians, school officials, social workers, health educators, neighborhood association representatives, political and business leaders. Interviews lasted from 45 minutes to two and a half hours and dealt with both priorities and strategies for community health improvements.

Focus Groups: Four groups were selected which were particularly important to identify both health needs and the ways that resources are used to meet those needs. Representatives of these groups met together to discuss their perspectives on needs and priorities. These groups included caregivers of young children; adolescents; primary care physicians; and a group of men in a rehabilitation program with personal experience with drug abuse, crime and violence in the community."

Philadelphia's Community Assessment Protocol Report includes city-wide information not included in the *Partners for a Healthy Community Needs Assessment*. This information is organized as requested in the Community Assessment Protocol document provided by PEFNet.

Morbidity and Mortality Statistics

Causes of Death

In 1991, the *leading causes of death* for children and young adults were as follows:

Ages 1-5

Accidents and Adverse Effects of Drugs	24	34.3%
Congenital Anomalies	10	14.3%
Conditions Originating in Perinatal Period	6	8.6%
Malignant Neoplasms	5	7.1%
Diseases of the Heart	4	5.7%
Homicide and Legal Intervention	4	5.7%
Pneumonia and Influenza	3	4.3%
<i>Total Deaths (1-5)</i>	<i>70</i>	

Ages 5-14

Accidents and Adverse Effects of Drugs	29	45.3%
Diseases of the Nervous System & Sense Organs	6	
Diseases of the Heart	5	7.8%
Infectious and Parasitic Diseases (Other than TB, HIV, Syphilis, Septicemia, & Viral Hepatitis)	5	7.8%
Human Immunodeficiency Virus	3	4.7%
Homicide and Legal Intervention	2	3.1%
<i>Total Deaths (5-14)</i>	<i>64</i>	

Ages 15-24

Homicide and Legal Intervention	141	44.9%
Accidents and Adverse Effects of Drugs	74	23.6%
Suicide	28	8.9%
Human Immunodeficiency Virus	11	3.5%
Diseases of the Nervous System & Sense Organs	8	2.5%
Diseases of the Heart	8	2.5%
Malignant Neoplasms	7	2.2%
<i>Total Deaths (15-24)</i>	<i>314</i>	

In 1991, the *ten most frequent causes of death for all age groups* combined are in order of most to least frequent:

- Diseases of the Heart
- Malignant Neoplasms
- Cerebrovascular Disease
- Accidents and Adverse Effects of Drugs
- Chronic Obstructive Pulmonary Disease
- Septicemia Diabetes Mellitus
- Pneumonia and Influenza
- Homicide and Legal Intervention
- Human Immunodeficiency Virus Infection

This data is drawn from the Philadelphia Department of Public Health Vital Statistics Report, 1991, (49, 52-57). See Figure 1.

AIDS Prevalence

The total cumulative number of AIDS cases in the City of Philadelphia is 6,522.

The cumulative number of AIDS cases by age group is:

Under 13	107
13-19	31
20-29	1,303

This data is drawn from AIDS Surveillance Quarterly Update, 9/30/94 (7) which is prepared by the Epidemiology Unit of the AIDS Activities Coordinating Office, Department of Public Health, City of Philadelphia. See Figure 2.

Sexually Transmitted Diseases

During 1993, the incidence of sexually transmitted disease(s) (STDs) among all adolescents and for all age groups combined is as follows:

<u>Disease</u>	<u>Age Group</u>		<u>All Ages</u>
	<u>10-14</u>	<u>15-19</u>	
Chlamydia	314	3,964	10,053
Gonorrhea	223	2,542	10,465
Primary Syphilis	0	7	190
Secondary Syphilis	1	28	325

This data is drawn from the Philadelphia Department of Health, Report of Civilian Cases of Sexually Transmitted Diseases, 1993. See Figure 3.

Adolescent Pregnancy Rates

In 1992 the total number of pregnancies and pregnancy rates were as follows:

	<u>Number</u>	<u>Rate per 1,000 Females</u>
10-14	436	9.09
15-17	3,497	121.18
18-19	4,398	208.54

This data is drawn from a report compiled by the Research Department of the Family Planning Council of SE/PA. See Figure 4.

Youth Risk Behavior Survey (YRBS) Data

The School District of Philadelphia has taken a lead role in analyzing the risk behaviors of its students. During the spring of 1993, the District administered the 84-item multiple choice YRBS to approximately 1,500 public high school students. YRBS survey. Survey administration procedures were designed to help protect the privacy and confidentiality of all participating students. Student participation was voluntary.

Key findings related to sexual risk taking behaviors:

- 87% of all students reported been taught about HIV/AIDS in school.
- 71% of all students reported ever having had sexual intercourse.
- 26% reported having had sexual intercourse prior to age 13.
- 36% reported having had sexual intercourse with four or more people.
- 42% reported using condoms or whose partner used condoms during the last sexual intercourse.

These data provide the School District with valuable baseline information about high school students' health risk behaviors that can assist in the identification of ongoing needs for developing appropriate health education programs and services.

In subsequent years, the YRBS will be administered annually in grades seven and eight and senior high schools in order to monitor priority health-risk behaviors, thus enabling support for effective and efficacious programmatic decision-making relative to curriculum, instruction and services. The School District will be working with Temple University and the Family Planning Council of Southeast Pennsylvania on these future evaluation projects.

See Attachment C in this Appendix.

Laws, Regulations and Policies Governing the Eight Components of Comprehensive School Health Programs

There are four tiers of law, regulations and policy governing schooling in Pennsylvania, and which may bear upon one or all of the eight components of Comprehensive School Health Programs.

A. **"The Public School Code of 1949,"** [Act of 1949, P.L. 30, No.14], as amended, provides the statutory authority for public schooling in Pennsylvania as enacted by the General Assembly of the Commonwealth of Pennsylvania.

1. Health Education: Under Article XV of the Public School Code, "Terms and Courses of Study," Section 1511 mandates that in every public and private elementary school "safety, health, including physical education and physiology" shall be taught.

Section 1513, Physiology and Hygiene, further stipulates that "special reference to the effect of alcoholic drinks, stimulants, and narcotics upon the human system" shall be included.

The Office of Health Education of the School District of Philadelphia is responsible for the implementation of this Section.

2. Health Services: Sections 1401 to 1422, (Article XIV) [added July 15, 1957, P.L. 937, No. 404] pertain to "School Health Services." In this section, schools are required to have school nurses, physicians and dentists to perform a variety of health tests and screening which include: hearing, vision, height and weight, tuberculosis, dental exams, vaccinations, and "such other tests as the Advisory Health Board may deem advisable."

The Division of School Health Services of the School District of Philadelphia is responsible for implementing this Article with a workforce of 234 nurses and six regional supervisors for over 200,000 students K-12. The School District provides nursing services for all schools, although almost all schools share nursing service. The nurses provide a wide-range of services including: prevention of illness and injury; case finding; identification of risk factors; facilitation of access to health care; follow-up; and health promotion. The District also hires ten physicians who provide physical examinations, serve as medical consultants, and provide medical clearances for events such as Special Olympics. Finally, the District hires 17 dental hygienists to conduct prevention and screening activities.

3. Physical Education: See Section 1511 above.

4. Counseling and Mental Health Services: There is no specific

language in the Public School Code referring to counseling and/or mental health services, although it appears that such services are permissible if "deemed advisable by the Advisory Health Board," see Sections 1402 and 1422.

5. Healthful School Environment: Section 1420, "Examinations of School Buildings and Grounds," directs the Secretary of Health to employ sanitarians or local health authorities "to make a careful examination of all privies, water-closets, urinals, cellars, the water-supply and drinking vessels and utensils and sewage and refuse disposal systems, lightening, heating and ventilation systems, and such additional examinations of the sanitary conditions of the school buildings and grounds as the regulations of the Secretary of Health may require."

Regarding physical security, Section 1317 of the School Code gives authority to principals and teachers to exercise authority over pupils regarding conduct and behavior during the time they are in attendance as "the parents, guardians or persons in parental relation to such pupils may exercise over them."

Section 1318 gives authority to suspend or expel a student for misconduct or "disobedience."

Beyond the school grounds, however, the School Code provides no explicit or implicit authority nor assigns any duty to school officials to provide a "healthful and safe environment for students in the surrounding community where students live."

6. Nutrition and Food Services: Section 504 empowers school district to establish cafeterias for students or to contract for such services, but neither this nor any other section in the Public School Code makes reference to providing "healthful choices in daily food" per se, nor does it require the "education of students and staff about healthy eating habits and food preparation."

7. Health Partnerships: The community planning committee (CPC) as contemplated by PEFNET CSHI is consistent with Section 1422 of the Public School Code which authorizes District Superintendents to set up "Advisory Health Councils." These Councils are "to study the health needs and to assist in organizing follow-up programs...and shall be composed of representatives of the medical and dental associations, social organizations, veterans' organizations, parent-teacher associations, service clubs and other organizations in the area served."

Section 1411 also authorizes any school district to "cooperate with any county, city, borough, town or township engaged in health work." This section further authorizes school districts of the first class (i.e., Philadelphia) with the approval of the Secretary of Health and the Superintendent of Public Instruction

to "contract with county health units or the department or Board of Health of any municipality for school health services."

Currently, the Division of School Health Services of the School District of Philadelphia cooperates with eight (8) school-based health clinics, and twenty-two (22) school-linked health services out of a total of 260 Philadelphia public schools.

8. Health Promotion of Faculty and Staff. The only Section of the School Code dealing with school employee health is Section 1418 (a) which requires pre-employment medical exams of all teachers and other school personnel; and Section 1418 (b) which requires tuberculosis tests according to the Advisory Health Board.

B. The Pennsylvania State Board of Education is the second tier of regulations and administrative law impacting on the eight components of comprehensive school health programs.

The State Board of Education is composed of 21 members appointed by the Governor with majority consent from the Pennsylvania Senate. For the purpose of formulating policy proposals, the State Board is divided into two councils: the Council of Basic Education and the Council of Higher Education. The Secretary of Education is the chief operating officer of the State Board.

The powers and duties of the Council of Basic education are to

- 1) develop a master plan for basic education;
- 2) investigate programs, conduct research studies, and formulate policy proposals in all education areas except higher education, which includes: "subjects to be taught and the activities to be conducted in elementary, secondary, adult education and other schools."

1. Health Education: Regarding HIV/AIDS education, the State Board promulgated regulations in 1989 [22 Pa Code 5.220] requiring such education of students K-12 on HIV/AIDS as may be appropriate to their age level.

In addition, in 1993, the State Board conducted a major revision of its Chapter Five regulations pertaining to curriculum. The first major revision was to shift from an "input" to an "outcomes-based" philosophy as embodied in nine areas and 53 "learning outcomes." Mere time spent learning mathematics, for example, is no longer sufficient to graduate, but rather a demonstration that a student achieved certain mathematical learning outcomes.

One of the nine areas is "Wellness and Fitness." The Wellness and Fitness area places emphasis on: injury prevention, ability to respond to emergencies, proper nutrition, lifelong physical

fitness, disease prevention, and participation in individual and team sports. Thus, the Wellness and Fitness learning outcomes and Section 5.220 places regulatory emphasis on HIV/AIDS education.

3. Physical Education: See new Chapter Five Learning Outcomes, "Wellness and Fitness."

7. Health Partnerships: The second major revision of the 1993 Chapter Five regulations is to require community, parent, and teacher participation in the development of local school "strategic plans." By September 1995, the School District of Philadelphia is to formulate a strategic plan. Thus, the establishment of Community Planning Committees is consistent with the strategic planning provisions of State Board regulations.

C. **The Board of Education of the School District of Philadelphia** is the third governing tier relating to comprehensive school health programs. The Pennsylvania School Code empowers the Philadelphia School Board to "legislate upon all matters concerning the conduct of the schools subject to the provisions of the [24 Pa School Code.]"

1. Health Education: School District of Philadelphia has a number of policies which direct health education:

a) The District mandates that health is taught every year in Kindergarten through eighth grade as well as in tenth and eleventh grades.

b) Policy 236 entitled AIDS/HIV Infection was adopted by the District on November 18, 1985 and revised December 17, 1990 concerns policy in dealing with HIV infected students.

c) Policy 123, addresses issues around Adolescent Sexuality. The District adopted this in June 1991. The Policy 123 calls for the development of a curriculum which promotes abstinence, teaches problem solving around issues of sexuality, and informs students of other means of preventing pregnancy, STDs and HIV infection.

7. Health Partnerships have been gaining increasing momentum in the School District of Philadelphia as parallel community health and human service initiatives are led by federal, state, and city agencies grant programs and local foundation and United Way efforts.

a) On December 13, 1993, four months after the retirement of Superintendent Constance Clayton, the Philadelphia School Board adopted a twelve-point Systemic Educational Reform Agenda written by Acting Superintendent Theresa Lemme. This reform agenda called the immediate development of

"radically reformed, university assisted, community schools that will serve as centers for the integration and delivery of a wide range of municipal services, community activity...and the delivery of health and human services."

b) Shortly thereafter, the Philadelphia Federation of Teachers issued its own reform agenda as a prelude to contract negotiations which called for community schools as well.

c) In August 1994, David Hornbeck was appointed as the new Superintendent of the School District of Philadelphia. He has issued a reform agenda as a "work in progress." His ten-point "Children Achieving Agenda" is intended to be consistent with Judge Smith's findings and her Educational Teams' recommendations.

Mr. Hornbeck's agenda emphasizes the importance of student health as part of education reform. Three of the ten points impact directly on health issues: Readiness for School; Community Services and Supports; and Public Engagement. Mr. Hornbeck calls for children to have access to good health care, nutrition and preventive health measures even before entering school. He also states the importance of linking services with schools in a way that addresses the needs of families, not just of children individually. Finally, he calls for a process which fully engages the public in shaping and supporting the reform agenda so that there will be long-term policy and financial support for all the reforms envisioned in "Children Achieving."

D. Judicial Oversight

Meanwhile, as part of a 23 year-old desegregation case, [Pennsylvania Human Relations Commission v. School District of Philadelphia] presiding Commonwealth Court Judge Doris Smith appointed an "Educational Team" which interviewed and heard testimony from hundreds of people about the state of public education in Philadelphia. Their report was issued on September 15, 1994. Judge Smith will make her final ruling pending a financial audit of the School District.

5. Healthful School Environment: See Judge Smith's Education Team Report, p. 19-20 & 52-55; Court Order, p. 17 -19 & 23-24; Re: lead poisoning; asbestos removal; regulation of noise; heating and lighting; fostering non-threatening relationships among kids, faculty & staff.

Existing Programs and Services

There has been a recent growth of school-based and school-linked health related programs and services to students throughout School District. [See the January 1994 Report from the Division of Health Services].

For purposes of this CSHI proposal, however, we have focused primarily on those services which exist in the Northwest Region of Philadelphia. We have selected the Northwest Region because the School District, City agencies, local health care providers, parents, and community groups have a history of health related collaboration.

In June 1994, for example, the Northwest Region of the School District of Philadelphia held a Comprehensive School Health Programs Conference which examined existing policies, issues and research around implementing and improving school health programs. One of the first Family Centers created under the auspices of the Mayor's new Office of Family Centers, is located at Pickett Middle School in the Northwest Region. Based on previous collaborations, we have identified nearly 200 organizations that can potentially be involved in comprehensive school health programs in the Northwest. [See Figure 5]

The analysis of gaps and barriers as well as information about community perceptions of accessibility are drawn from a report entitled *Partners for a Healthy Community* which focuses on service delivery in Northwest Philadelphia and its surrounding suburbs. (The report is attached in this appendix.)

Summary and Conclusions

There are two main findings of PATHS/PRISM'S community assessment:

1. City, school and community entities need to develop the capacity to institutionalize multi-agency comprehensive school health programs and funding in a manner which is integrated into local school reform efforts, specifically in the areas of curriculum, pedagogy and site-based/shared decision-making governance.
2. The institutionalization of comprehensive school health programs and education will require the development of new communication mechanisms and operating practices wherein multiple interagency and school/community collaboration is a regular feature of daily program activity, rather than a feature of intermittent, ad hoc, grant project development activities.

Discussion

Within the past five years in Philadelphia, there have been steadily accelerating and parallel reform movements in areas of public schooling, health education, human/social service delivery, health-care service delivery, and community-based economic initiatives. [See the Appendix for a Chronology of Events].

Each of these reform areas have been driven by different sets of lead institutions, some of which overlap into more than one area. Thus:

1. Public school reform has been led by the Superintendent of the School District of Philadelphia, The Pew Charitable Trusts, and PATHS/PRISM;
2. Health education, specifically with regard to HIV/AIDS, has been led by the School District's Health Education office and area universities;
3. Human/social service delivery reform has been led by the Mayor and the Commissioners of Health and Human Services of the City of Philadelphia, The United Way, and Philadelphia Citizens for Children and Youth (PCCY);
4. Health-care delivery reform has been led by the Philadelphia Department of Health and area health institutions such as Germantown Hospital, and regional school district superintendents; and
5. Community economic development and social amelioration has

been led by the Mayor, area corporations and community-based organizations (CBOs), most notable is Philadelphia's recent designation as a federal "Empowerment Zone" city.

Although each of these reform efforts may be driven by different sets of lead institutions, there is a remarkable convergence of reform philosophy. The common threads of reform are that change needs to be: "school-linked," "comprehensive," "integrated," "community-based," "decentralized," "collaborative," "participatory," "outcome-based," "cross-categorical," and "systemic."

As a result of these parallel reform efforts, multiple versions of "community assessment" documents have been produced by entities of each respective reform area. We have collected the key Philadelphia community assessment documents from our partners and describe the results of these complementary assessments in the Appendix.

The initiation and growth of Comprehensive School Health Programs, which focus on reducing youth risk factors such as HIV/AIDS, represent the intersection of these five parallel reform efforts within the City of Philadelphia. We have chosen to focus on the Northwest Region of Philadelphia (Germantown) and to use a cluster of one middle school (Pickett) and its four elementary schools as our "testbed site" for our planning activities because of the quantity and quality of the community assessment data which has already been collected.

FIGURE 1, A
TABLE 32. THE TEN MOST FREQUENT CAUSES OF RESIDENT DEATHS, BY AGE GROUP
 ALL RACES
 PHILADELPHIA: 1991

I.C.D. Code 9th Rev.	CAUSE OF DEATH	AGE GROUP								Total *
		Und. 5	5 - 14	15 - 24	25-44	45-54	55-64	65-74	75 & Over	\
390-398,402,404-429	Diseases of Heart	9	5	8	149	299	768	1,433	3,306	5,982
140-208	Malignant Neoplasms	5	1	7	168	370	820	1,498	1,700	4,570
430-438	Cerebrovascular Disease	0	1	1	43	58	108	253	659	1,123
E800-E949	Accidents and Adverse Effects of Drugs	31	29	74	289	49	53	68	137	730
490-496	Chronic Obstructive Pulmonary Disease	1	1	5	14	28	84	199	308	640
038	Septicemia	1	1	3	26	18	42	101	320	513
250	Diabetes Mellitus	0	1	1	19	29	88	154	194	486
480-487	Pneumonia and Influenza	7	1	2	19	17	31	64	318	460
E960-E978	Homicide and Legal Intervention	8	2	141	209	33	22	11	11	437
042-044	Human Immunodeficiency Virus Infection	1	3	11	312	70	18	11	0	426
	All Other Causes	421	19	61	357	236	357	649	1,569	3,676
	All Causes	484	64	314	1,605	1,207	2,391	4,441	8,522	19,043

* "Total" column includes 15 deaths of unknown age.

TABLE 33. THE TEN MOST FREQUENT CAUSES OF RESIDENT DEATHS, BY AGE GROUP
 WHITE RACE

TABLE 36. RESIDENT DEATHS BY AGE GROUPS BY SELECTED CAUSES
ALL PERSONS
PHILADELPHIA: 1991

I.C.D. Code 9th Rev.	Cause of Death	Total	Und. 1 Yr.	1-4	5-9	10- 14	15- 19	20- 24	25- 29	30- 34	35- 39	40- 44	45- 49	50- 54	55- 59	60- 64	65- 69	70- 74	75- 79	80- 84	85+ 85+	Unk
001-139	I. INFECTIOUS AND PARASITIC DISEASES	1023	4	2	6	3	2	13	57	95	102	99	60	34	29	44	50	80	93	96	153	1
010-012	Tuberculosis of respiratory system	16	0	0	0	0	0	0	0	1	1	2	0	0	3	1	1	1	2	3	1	0
013-018	Tuberculosis, other forms	2	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0
038	Septicemia	513	1	0	1	0	2	1	6	4	6	10	7	11	13	29	38	63	86	86	148	1
042-044	Human Immunodeficiency Virus Infection	426	1	0	2	1	0	11	50	87	91	84	50	20	10	8	5	6	0	0	0	0
070	Viral hepatitis	9	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	2	2	1	1	0
090-097	Syphilis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Residual	All other infectious and parasitic diseases	57	2	2	3	2	0	1	1	3	2	3	3	2	3	6	5	8	3	5	3	0
140-239	II. NEOPLASMS	4622	0	6	0	1	2	5	16	26	41	87	128	243	320	503	729	788	729	531	466	1
140-149	Lip, oral cavity and pharynx	86	0	0	0	0	0	0	1	0	3	2	1	5	15	17	11	13	8	7	3	0
151	Stomach	168	0	0	0	0	0	0	0	1	2	2	4	9	8	18	21	35	29	13	26	0
153	Colon	459	0	0	0	0	0	0	0	2	3	4	4	18	21	44	64	82	90	58	69	0
157	Pancreas	219	0	0	0	0	0	0	0	0	0	6	5	8	14	22	33	30	38	34	29	0
150,152,154-156,158-159	Other digestive organs and peritoneum	334	0	0	0	0	0	0	2	3	3	4	8	15	35	33	55	54	46	38	38	0
162	Trachea, bronchus and lung	1248	0	0	0	0	0	0	1	1	5	19	35	79	98	175	241	213	203	119	59	0
160-161,163-165	Other respiratory and intrathoracic	72	0	0	0	0	0	0	0	0	0	1	5	6	6	11	13	10	9	5	5	1
170-173	Bone, connective tissue and skin	79	0	0	0	0	0	1	1	4	0	2	4	3	3	6	10	10	17	8	10	0
174-175	Breast	399	0	0	0	0	0	0	0	4	13	14	21	31	44	41	68	52	45	36	30	0
180	Cervix uteri	52	0	0	0	0	0	0	1	1	2	8	4	6	8	4	5	4	5	2	2	0
179,181-184	Other female genital organs	180	0	0	0	0	0	0	0	0	2	2	3	8	10	9	34	39	29	23	21	0
185	Prostate	266	0	0	0	0	0	0	0	0	0	0	1	4	3	21	39	52	49	52	45	0
186-187	Other male genital organs	3	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1	0	0	0
188	Bladder	93	0	0	0	0	0	0	0	0	0	1	0	4	2	3	13	21	12	17	20	0
189	Other urinary organs	91	0	0	0	1	0	1	0	1	0	3	2	8	8	9	10	13	12	9	14	0
190-199	Other and unspecified sites	461	0	3	0	0	0	0	2	5	4	9	18	26	29	52	67	72	75	55	44	0
200-203	Lymphatic and hematopoietic tissue, except leukemia	216	0	0	0	0	0	0	4	2	3	6	5	7	8	27	18	46	37	28	25	0
204-208	Leukemia	144	0	2	0	0	2	3	3	2	1	2	8	5	6	10	18	31	18	19	14	0
140-208	TOTAL MALIGNANT NEOPLASMS	4570	0	5	0	1	2	5	15	26	41	86	128	242	318	502	721	777	723	523	454	1
210-239	Benign neoplasms, carcinoma in situ, neoplasms of uncertain behavior and unspecified nature	52	0	1	0	0	0	0	1	0	0	1	0	1	2	1	8	11	6	8	12	0
240-279	III. ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES AND IMMUNITY DISORDERS	681	1	1	1	1	0	1	3	7	6	12	17	20	41	62	81	106	90	88	143	0
250	Diabetes mellitus	486	0	0	0	1	0	1	1	5	5	8	15	14	37	51	69	85	73	50	71	0
240-246,251-259	All other endocrine disorders and diseases	12	0	0	0	0	0	0	0	0	0	1	0	1	0	3	0	2	3	1	1	0
260-269	Nutritional deficiencies	31	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3	9	16	0
270-279	Other metabolic and immunity disorders	152	1	1	1	0	0	0	2	2	1	3	2	5	4	8	12	16	11	28	55	0
280-289	IV. DISEASES OF BLOOD AND BLOOD-FORMING ORGANS	98	0	1	0	0	1	2	3	2	2	3	6	1	6	5	9	10	12	9	26	0

(CONTINUED)

FIGURE 1, C

TABLE 36. RESIDENT DEATHS BY AGE GROUPS BY SELECTED CAUSES
ALL PERSONS
PHILADELPHIA: 1991

I.C.D. Code 9th Rev.	Cause of Death	Total	Und. 1 Yr.	1-4	5-9	10- 14	15- 19	20- 24	25- 29	30- 34	35- 39	40- 44	45- 49	50- 54	55- 59	60- 64	65- 69	70- 74	75- 79	80- 84	85+ 85+	Unk
290-319	V. MENTAL DISORDERS	134	0	0	1	0	0	0	1	0	9	7	7	3	8	4	8	6	16	21	42	1
303	Alcohol dependence syndrome	28	0	0	0	0	0	0	0	0	4	4	5	2	4	4	4	1	0	0	0	0
304	Drug dependence	4	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0	0	1
Residual	All other mental disorders	102	0	0	1	0	0	0	0	0	4	3	2	0	4	0	4	5	16	21	42	0
320-389	VI. DISEASES OF NERVOUS SYSTEM AND SENSE ORGANS	276	5	1	1	5	3	5	4	1	9	10	11	8	10	21	15	29	43	44	51	0
390-459	VII. DISEASES OF CIRCULATORY SYSTEM	7515	5	4	2	4	2	7	18	34	57	99	153	216	342	577	756	1036	1143	1223	1832	5
390-398	Acute rheumatic fever and chronic rheumatic heart disease	28	0	0	0	0	0	0	0	0	1	0	0	1	3	3	0	5	9	5	1	0
402,404	Hypertensive heart and hypertensive heart and renal disease	175	0	0	0	0	0	0	2	2	1	5	7	15	13	15	17	25	23	22	28	0
410	Acute myocardial infarction	1945	1	1	0	0	0	0	0	4	12	9	25	42	82	146	216	282	339	347	437	2
411-414	Other ischemic heart disease	1278	0	0	0	0	0	0	1	6	8	8	15	22	39	78	107	182	199	255	360	0
415-417	Diseases of pulmonary circulation	142	2	0	0	0	0	1	1	1	5	4	5	6	9	16	13	21	23	16	19	0
420-429	Other forms of heart disease	2414	2	3	1	4	2	5	7	9	17	48	69	92	141	223	246	319	330	335	558	3
390-398,402, 404-429	TOTAL DISEASES OF HEART	5982	5	4	1	4	2	6	11	22	42	74	121	178	287	481	599	834	923	980	1403	5
401,403	Hypertension and hypertensive renal disease	65	0	0	0	0	0	0	0	0	2	1	1	2	2	6	13	8	12	8	10	0
430-438	Cerebrovascular disease	1123	0	0	1	0	0	1	5	9	13	16	29	29	38	70	108	145	159	186	314	0
440	Atherosclerosis	110	0	0	0	0	0	0	0	0	0	0	0	0	2	3	7	14	20	16	48	0
441-448	Other diseases of arteries, arterioles and capillaries	202	0	0	0	0	0	0	1	2	0	3	2	5	12	15	22	33	26	29	52	0
451-459	Diseases of veins and lymphatics, and other circulatory system diseases	33	0	0	0	0	0	0	1	1	0	5	0	2	1	2	7	2	3	4	5	0
460-519	VIII. DISEASES OF RESPIRATORY SYSTEM	1377	5	5	2	1	6	2	7	11	19	12	21	35	44	90	149	170	223	228	346	1
480-486	Pneumonia	456	4	3	1	0	2	0	3	6	5	4	8	9	12	19	20	43	64	84	168	1
487	Influenza	4	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	1	1	0
490-491	Bronchitis, chronic and unspecified	16	0	1	0	0	0	0	0	0	0	1	0	1	2	1	2	0	5	1	2	0
492	Emphysema	75	0	0	0	0	0	0	0	0	1	0	1	2	0	8	16	14	9	18	6	0
493	Asthma	46	0	0	1	0	4	1	2	2	3	0	5	5	2	3	7	4	5	0	2	0
494-496	Other chronic obstructive pulmonary diseases	503	0	0	0	0	0	0	0	0	1	4	1	13	21	47	78	78	99	82	79	0
490-496	TOTAL CHRONIC OBSTRUCTIVE PULMONARY DISEASES AND ALLIED CONDITIONS	640	0	1	1	0	4	1	2	2	5	5	7	21	25	59	103	96	118	101	89	0
Residual	All other diseases of respiratory system	277	1	1	0	1	0	1	2	3	8	3	6	5	7	12	26	30	41	42	88	0
520-579	IX. DISEASES OF DIGESTIVE SYSTEM	742	2	1	0	0	2	2	4	13	31	44	45	41	47	79	70	96	68	79	118	0
531-534	Gastric, duodenal and gastrojejunal ulcers and peptic ulcers, site unspecified	34	0	0	0	0	0	0	0	0	0	3	0	1	1	6	1	5	2	6	9	0
540-543	Appendicitis	5	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	2	0	1	0	0
550-553,560	Hernia of abdominal cavity and intestinal obstruction without hernia	58	0	0	0	0	0	0	0	0	1	0	1	2	1	3	8	6	3	12	21	0
571	Chronic liver disease and cirrhosis	244	0	0	0	0	1	0	0	6	19	25	30	21	21	34	26	30	17	10	4	0
Residual	All other diseases of digestive system	401	2	1	0	0	0	2	4	7	11	15	14	17	24	36	35	53	46	50	84	0

(CONTINUED)

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TABLE 36. RESIDENT DEATHS BY AGE GROUPS BY SELECTED CAUSES
ALL PERSONS
PHILADELPHIA: 1991

I.C.D. Code 9th Rev.	Cause of Death	Total	Und. 1 Yr.	1-4	5-9	10- 14	15- 19	20- 24	25- 29	30- 34	35- 39	40- 44	45- 49	50- 54	55- 59	60- 64	65- 69	70- 74	75- 79	80- 84	85+ 85+	Unk
580-629	X. DISEASES OF GENITOURINARY SYSTEM	495	1	0	0	0	1	2	2	4	6	11	8	14	18	32	43	71	77	79	126	0
580-589	Nephritis, nephrotic syndrome and nephrosis	265	1	0	0	0	1	1	2	2	2	5	5	9	9	18	28	43	44	39	56	0
590-629	Other diseases of genitourinary system	230	0	0	0	0	0	1	0	2	4	6	3	5	9	14	15	28	33	40	70	0
630-676	XI. COMPLICATIONS OF PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	3	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0
680-709	XII. DISEASES OF SKIN AND SUBCUTANEOUS TISSUE	53	0	0	0	0	0	0	0	0	0	0	1	1	0	1	4	5	9	11	20	1
710-739	XIII. DISEASES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE	58	0	0	0	0	2	0	0	4	2	2	5	3	3	1	5	9	7	5	10	0
740-759	XIV. CONGENITAL ANOMALIES	89	60	10	4	0	0	2	1	0	0	2	0	2	2	2	0	1	1	0	2	0
760-779	XV. CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD	247	237	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
780-799	XVI. SYMPTOMS, SIGNS AND ILL-DEFINED CONDITIONS	247	83	5	0	0	2	3	4	7	8	7	8	3	6	6	8	12	17	23	44	1
E800-E999	XVII. EXTERNAL CAUSES OF INJURY AND POISONING	1383	11	28	15	17	91	156	150	185	148	108	66	47	43	45	53	42	61	57	60	0
E810-E825	Motor vehicle accidents	161	0	2	3	4	19	18	16	11	8	10	10	5	8	7	8	8	10	8	6	0
E800-E807,E826-E848	Other transport accidents	13	0	0	0	3	2	0	1	1	1	1	1	1	0	0	1	1	0	0	0	0
E850-E869	Accidental poisoning	267	3	1	0	1	4	20	23	65	66	48	14	6	4	2	1	2	4	0	3	0
E870-E879	Misadventures to patients and abnormal reactions or complications 1	38	1	0	0	0	0	2	0	1	0	0	1	2	1	5	6	9	4	3	3	0
E880-E888	Accidental falls	93	1	0	0	0	0	0	2	3	3	4	3	0	8	3	8	6	9	20	23	0
E890-E899	Accidents caused by fires and flames	58	1	16	5	3	0	1	2	4	1	2	1	2	1	4	6	1	4	2	2	0
E910	Accidental drowning and submersion	19	0	3	3	2	1	1	2	1	1	0	0	0	1	1	1	1	0	0	0	0
E900-E909,E911-E929	Other accidents	79	1	2	4	1	1	5	2	5	2	2	2	1	3	5	6	2	11	9	15	0
E930-E949	Adverse effects to drugs in therapeutic use 2	2	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0
E950-E959	Suicide	177	0	0	0	1	6	22	24	28	17	9	13	10	7	4	8	5	11	8	4	0
E960-E969	Homicide	434	4	4	0	2	56	84	76	57	45	29	17	16	10	12	6	5	5	5	1	0
E970-E978	Legal intervention	3	0	0	0	0	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0
E980-E989	Injury undetermined 3	38	0	0	0	0	1	3	2	8	2	2	4	4	0	2	1	2	2	2	3	0
E990-E999	Operations of War	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL	19043	414	70	32	32	114	200	270	390	441	504	536	671	919	1472	1980	2461	2589	2494	3439	15

1. Misadventures to patients during surgical and medical care and surgical and medical procedures as the cause of abnormal reaction of patient or late complication, without mention of misadventure at the time of procedure.

2. Drugs, medicaments and biological substances causing adverse effects in therapeutic use.

3. Injury undetermined whether accidentally or purposely inflicted.

FIGURE 2

TABLE 3. PHILADELPHIA AIDS CASES BY GENDER AND DATE REPORTED

	1981 to 09-30-93		latest 12 months		total		current quarter
Gender	n	col%	n	col%	n	col%	n
MALE	4369	88.8	1313	82.0	5682	87.1	338
FEMALE	551	11.2	289	18.0	840	12.9	83
TOTAL	4920	100.0	1602	100.0	6522	100.0	421

TABLE 4. PHILADELPHIA AIDS CASES BY RACE AND DATE REPORTED

	1981 to 09-30-93		latest 12 months		total		current quarter
Race	n	col%	n	col%	n	col%	n
WHITE	1584	32.2	399	24.9	1983	30.4	84
BLACK	2900	58.9	976	60.9	3876	59.4	284
LATINO	428	8.7	218	13.6	646	9.9	52
OTHER	8	0.2	9	0.6	17	0.3	1
UNKNOWN	0	0.0	0	0.0	0	0.0	0
TOTAL	4920	100.0	1602	100.0	6522	100.0	421

FIGURE 3, A

Philadelphia Department of Health
 REPORT OF CIVILIAN CASES OF SEXUALLY TRANSMITTED DISEASES
 BY REPORTING SOURCE, SEX, RACE/ETHNICITY, AND AGE GROUP
 YEAR: '93 WEEKS # 1 - 52

DATE: 02/0
 PAGE: 1

Disease: CHLAMYDIA

Race/Ethnic:	White (Not of Hispanic Ogn)		Black (Not of Hispanic Ogn)		Hispanic		Asian or Pacific Islander		American Indian or Alaskan		Not Specified		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
Sex:															
Age:	Reported by Private Physicians, Private Hospitals, and Private Institutions														
0-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5-9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10-14	1	2	0	104	0	0	0	0	0	0	5	202	6	308	314
15-19	0	54	38	905	0	8	0	3	0	0	110	2406	148	3376	3524
20-24	2	45	17	555	0	8	0	1	0	0	77	1638	96	2247	2343
25-29	1	13	12	189	0	1	0	0	0	0	34	687	47	890	937
30-34	0	7	6	95	0	0	0	0	0	0	19	317	25	419	444
35-39	1	6	7	30	0	1	0	0	0	0	13	154	21	191	212
40-44	0	4	1	10	0	0	0	0	0	0	3	73	4	87	91
45-54	0	2	1	8	0	1	0	1	0	0	8	32	9	44	53
55-64	1	1	0	1	0	0	0	0	0	0	2	5	3	7	10
65 and Over	0	0	0	2	0	0	0	0	0	0	2	13	2	15	17
SUM	6	134	82	1899	0	19	0	5	0	0	273	5527	361	7584	7945
Age Not Specified	0	2	6	16	0	0	0	0	0	0	62	863	68	881	945
TOTAL	6	136	88	1915	0	19	0	5	0	0	335	6390	429	8465	8894

Reported by Public Clinics, Public Hospitals, and Public Institutions															
0-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5-9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10-14	0	0	0	38	0	1	0	0	0	0	0	3	0	42	42
15-19	0	12	30	324	1	18	0	2	0	0	19	34	50	390	440
20-24	2	11	49	195	0	18	0	5	0	0	29	27	80	256	336
25-29	0	2	31	86	1	2	0	2	0	0	10	5	42	97	139
30-34	1	1	17	36	0	3	0	1	0	0	11	4	29	45	74
35-39	0	2	9	16	0	3	0	2	0	0	4	3	13	26	39
40-44	0	0	5	9	0	0	0	1	0	0	4	1	9	11	20
45-54	0	1	3	1	0	2	0	0	0	0	0	0	3	4	7
55-64	0	0	2	0	0	0	0	0	0	0	1	0	3	0	3
65 and Over	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SUM	3	29	146	705	2	47	0	13	0	0	78	77	229	871	1100
Age Not Specified	0	1	0	4	0	0	0	0	0	0	19	35	19	40	59
TOTAL	3	30	146	709	2	47	0	13	0	0	97	112	248	911	1159
GRAND TOTAL	9	166	234	2624	2	66	0	18	0	0	432	6502	677	9376	10053

FIGURE 3, B

Philadelphia Department of Health
 REPORT OF CIVILIAN CASES OF SEXUALLY TRANSMITTED DISEASES
 BY REPORTING SOURCE, SEX, RACE/ETHNICITY, AND AGE GROUP
 YEAR: '93 WEEKS # 1 - 52

DATE: 02/03
 PAGE: 1

Disease: GOMORRHEA

Race/Ethnic:	White (Not of Hispanic Ogn)		Black (Not of Hispanic Ogn)		Hispanic		Asian or Pacific Islander		American Indian or Alaskan		Not Specified		Total		
Sex:	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
Reported by Private Physicians, Private Hospitals, and Private Institutions															
Age:															
0-4	0	1	0	0	1	0	0	0	0	0	1	4	2	5	7
5-9	0	0	0	0	0	0	0	0	0	0	1	1	1	1	2
10-14	0	3	1	49	0	0	0	0	0	0	19	114	20	166	186
15-19	1	17	58	491	2	10	0	2	0	0	276	761	337	1281	1618
20-24	9	14	57	377	1	9	0	1	0	0	223	513	290	914	1204
25-29	9	11	50	199	0	11	0	1	0	0	190	273	249	495	744
30-34	5	7	27	149	3	2	0	1	0	0	180	246	215	405	620
35-39	4	3	15	72	0	1	0	0	0	0	117	82	136	158	294
40-44	4	1	17	13	0	2	0	0	0	0	47	48	68	64	132
45-54	0	1	10	7	0	1	0	0	0	0	60	13	70	22	92
55-64	1	0	2	1	2	0	0	0	0	0	20	5	25	6	31
65 and Over	0	0	1	0	1	0	0	0	0	0	9	2	11	2	13
SUM	33	58	238	1358	10	36	0	5	0	0	1143	2062	1424	3519	4943
Age Not Specified	4	2	3	2	0	0	0	0	0	0	190	238	197	242	439
TOTAL	37	60	241	1360	10	36	0	5	0	0	1333	2300	1621	3761	5382

Reported by Public Clinics, Public Hospitals, and Public Institutions																
0-4	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1
5-9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10-14	0	1	12	18	2	1	0	0	0	0	0	3	14	23	37	37
15-19	6	4	648	227	6	5	0	1	0	0	17	10	677	247	924	924
20-24	9	3	1002	176	22	2	1	0	0	0	13	8	1047	189	1236	1236
25-29	11	2	754	112	9	1	0	3	0	0	5	8	779	126	905	905
30-34	13	3	705	89	10	1	0	0	0	0	9	5	737	98	835	835
35-39	9	1	449	45	3	3	2	0	0	0	8	1	471	50	521	521
40-44	7	1	262	17	7	0	0	0	0	0	4	0	280	18	298	298
45-54	5	0	218	5	0	0	0	0	0	0	3	0	226	5	231	231
55-64	0	0	54	0	2	0	0	0	0	0	1	0	57	0	57	57
65 and Over	0	0	20	0	1	0	0	0	0	0	0	0	21	0	21	21
SUM	60	15	4124	690	62	13	3	4	0	0	60	35	4309	757	5066	5066
Age Not Specified	0	0	8	0	0	0	0	0	0	0	9	0	17	0	17	17
TOTAL	60	15	4132	690	62	13	3	4	0	0	69	35	4326	757	5083	5083
GRAND TOTAL	97	75	4373	2050	72	49	3	9	0	0	1402	2335	5947	4518	10465	10465

GRAND TOTAL		97	75	4373	2050	72	49	3	9	0	0	1402	2335	5947	4518	10465
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FIGURE 3, C

Philadelphia Department of Health
REPORT OF CIVILIAN CASES OF SEXUALLY TRANSMITTED DISEASES
BY REPORTING SOURCE, SEX, RACE/ETHNICITY, AND AGE GROUP
YEAR: '93 WEEKS # 1 - 52

DATE: 02/07
PAGE: 1

Disease: PRIMARY SYPHILIS

Race/Ethnic:	White (Not of Hispanic Ogn)		Black (Not of Hispanic Ogn)		Hispanic		Asian or Pacific Islander		American Indian or Alaskan		Not Specified		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
Sex:															
Age:	Reported by Private Physicians, Private Hospitals, and Private Institutions														
0-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5-9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15-19	0	0	1	1	0	0	0	0	0	0	0	0	1	1	2
20-24	1	0	3	1	1	0	0	0	0	0	2	1	7	2	9
25-29	4	0	3	2	1	0	1	0	0	0	1	1	10	3	13
30-34	3	0	6	2	2	0	0	0	0	0	1	0	12	3	15
35-39	0	1	2	1	0	0	0	0	0	0	3	1	5	3	8
40-44	2	0	1	0	0	0	0	0	0	0	0	1	3	1	4
45-54	0	0	0	0	1	0	0	0	0	0	2	0	9	0	9
55-64	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65 and Over	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SUM	10	2	22	7	5	0	1	0	0	0	9	4	47	13	60
Age Not Specified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	10	2	22	7	5	0	1	0	0	0	9	4	47	13	60

Reported by Public Clinics, Public Hospitals, and Public Institutions															
0-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5-9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15-19	0	0	3	2	0	0	0	0	0	0	0	0	3	2	5
20-24	1	0	24	3	1	0	0	0	0	0	1	1	27	4	31
25-29	1	0	12	3	1	0	1	0	0	0	0	0	15	3	18
30-34	2	0	16	6	1	0	0	0	0	0	1	0	20	6	26
35-39	0	0	17	1	0	0	0	0	0	0	2	0	19	1	20
40-44	2	0	9	0	0	0	0	0	0	0	0	0	11	0	11
45-54	2	0	7	0	1	0	0	0	0	0	0	0	10	0	10
55-64	0	0	4	0	0	0	0	0	0	0	0	0	4	0	4
65 and Over	1	0	4	0	0	0	0	0	0	0	0	0	5	0	5
SUM	9	0	96	15	4	0	1	0	0	0	4	1	114	16	130
Age Not Specified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	9	0	96	15	4	0	1	0	0	0	4	1	114	16	130

GRAND TOTAL	19	2	118	22	9	0	2	0	0	0	13	5	161	29	190
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FIGURE 3, D

Philadelphia Department of Health
 REPORT OF CIVILIAN CASES OF SEXUALLY TRANSMITTED DISEASES
 BY REPORTING SOURCE, SEX, RACE/ETHNICITY, AND AGE GROUP
 YEAR: '93 WEEKS # 1 - 52

DATE: 02/07/94
 PAGE: 2

DATE: 02/07/94
 PAGE: 3

Disease: SECONDARY SYPHILIS

Race/Ethnic:	White (Not of Hispanic Ogn)		Black (Not of Hispanic Ogn)		Hispanic		Asian or Pacific Islander		American Indian or Alaskan		Not Specified		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
Sex:															
Age:															
Reported by Private Physicians, Private Hospitals, and Private Institutions															
0-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5-9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10-14	0	0	0	1	0	0	0	0	0	0	0	0	6	11	17
15-19	0	0	4	10	2	1	0	0	0	0	0	2	6	20	26
20-24	1	1	5	16	0	1	0	0	0	0	2	1	7	25	32
25-29	2	4	2	19	1	1	0	0	0	1	2	3	17	22	39
30-34	2	0	12	17	1	1	0	0	0	0	1	4	11	16	27
35-39	1	1	7	11	3	0	0	0	0	0	1	2	4	8	12
40-44	0	0	3	6	1	0	0	0	0	0	1	2	11	8	19
45-54	3	1	6	4	1	0	0	1	0	0	0	0	2	3	5
55-64	1	0	1	3	0	0	0	0	0	0	0	0	0	0	0
65 and Over	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SUM	10	7	40	87	8	4	0	1	0	1	6	14	64	114	178
Age Not Specified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	10	7	40	87	8	4	0	1	0	1	6	14	64	114	178
Reported by Public Clinics, Public Hospitals, and Public Institutions															
0-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5-9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10-14	0	0	0	0	0	0	0	0	0	0	0	0	5	6	11
15-19	0	0	5	6	0	0	0	0	0	0	0	0	13	11	24
20-24	0	2	13	9	0	0	0	0	0	0	0	0	16	13	29
25-29	0	0	15	13	1	0	0	0	0	0	0	0	13	11	24
30-34	1	0	23	7	1	2	0	0	0	0	1	0	26	9	35
35-39	1	0	8	7	0	0	0	0	0	0	2	0	8	9	17
40-44	0	0	3	0	0	0	0	0	0	0	0	0	3	0	3
45-54	0	0	3	0	0	0	0	0	0	0	0	0	4	0	4
55-64	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0
65 and Over	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SUM	2	2	82	53	3	2	0	0	0	0	1	2	88	59	147
Age Not Specified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	2	2	82	53	3	2	0	0	0	0	1	2	88	59	147
GRAND TOTAL	12	9	122	140	11	6	0	1	0	1	7	16	152	173	325

1370 1439 2829

FIGURE 4, A

PHILADELPHIA COUNTY

TABLE 8A-Total Female Population, Patients Served, and Percent Served: 1983-1993

	Total Population *							TOTAL
	10-14	15-17	18-19	20-24	25-29	30-34	35-44	
1983	56,285	39,494	28,664	80,479	77,042	63,632	98,959	444,555
1984	53,961	38,429	27,627	79,382	78,118	64,322	101,287	443,126
1985	52,113	37,247	26,506	78,285	79,564	66,594	105,687	445,996
1986	51,503	35,707	25,676	76,104	78,450	67,759	108,341	443,540
1987	51,192	34,779	25,636	74,043	76,615	69,519	111,515	443,299
1988	50,860	33,556	25,571	72,252	75,401	71,230	114,629	443,499
1989	50,546	32,715	24,649	69,870	74,169	72,862	117,785	442,596
1990	49,674	29,337	24,322	68,835	72,322	70,195	112,838	427,523
1991	48,750	30,558	22,406	65,722	71,041	69,893	114,139	422,509
1992	47,957	28,859	21,089	61,850	71,933	71,595	117,606	420,889
1993	47,521	27,616	19,847	57,898	71,074	71,989	118,786	414,731

	Patients Served **							TOTAL
	10-14	15-17	18-19	20-24	25-29	30-34	35-44	
1983	892	7,961	8,976	19,827	11,959	5,173	3,022	57,810
1984	849	8,017	9,015	20,262	12,080	5,272	2,462	57,957
1985	835	7,458	8,426	19,542	11,752	5,235	2,606	55,854
1986	876	7,839	8,038	19,285	11,609	5,357	2,657	55,661
1987	911	8,231	7,864	18,757	11,199	5,509	2,574	55,045
1988	972	7,902	8,288	17,889	10,875	5,397	2,721	54,044
1989	1,200	8,201	9,234	19,870	12,480	6,502	3,700	61,187
1990	1,512	8,223	7,743	17,248	10,764	5,877	3,443	54,810
1991	1,964	9,457	7,608	17,395	10,602	5,960	3,750	56,736
1992	2,099	10,280	7,371	17,413	9,747	6,231	4,178	57,319
1993	2,126	11,020	7,541	17,526	9,930	6,609	4,688	59,440

	Percent of Female Population Served							TOTAL
	10-14	15-17	18-19	20-24	25-29	30-34	35-44	
1983	1.58	20.16	31.31	24.64	15.52	8.13	3.05	13.00
1984	1.57	20.86	32.63	25.52	15.46	8.20	2.43	13.08
1985	1.60	20.02	31.79	24.96	14.77	7.86	2.47	12.52
1986	1.70	21.95	31.31	25.34	14.80	7.91	2.45	12.55
1987	1.78	23.67	30.68	25.33	14.62	7.92	2.31	12.42
1988	1.91	23.55	32.41	24.76	14.42	7.58	2.37	12.19
1989	2.37	25.07	37.46	28.44	16.83	8.92	3.14	13.82
1990	3.04	28.03	31.84	25.06	14.88	8.37	3.05	12.82
1991	4.03	30.95	33.96	26.47	14.92	8.53	3.29	13.43
1992	4.38	35.62	34.95	28.15	13.55	8.70	3.55	13.62
1993	4.47	39.90	38.00	30.27	13.97	9.18	3.95	14.33

* Population estimates provided by the State Health Data Center, except for 1992 and 1993 which were forecasted using trend analysis.

** Obtained from 1983-1993 Council Patient Population Profile Report.

FIGURE 4, B

PHILADELPHIA COUNTY

TABLE 8B-Total Pregnancies and Pregnancy Rates: All Ages: 1983-1992

	Total Pregnancies *							TOTAL
	10-14	15-17	18-19	20-24	25-29	30-34	35-44	
1983	372	3,811	5,623	14,522	11,103	5,552	2,316	43,299
1984	338	3,615	5,350	14,135	11,209	5,799	2,345	42,791
1985	327	3,639	5,083	13,613	11,204	5,945	2,436	42,247
1986	320	3,702	5,141	13,910	11,586	6,431	2,731	43,821
1987	325	3,750	5,084	13,765	11,826	6,836	2,927	44,513
1988	333	3,742	5,405	13,391	11,615	7,021	3,068	44,575
1989	383	3,548	5,134	13,805	12,040	7,402	3,153	45,465
1990	426	3,426	5,217	14,259	12,359	7,756	3,436	46,879
1991	422	3,431	4,832	13,922	11,800	7,543	3,593	45,543
1992	436	3,497	4,398	13,933	11,295	7,438	3,760	44,757

	Pregnancy Rate **							TOTAL
	10-14	15-17	18-19	20-24	25-29	30-34	35-44	
1983	6.61	96.50	196.17	180.44	144.12	87.25	23.40	97.40
1984	6.26	94.07	193.65	178.06	143.49	90.16	23.13	96.57
1985	6.27	97.70	191.77	173.89	140.82	89.27	23.05	94.73
1986	6.21	103.68	200.23	182.78	147.69	94.91	25.21	98.80
1987	6.35	107.82	198.31	185.91	154.36	98.33	26.25	100.41
1988	6.55	111.52	211.37	185.34	154.04	98.57	26.76	100.51
1989	7.58	108.45	208.28	197.58	162.33	101.59	26.77	102.72
1990	8.58	116.78	214.50	207.15	170.89	110.49	30.45	109.65
1991	8.66	112.28	215.66	211.83	166.10	107.92	31.48	107.79
1992	9.09	121.18	208.54	225.27	157.02	103.89	31.97	106.34

* Pregnancies = live births + fetal deaths (not induced) + abortions.

** Rate of live births, fetal deaths and induced abortions per 1000 females.

NOTE: Fetal deaths for 1992 estimated using data from previous years.

These data were supplied by the State Health Data Center,
 Pennsylvania Department of Health, Harrisburg, Pennsylvania.
 The Department specifically disclaims responsibility for any
 analyses, interpretations, or conclusions.

Compiled by:
 The Research Department
 Family Planning Council of SE/PA
 (215) 985-2622

FIGURE 4, C

PHILADELPHIA COUNTY

TABLE 8C-Live Births and Live Birth Rates: All Ages: 1983-1992

	Live Births							TOTAL
	10-14	15-17	18-19	20-24	25-29	30-34	35-44	
1983	164	1,876	2,789	7,932	7,346	3,753	1,319	25,17
1984	120	1,710	2,646	7,715	7,497	3,958	1,314	24,96
1985	159	1,919	2,760	8,206	7,933	4,212	1,470	26,65
1986	159	1,978	2,887	8,527	8,161	4,603	1,669	27,98
1987	171	2,025	2,684	8,497	8,375	4,938	1,799	28,48
1988	177	2,088	2,892	8,391	8,356	5,083	1,887	28,87
1989	188	2,066	2,998	8,393	8,306	5,244	2,032	29,22
1990	212	1,985	2,910	8,369	8,526	5,487	2,206	29,69
1991	221	2,003	2,868	8,153	8,026	5,363	2,421	29,05
1992	228	2,101	2,538	7,845	7,477	5,358	2,479	28,02

	Live Birth Rate *							TOTAL
	10-14	15-17	18-19	20-24	25-29	30-34	35-44	
1983	2.91	47.50	97.30	98.56	95.35	58.98	13.33	56.64
1984	2.22	44.50	95.78	97.19	95.97	61.53	12.97	56.33
1985	3.05	51.52	104.13	104.82	99.71	63.25	13.91	59.77
1986	3.09	55.40	112.44	112.04	104.03	67.93	15.41	63.09
1987	3.34	58.22	104.70	114.76	109.31	71.03	16.13	64.27
1988	3.48	62.22	113.10	116.14	110.82	71.36	16.46	65.10
1989	3.72	63.15	121.63	120.12	111.99	71.97	17.25	66.04
1990	4.27	67.66	119.64	121.58	117.89	78.17	19.55	69.46
1991	4.53	65.55	128.00	124.05	112.98	76.73	21.21	68.77
1992	4.75	72.80	120.35	126.84	103.94	74.84	21.08	66.59

* Rate of Live Births per 1000 females.

These data were supplied by the State Health Data Center,
Pennsylvania Department of Health, Harrisburg, Pennsylvania.
The Department specifically disclaims responsibility for any
analyses, interpretations, or conclusions.

Compiled by:
The Research Department
Family Planning Council of SE/PA
(215) 985-2622

Record#	LNAME	FNAME	ORGANNAME	ORGANPOSIT
1	Thomas	Ethel		
2	Ruane	Joseph		
3	Robinson	Lawrence		
4	Little	Marcy	1100 Block Windrin Avenue	
5	Clark	Audrey	13th St. Block Assoc.	
6	Reid	Elizabeth	13th Street Block Assoc.	
7	Dooley	Capt. Jeanette	14th Police District	Captain
8	Williams, CRO	Ofc. George	14th Police District	
9	Poindexter	Allen	35th Police District	Comm. Relations
10	Williams	George	35th Police District	Comm Relations
11	Gregory	Shirley	49th Ward	Ward Leader
12	O'Connell	Julie	5500 Morris Block	Block Captain
13	Carre	Capt. Augustine	5th Police District	
14	Tansimore, Jr.	Ellie	700 E. Rittenhouse St. Block Com.	
15	Saunders	Antonia	8000 Temple Rd. Block Assoc.	
16	Hall, Jr.	Arnold	A.B. Day Home & School Assoc	
17	Richman	Steven	ACT	Dir.
18	Williams	Eugene	ACT	
19	Pinckney	Rev. Mattie	AGAPE Ministries	
20	Shine	Delores	Ad Hoc Committee for Logan	President
21	Robinson	Patrick	Ad-Hoc Committee for Logan	
22	Tillman	Kathy	Aetna Life Insurance	Comm Coord
23	Kuhn	Mary	After School Program at St Gabriel	Director
24	Barnett	Peggy	Albanus Street Neighbors	
25	Chapman	Mary	Alliance for the Mentally Ill	
26	Gillespie	Sally	Andorra Civic Assoc.	
27	Livingston	Ed	Belfield Recreation Center	Superintendent
28	Keyes	Valarie	Belfield Recreation Ctr.	Vice President
29	Loughlin	Denise	Bell Atlantic	Mgr Extern Aff
30	Reed	James	Bell Atlantic	Dir Extern Aff
31	Datts	Lee	Better Health Society	
32	Weber	Tom	Big Brother/Big Sisters	
33	Butler	Janice	Birney School	Principal
34	Barnebey	Rebecca	Block Captains of S.W. Germantown	
35	Laney	Sheila	Block Captains of S.W. Germantown	President
36	Doran	Richard	Blue Cross	Vice President
37	Roman	Rev. Gud	Cannan Baptist Church	
38	Senechal	Philipp	Center for Social Policy	
39	Cohen	Rennie	Center in the Park	
40	Edelson	Charles	Central High School	Asst. Principal
41	Easley	Ollie Earline	Champlost Homes Tenant Mgmt. Corp.	
42	Dezzi	Eleanor	Chapel Hill Civic Assoc & Twn Wtch	
43	Church	Geneva	Cherashore P.G. Advisory Committee	

Figure 5, B

44	Stevenson	Shirley	Cherashore Playground A.C.	
45	Dawson	Peggy	Chestnut Hill Business Assoc.	
46	Chestnut Hill Local	Editor,	Chestnut Hill Local	
47	Arisman	Dr. Susan	Cheyney University	
48	Norwood	Patricia	Christ Our Redeemer Baptist Church	
49	Love	Rev. Ora	Christian United Against Addiction	
50	Thompson	Carole	Cigna Insurance Company	Dir Civic Aff
51	Hughes	Raynard	Citizen of West Logan	
52	Robinson	Jason Guy	Citizens Against Drugs, Inc.	
53	Robinson	Jimmie	Citizens of West Logan	President
54	Sims	Catina	Community College	
55	Stinson	Althea	Community Intervention Program	
56	Richardson	Louise	Community to Cooperate	
57	Urquhart	E. Randy	Concerned Black Men, Inc.	President
58	McKnight	Deborah	Concerned Citizens for Adult Ed.	
59	Campbell	Ed	Concerned Citizens of E Germantown	
60	Livingston	Cathy	Core States First Penna. Bank	
61	Whealin	John	CoreState 1st Bank Penn.	VP Comm Dev Con
62	DuBois	Ruth	Corporate Alliance for Drug Ed.	
63	Smith	Rosetta	Covenant House	
64	Okudzeto	Janice	Covenant House Health Services	
65	Whitaker	Joanna	DHS	
66	Kramer	Pam	Delta Dental	PR Communicatio
67	Carter	Justine	Dept of Public Welfare	
68	Robinson	Lawrence	Dept. of Public Health	
69	Williams	Loretta	Dignity Housing	Officer
70	Datner	Shirley	Dobson School	School Nurse
71	Chapman	Robert	Drug & Alcohol Education	Coordinator
72	Evans	Terri Rene	EUNICE	
73	Raines	Bonnie	Educating Children Through Parent	Exec. Dir.
74	Spiwak	Bryan	Ellwood School	Mentor Coord.
75	Jones	Bernadette	Family Court, R-231-K	
76	Lervino	Frank	Family Court, Room 228	
77	Ferguson, Jr.	Leonard	Family Court, Room 228	
78	Milborn	Stephen	Family Court, Room 229	
79	Williams	Craig	First Fidelity Bank	Comm Reinvest
80	Bergstresser	Rev. Larry	First U.M.C. of Roxborough	
81	Curtis	Saleema	Fisher Avenue Organization	
82	Wilkerson	Elvedirie	Francis D. Pastorius School	
83	Cooke	Gregory	Franklin Park Apts.	Social Worker
84	Blakely	Christine	Gaudenzia New Image	
85	Harle	Michael	Gaudenzia, Inc.	
86	Vandergrift	Kate	Gaudenzia-New Image	Director
87	Zelev	Scott	Germantown Business Assoc.	
88	Bonds	Rosa	Germantown Community Improvement	

Figure 5, C

89	Kennedy	Kathleen	Germantown Hospital	
90	Skelton	Sharon	Germantown Hospital	
91	Skelton	Sharon	Germantown Hospital	
92	Marcus	Jalma	Germantown Hospital	Director
93	Ricci	David	Germantown Hospital & Medical Ctr	Exec. V. Pres.
94	Freeman	Emanuel	Germantown Settlement	President
95	Schwartz	William	Germany Hill Civic Assoc Town Watc	
96	Dye	Natasha	Good Shepherd Mediation	
97	Coleman-White	DeVonne	Good Shepherd Mediation Program	
98	Tortu	Debbie	Greater Atlantic Health Plan	Dir Mkt & Comm
99	Roseman	Jodi	Green Tree School	
100	Bahn	Sandy	Green Valley Civic Assoc.	
101	Harris	James	Happy Hollow	
102	Kerler	Arlene	Hermitage St. Town Watch	
103	Anderson	Ken	Hill Community Town Watch	
104	Davis	Rev. Harry	Holy Temple Baptist Church	
105	Davis	Percy	IBM	Dir Comm Relat
106	Goyne	Mary Lee	Interim House, Inc.	Director
107	Jenkins	Jimmy	J2 Production and Star Production	
108	Browne	Dr. Craig	Jay Cooke Middle School	Principal
109	Ruane	Nancy	La Salle School of Nursing	
110	Ryan	Edward	LaSalle University	Res. Drug Ed.
111	Bartley. F.S.C.	Brother Andrew	LaSalle University	
112	Leader/G'town Paper	Editor,	Leader/Germantown Paper	
113	Ackerman	Phillip	Logan Business Assoc	President
114	Libson	Norma	Logan Do Hoc	
115	Johnson	Ethel	Logan Elementary School	
116	Haddad	Juanita	Logan Police Mini-Station	
117	Scott	Charlotte	Logan Task Force on Crime & Safety Chair	
118	Carter	Daisy	Lonnie Young Rec. Center	
119	Taylor	Jean	Lutheran Children and Family Serv.	Dir. of Program
120	Pickett	Blanche	M. L. King Special Olympics	
121	Battle	Eddie	MABLE	
122	Gold	Dennis	Martin Luther King High School	Asst. Principal
123	Cauthorn	Frank	Martin Luther King High School	Teacher
124	Alexander	Joyce	Mayor's Action Center	
125	Felder-Grasty	Merrie	Mayor's Action Center	Director
126	Harris	Wayne	Mayor's Office	
127	Wilder	N. John	Mayor's Office for Drug Control	Deputy Mayor
128	Evans	Sonya	Mayor's Office of Community Serv.	
129	Johnson	Maisha	Mercy Health Plan	
130	McKinly	Kathleen	Morton Civic Center	
131	Cooper	Ethel	Morton Homes Residents' Council	President
132	Nolan	Mary Lally	Mt. Airy Advisory Council	
133	Busu	Susan	Mt. Airy Business Association	

Figure 5, D

134	Lewis	Richard	Mt. Airy Church of God in Christ	
135	Bender	Sharon	Mt. Airy Times-Express	Asst. Editor
136	Gibbs	John	Mt. Airy-Germantown Youth Outreach	
137	Myers	Barbara	N.W. Youth in Action	
138	Deats	Nina	Need In Deed	
139	Williams	Corinne	Neighbors Helping Neighbors	
140	Holman	Veronica	North Central Communities, Inc.	
141	Greene	Dexter	North Police Division	Inspector
142	Lewis	Michelle	Northwest Counseling Service, Inc.	
143	Fernandez	Rev. Richard	Northwest Interfaith Movement	Ex. Director
144	Williams	Anita	Northwest Region	
145	Bachrach	Catherine	Northwest Victim Services	Director
146	Castro	David	Nuisance Bar Task Force	Asst Dist Atty
147	Watts	Phyllis	Oak Lane Community Action Assoc.	President
148	Scott	Stephanie	Office Student Substance Abuse Pgm	
149	Zembroski	Anne	Office Student Substance Abuse Pgm	
150	Porter	Gwendolyn	Office of Student Substance Abuse	Project Admin.
151	Holly	Rev. Edward	Ogontz Area Neighbors Assoc.	Vice President
152	Windham	Mable	Ogontz Area Neighbors, Assoc.	
153	Warner	Minnie	Ogontz Triangle Neigh. Assoc.	President
154	Kuns	Nargaret	Olney Businessmen's Assoc.	President
155	Brown	Carmen	Olney Neighborhood Center	Chair
156	Anderson	Mary	Olney-Feltonville Neighbors Assoc.	President
157	Small	Horace	PAAN	
158	Fields	Lynn	PGW	VP Comm Relat
159	Ore	Sadiq	Pan African Society	
160	Daniels	Barbara	Parents Against Drugs	
161	Davis	Karen	Partnership Project	Research Asst.
162	Corbin	Laurie	Partnership Project	Evaluator
163	Wilkerson	Elvedine	Pastorius School	
164	Merlino	Joseph	Paths/Prism	
165	Hazell	C.J.	Penn Knox Neighbors Assn.	
166	Hollis	Paula	Phila. Dept. of Health	
167	Rice	Sharon	Phila. Home & School Council	
168	Cahill	Walter	Philadelphia Dept. of Streets	Admin. Asst.
169	Gniener	Edward	Philadelphia Fed. of Teachers	
170	Kirsch	Ted	Philadelphia Federation of Teacher	President
171	Blackburn	Lt. William	Philadelphia Police Narcotics Unit	
172	Pendleton	Tonya	Philadelphia Tribune	
173	Paul	Rev. Robert H.	Piney Grove Baptist Church	
174	Raines	Warren	Plymouth St. Neighborhood Assoc.	
175	Reese	Ethel	Pomona-Cherokee Civic Council	
176	Ballard-Morrill	Lorraine	Power 99 FM	
177	Robinson	Veronica	Price Hall Grade School	
178	Grade	Tom	Price Knox Neighbors	

Figure 5, E

179	Eisenberg	Reeva	Prince Hall School	
180	Simmons	Rev. Gordon	Reformation Church	
181	Wells	Ethel	Resident	
182	Cellini	David	Residents of Shawmont Avenue	
183	Earl	Warren	Restoration Outreach Organization	
184	Payne	Delbert	Rohm & Hass	Mgr Corp Soc In
185	Carlsson	Michael	Roosevelt Middle School	
186	Roesler	Leslie	School Age Project	
187	Hathaway	Diane	School Dist of Phila	
188	Green	Esther	School Dist. of Phila.	
189	Barson	Alan	School Dist. of Phila. NW Region	
190	Ritter	Rev. Thomas	Second Macedonia Baptist Church	
191	Ritter	Betty	Second Macedonia Baptist Church	
192	Trocky	Lynn	Shalom, Inc.	Prev Specialist
193	Curry	John	Simons Recreation Center	
194	Savage	Clarence	Simons Recreation Center	
195	Caughlan	Rev. Jerrold	Social Ministry	Director
196	Williams	Carol	Somerville Concerned Neighbors	
197	Belle	Grace	Soroptimist International	
198	Powell	Adrian	Southwest Germantown Assoc.	
199	Labor	Rev. Clarence	St, Stephen's U.M.C.	Pastor Advocate
200	Felder	Evelyn	State Senator Allyson Y Schwartz	
201	Thomas	Lewis	Student Council, U.S.A.	President
202	Hill	Kenneth D.	Sun Company, Inc.	VP Comm Rel
203	Cotto	Rev. Efrain	Tabor United Church of Christ	
204	Moy	Shirley	Temple University	
205	Clariden	F. G.	Temple University	
206	Beetham	George	The Review	Editor
207	Buller	Rev. Richard	The Third Blase: Place Before Home	
208	McCuen	Harold (Mack)	To Live Again	
209	Hudgins	Elaine	Town Watch	
210	Halton	Jean	Triumph Overcomers	
211	Bookbinder	Lori	U.S. Health Care	Pub Rela Dept
212	Campbell	Renee	United Logan Neighborhood Committee	
213	Branch-Cooper	Ethel	United Morton Homes	President
214	Mackie	Mary	United Way Volunteer Center	
215	Carvalho	Millicent	Urban Studies and Community Center	
216	Thomas	Lydia	Vera GUNN	
217	Wright	Susan	W. Central Germantown Neighbors	President
218	Kowey	Dorothy	W. Mt. Airy Neighbors	
219	Jakinaugh	Ed	West Cheltenham Neighbors	President
220	Hawkins	Cynthia	West Germantown Against Drugs	
221	Nash	Joseph	West Oak Lane Against Drugs	
222	Sheridan	Dr. Althiris	West Oak Lane Com. Div. Corp.	Ex. Director
223	Miner	Lloyd	West Sharpnack Civic Council	

Figure 5, F

224	Paulmier	Greg	West Side Neigh. Council
225	Brown	Robert	Wharton Center
226	Waugh	Donna	Wissahickon Boys & Girls Club
227	Freeman	Pamela	Wissahickon Counseling
228	Glodek	Carol	Wissahickon Interested Citizens
229	Scott-Walker	Loretta	Wissahickon Playground
230	Garret	Cheryl	Wister Townhomes

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CHRONOLOGY OF THE SCHOOL-LINKED SERVICES MOVEMENT IN PHILADELPHIA

The School District of Philadelphia has made a major policy commitment to move the district to *"radically revised university-assisted community schools."* Although the idea of community schools is not entirely new (New Haven, Connecticut had them back in the 1960s and 1970s), the more recent trend towards revisiting and rethinking the concept of "community schools" and "school-linked social services" began when President Bush and the nation's fifty governors adopted, **"The National Education Goals,"** at a Charlottesville, Virginia conference, September 27-29, 1989.

On April 18, 1991, President Bush unveiled his, "America 2000: An Education Strategy," that was supposedly designed to implement the National Education Goals. One initiative was the formation of "The New America Schools Development Corporation," ("NASDC"), which was to raise \$30 million in corporate contributions to fund new "break the mold" school designs.

During the fall of 1991, several meetings were held with Philadelphia school district officials and community partners, (myself included) to brainstorm "break the mold" designs for a Philadelphia application to NASDC.

In February, 1992, Superintendent Constance Clayton submitted, "The PARADIGM PROJECT," to NASDC for funding. The PARADIGM PROJECT proposal moved beyond the concept of decentralized site-based management which was officially inaugurated in 1989-90, toward a more fundamental re-conceptualization of school-community-district-regional institutional relationships. This re-conceptualization was based in part on the school-community partnership work done by Ira Harkavy's, "Center for Community Partnerships," at the University of Pennsylvania in West Philadelphia, known as W.E.P.I.C. The PARADIGM proposal, however, went beyond Harkavy's work, to detail a bold vision of broad and sustained collaboration between city agencies, schools and regional community partners to restructure ways of educating children and delivering health and human services through coordinated "school-linked" mechanisms.

In March, 1993, along a parallel track, Mayor Ed Rendell appointed a "Task Force on Children and Families," co-chaired by Shelly Yanoff, Executive Director of Philadelphia Citizens for Children and Youth, ("PCCY"), and Dr. Robert Ross, then Commissioner for the Philadelphia Department of Health.

In June, 1993, the Task Force issued a report with recommendations for action consistent with the National Education Goals. Among other things, the Task Force recommended the establishment of a series of school-linked "Family Centers" and the establishment of a Mayor's "Children's Cabinet" to coordinate city services for children and families, and decentralize their delivery at or near schools.

In August, 1993, Mayor Rendell issued an Executive Order establishing the Children's Cabinet. Joan Reeves, Commissioner of Human Services was appointed chair. In September, 1993 the Mayor submitted a proposal to the PEW charitable trusts (later rejected) for \$10 million to fund the establishment of the Task Force's school-based Family Centers.

Also in August, 1993, Clayton retired as Superintendent along with most of her top echelon staff. Theresa Lemme, Regional Superintendent for the Central East Region was appointed Acting-Superintendent. Lemme, based on her experience with Latino students and parents, also embraced the move to more closely link schools and the surrounding community.

On December 13, 1993, the Board of Education adopted a resolution endorsing Acting Superintendent Theresa Lemme's 12-point **Systemic Education Reform Agenda**. Consistent with the thinking embodied in the PARADIGM PROJECT proposal, Lemme's Agenda called for "radically restructured university assisted community schools." These community schools would be a base for the provision of a variety of human services, such as comprehensive health education, school-based health clinics and counseling services.

In January, 1994, Lemme appointed a large task force to develop an action plan for the School District around each of her 12 points of reform.

On March 31, 1994, President Clinton signed into law "GOALS 2000: Educate America Act" which codified the National Education Goals and authorized grants to states and school districts for planning purposes. This supplanted President Bush's "America 2000" strategy.

In April, 1994, Superintendent Lemme's Task Force Action Plan on how to implement her 12-point Systemic Education Reform Agenda was released. This Action Plan called for the establishment of six community schools in the School District of Philadelphia - one in each of six Regions - with an anticipated budget of \$400,000 per school for the first year. The community school designated for the Northwest Region is Pickett Middle School.

Meanwhile, the Philadelphia Federation of Teachers ("PFT"), whose contract was set to expire on August 31, 1994, publicly issued their own "**Education Reform Proposals**." Their first proposal was the recommendation that representatives of the PFT and the School Board meet with city council, the mayor and other appropriate state agencies in order to *"develop community schools that include city and state after-school services, health care, pre-natal care, recreation programs, library programs, police sub-stations, food services, literacy classes, other adult classes deemed necessary for the community, and other city and state meaningful involvements."*

Meanwhile, Leann Ayers, an associate of Shelly Yanoff's at PCCY, was appointed by Mayor Rendell to be the Executive Director of his newly formed Children's Cabinet under Reeves. One of Ayers' first tasks was to reapply to the Commonwealth of Pennsylvania for a state grant to establish three "Family Centers" in the City of Philadelphia. One of the Family Centers is also Pickett Middle School, in the Northwest Region.

On June 1, 1994, Northwest Regional Superintendent Judy Brody sponsored a "Comprehensive School Health Conference," held at La Salle University with approximately 400 attendees and two dozen presenters.

On June 3 and 4th, 1994, Stefan Pryor, an Alderman in the City of New Haven, and research fellow for the Yale Center for Youth Development was the keynote presenter at a community-based conference on school-linked services, entitled, "Reconstructing the Village," also held at La Salle University. Mr. Pryor's presentation was noteworthy because of New Haven's thirty year history past experience with community schools and their current effort to refine an earlier failed model. Pryor unveiled a new Community-School model that combined school-linked services and school site education reform. Dubbed, "CoZi," New Haven's new community school initiative combined educational reformer James Comer's school restructuring model with the new Family Center model of Ed Ziegler, one of the founders of Head Start.

In August, 1994, Pennsylvania received \$3.9 million in GOALS 2000 funds for communities, parents and schools to **jointly** plan reform efforts.

Also in August, 1994, David Hornbeck was appointed Superintendent of Philadelphia Schools replacing Acting-Superintendent Theresa Lemme. Hornbeck was the architect of the **Kentucky Education Reform Act**, "KERA," which resulted in sweeping state-wide changes in Kentucky schools. One of the changes was the move to community schools and school-linked services throughout Kentucky's public schools.

In September, 1994, Superintendent Hornbeck appointed Theresa Lemme to oversee the district's community school initiative, while unveiling his own 10-point "Children Achieving" education reform agenda. Shelly Yanoff was also asked to help fundamentally reshape school district organization. This reorganization is being guided by the August, 1994 report of Commonwealth Judge Doris Smith's Educational Panel as part of the concluding chapter of a 23 year old desegregation suit.

In September 1994, President Clinton signed both the "Crime Bill" and the revised "Elementary and Secondary Education Act" into law. Both provide billions for school-based health education, drug and alcohol abuse prevention, conflict medication and other human services.

On October 7, 1994, the first applications from Pennsylvania school districts for federal GOALS:2000 funds were due in Harrisburg.

On October 24-25, 1994, Dr. Harkavy and the University of Pennsylvania sponsored a "National Conference on Planning and Operation of University-Assisted Community Schools." The first day's keynote address was by Richard Riley, Secretary, U.S. Department of Education. The second day's keynote was William A. Galston, Deputy Assistant to President Clinton's Domestic Policy Council.

It is clear from the above chronological summary that the Philadelphia community school movement is assembled from a convergence of forces at the federal, state, city, school district, union and community levels. Consistent with this movement is Germantown Hospital's May 1994 community health assessment report, entitled **"Partners for a Healthy Community: Health Assessment for Northwest Philadelphia and Adjoining Suburbs."** The "Partners report" is timely for a number of reasons:

First, within the City of Philadelphia, the Northwest Region is perhaps the most active in the community-school restructuring movement, particularly as it relates to school-based health clinics.

Second, the report was developed by a diverse, sixteen member "Community Health Assessment Advisory Committee," ("C.H.A.A.C."). This kind of collaboration is increasingly being required by both private foundation and federal grant making agencies. i.e., the US Department of Education and Health and Human Services.

Third, the substance of the report itself can serve as a baseline study that will likely be a prerequisite for any school-community health collaboration.

In conclusion, there are many elements already in place in Philadelphia and its Northwest Region to take advantage of the broader policy and funding context which has emerged in support of community schools. Successful collaboration between institutions, schools, and the broader community, however, will require the skillful "brokering" of diverse personal and institutional interests and agendas. Neutral "third parties" experienced in collaborative processes and grant writing can be useful to bring people together to focus on the sequential tasks of:

1) goal definition, 2) program development, 3) program management and structure, 4) program implementation, and 5) program institutionalization.

Beyond specific programs, however, is the challenge of restructuring community/school/health & human institutional relationships so that collaboration is less ad hoc and more a normal way of achieving common objectives.

SCHOOL DISTRICT OF PHILADELPHIA

YOUTH RISK BEHAVIOR SURVEY

The YRBS was developed by the Division of Adolescent and School Health, National Center for Chronic Disease and Health Promotion, Centers for Disease Control and Prevention (CDC) in collaboration with representatives from 71 state and local departments of education and 19 other federal agencies, to monitor priority health-risk behaviors that contribute to the leading causes of mortality, morbidity, and social problems among youth and adults in the United States. These behaviors fall into six categories:

- Behaviors that result in unintentional and intentional injuries.
- Tobacco use.
- Alcohol and other drug use.
- Sexual behaviors that result in HIV infection, other sexually transmitted diseases (STDs), and unintended pregnancies.
- Dietary behaviors.
- Physical activity.

The 84-item multiple choice YRBS was administered to approximately 1,500 public high school students in Philadelphia during the spring of 1993. Survey administration procedures were designed to help protect the privacy and confidentiality of all participating students. Student participation was voluntary.

Key findings related to sexual risk taking behaviors:

- 87% of all students reported having been taught about HIV/AIDS in school.
- 71% of all students reported ever having had sexual intercourse.
- 26% reported having had sexual intercourse prior to age 13.
- 36% reported having had sexual intercourse with four or more people.
- 42% reported using condoms or whose partner used condoms during last sexual intercourse.

These data provide the School District with valuable baseline information about high school students' health risk behaviors that can assist in the identification of ongoing needs for developing appropriate health education programs and services.

In subsequent years, the YRBS will be administered annually in grades seven and eight and senior high schools in order to monitor priority health-risk behaviors, thus enabling support for effective and efficacious programmatic decision-making relative to curriculum, instruction and services. The School District will be working with Temple University and the family Planning Council of S.E. Pennsylvania on these future evaluation projects.

EVALUATION OF 1993 YOUTH RISK BEHAVIOR SURVEY RESULTS;
Sexual, Violence, and Suicide related behaviors

SAMPLE DESCRIPTION

Overall, a total of 1513 high school students participated in the survey. Of these, 728 (48.1%) were males and 777 (51.4%) were females. Within age groups, 16 and 17 year olds represented 45.5% of the total group. Out of all four grades, 9th and 12th grade students represented 61.7% of the total subject population. Black students represented 57.2% of the population, White students 21.3%, and Hispanic students 9.4%.

SEXUAL RISK-TAKING BEHAVIOR (Questions 55 through 65)

The percentage of respondents (avg. 86.9%, N=1471) reporting that they were taught about AIDS/HIV infection in school ranged from 83.9% (18 years +) to 88.3% (16 & 17 years). The highest percentage was reported by 16 and 17 year old White students, both males and females. There appears to be a significant difference between white students (91.8%) and all other races (Blacks 85.75, Hispanics 84.9%, and others 85.4%).

The percentage of respondents (avg. 72.3%, N=1471) who ever talked about AIDS/HIV infection with their parents or other adults in their family ranged from 70.7% to 74.0% with the highest percentages reported by both the 15 or less and 18 and older age groups. It is interesting to note that Black respondents (75.3%) and Hispanic (74.85) were more likely than White respondents (70.5%) to have discussed AIDS despite a higher percentage of White students having reported being taught about AIDS. Females (76.8%) are significantly more likely than males (67.3%) to have discussed AIDS.

The percentage of respondents (avg. 71.2%, N=1410) who ever had sexual intercourse ranged from 56.4% for the 15 or less age group to 85.5% for the 18 or older age group. Percentages reported increase with age as would be expected with the highest percentage seen among Black males (90%) and females (72.7%) and the lowest among White males (54.5%) and White females (53.9%).

Out of 1402 respondents, 25.8% reported having had sexual intercourse for the first time prior to age 13 with males being significantly greater than females (42% versus 11.1% respectively).

Approximately 36% of 1388 subjects reported having had sexual intercourse with 4 or more people during their life. Males are significantly more likely (53.4%) than females (21.4%) to have had multiple partners and Black males (69.5%) and Black females (26.5%) are significantly higher than White males (24.7%) and White females (13.1%). Blacks* in general, are higher than all other races (Whites- 18.8%, Hispanic 21.5%, and others 31.2%). *46.9%
It is interesting to note that, although the percentage of participants having had sexual intercourse increases with age, 21.2% of the 15 or less age group reported having had sexual intercourse with 4 or more partners. Although this age group is more likely to have discussed AIDS with an adult, they are less likely to have been taught about AIDS.

Percentages of respondents (7.2%, N=1397) who had sexual intercourse with 4 or more people during the past three months was highest among the 18 and older age group, males, and Blacks with Black males having the highest rate of multiple partners (19.5%) compared to 3.2% for White males. Black (1.4%) and White (.7%) females are much less likely than their male counterparts to have multiple partners.

The use of alcohol or drugs prior to sexual intercourse was reported by 9.5% of 1399 respondents. Males (12.9%) reported higher usage than females (6.5%) and White males (19.6%) and females (10.5%) are significantly higher than Black males (10.6%) and females (5%). Hispanic respondents were close to the average.

Overall, the percentage of respondents who reported using condoms during their last sexual intercourse was 42.3% (N=1378). Males (52.8%) were significantly more likely to have used a condom than female partners (32.9%) and use among Black males (63.5%) is significantly higher than among White males (32.6%). There is little difference between Black and White females. However, the lowest use of condoms was reported in the 15 or under age group across gender. It is important to note that 21% of this age group also reported having sexual intercourse with 4 or more partners during their lives. This may emphasize the need for increased sex education at earlier ages in school. Another interesting point to note is that Black males reported a higher use of condoms and also reported in Question 56 a greater tendency to have discussed AIDS with an adult.

The use of birth control pills during their last sexual intercourse overall is low (9.3%, N=1356) with use increasing with age and an appreciable increase seen between 16 and 17 year old females (12.4%) and 18 and older females (20%). Black females (12.7%) reported using birth control pills more often than White females (6.6%). However, for females across all age and racial groups, use of condoms by male partners or birth control pills by the females themselves is less than 50% of all females engaging in sexual activity. This statistic takes on greater significance when seen in the context of question 64 - the percent of respondents reporting ever having been pregnant or gotten someone pregnant one or more times. Although the overall average is 19.5% (N=1429), the highest percent is seen among 18 or older females (39.8%) with significant differences in pregnancies seen from one age group to another (15 or less - 8.4%, 16 and 17 year olds - 24.3%, and 18 and older - 39.8%)

VIOLENCE RELATED BEHAVIOR (Questions 13-22)

The percentage of respondents who reported carrying a weapon on one or more of the past 30 days was 30.6% (N=1454) on the average. Males (39%) are significantly more likely than females (23.1%) to carry weapons. Within each gender group, the 18 + group of males (46.4%) had the highest rate while the 15 or less group of females (24.2%) had the highest rate among females. An interesting observation is that White males (45%) are more likely than Black males (36.6%) to carry a weapon while Black females (25.9%) are more likely than White females (15.2%) to carry a weapon.

The percentage of respondents who reported carrying a gun is 11.6% (N=1473) which constitutes approximately one-third of all respondents reporting carrying weapons. This indicates that the majority of weapons being carried are things other than guns. Males are significantly more likely than females to carry guns (19.2% versus 4.8% respectively) and respondents categorized as other by race reported the highest rate at 14.1%. Ninth and tenth grade males and females are significantly more likely to carry guns than 11th and 12th graders with 10th grade males having the highest rate of 31%. Black males are more likely to carry guns than White males. However, White males are more likely to carry any type of weapon as seen in question 13.

The percentage of respondents who carried any type of weapon on school property was 16.6% (N=1465) with the rates being evenly distributed across age and grade. Males (21%) are more likely than females (12.5%) to perform this behavior and Black females are more likely than White females to carry a weapon on school property (13.3% versus 6.9% respectively). Overall, Hispanics (17.3% and other racial groups (23.2%) reported the highest rate of carrying weapons on school property.

Approximately 12% (N=1493) of respondents reported not going to school because they felt unsafe with the highest percentage being reported among 9th grade males and females and all Hispanic and "other" racial groups.

Approximately 11% (N=1491) of respondents reported being threatened or injured with a weapon on school property while 27.9% (N=1493) reported having property damaged or stolen on school property. Rates are evenly distributed among all age, grade, and racial groups.

The percentage of respondents who reported being in a physical (ques.19) fight was 51.4% (N=1427) with males* being more likely than females* to have engaged in a fight and the youngest age group and the 9th grade level having significantly higher rates than older respondents (males: 59.6% versus 49.2% respectively, females: 53.3% versus 37.7% respectively). Little difference is seen between Blacks and Whites. Approximately 19% of respondents reported being in a physical fight on school property (question 22) with a similar breakdown by gender and grade categories to question 19 above. However, Black males (29%) and females (18.7%) are significantly more likely than White males (18.6%) and females (6.9%) to have been in a physical fight.

* males-56.5%, females-46.6%

The percentage of respondents who fought with a friend or acquaintance was 44.5% (N=1451) with females (49.1%) having a higher rate than males (39.4%) and younger amles (15 or less, 47.1%) and females (51.7%) having significantly higher rates than their older (18+) counterparts (18+males - 35.3%, 18+females - 44.4%).

The percentage of respondents who were injured in a physical fight and had to be treated medically was 7.9% (N=1464) with the highest rates seen among 15 or less males (11.3%) and 18 or older females (10.2%). A significant difference is also seen between Black females (8.4%) and White females (1.3%)

SUICIDE RELATED BEHAVIOR (QUESTIONS 24-27)

The percentage of respondents who ever considered attempting suicide was 20.9% (N=1489) with females (25.4%) being significantly more likely than males (16.1%) and White males (18.2%) and females (25.6%) being more likely than Black males (13.7%) and females (20.4%) to perform the behavior. However, Hispanic and the "other" racial group reported rates higher than both Blacks and Whites (Hispanic - 32.6%, Other-27.2%).

PLAN { The percentage of respondents who made a plan (17.1%) and actually attempted suicide (12.3%) followed a similar pattern of percentage breakdowns as seen in question 24 (ever considered attempting suicide). Females are more likely than males to perform these behaviors (21.8% versus 11.9%); 10th grade males (19%) and females (24.2%) have the highest rates; and Whites are more likely than Blacks to perform the behavior (19.1% versus 14.3% respectively: males - 14.5 vs 10.7% and females: 23.7 vs 17.3%). Hispanics and "others" have the highest rates overall among all races with 25 and 21% respectively.

The percentage of respondents who attempt suicide resulting in an injury was 4.7% (N=1311). Here there is a smaller difference seen between males (4%) and females (5.4%) and the highest rates are seen among 18 or older females (8.3%). Hispanic and the other racial group still report the highest rates among all races (5.7% and 8% respectively). The most dramatic difference is seen among racial groups for those reporting actually attempting suicide (Hispanics - 19.5%, other - 18.6%, White - 11.4%, Black - 10.1%). The average is 12.3% with females averaging 15.6% and males 8.6%.

About the Youth Risk Behavior Survey (YRBS)

The YRBS was developed by the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC) in collaboration with representatives from 71 state and local departments of education and 19 other federal agencies, to monitor priority health-risk behaviors that contribute to the leading causes of mortality, morbidity, and social problems among youth and adults in the United States. These behaviors fall into six categories:

- Behaviors that result in unintentional and intentional injuries.
- Tobacco use.
- Alcohol and other drug use.
- Sexual behaviors that result in HIV infection, other sexually transmitted diseases (STDs), and unintended pregnancies.
- Dietary behaviors.
- Physical activity.

The questionnaire first was used during spring of 1990 by 31 state education agencies and local education agencies and again in spring of 1991 by 39 SEAs and LEAs. Additionally, it was used by CDC in 1990 and 1991 to assess the prevalence of health-risk behaviors among nationally representative samples of high school students. Beginning in 1991, these national, state, and local school-based surveys will be conducted biennially using the self-administered YRBS questionnaire.

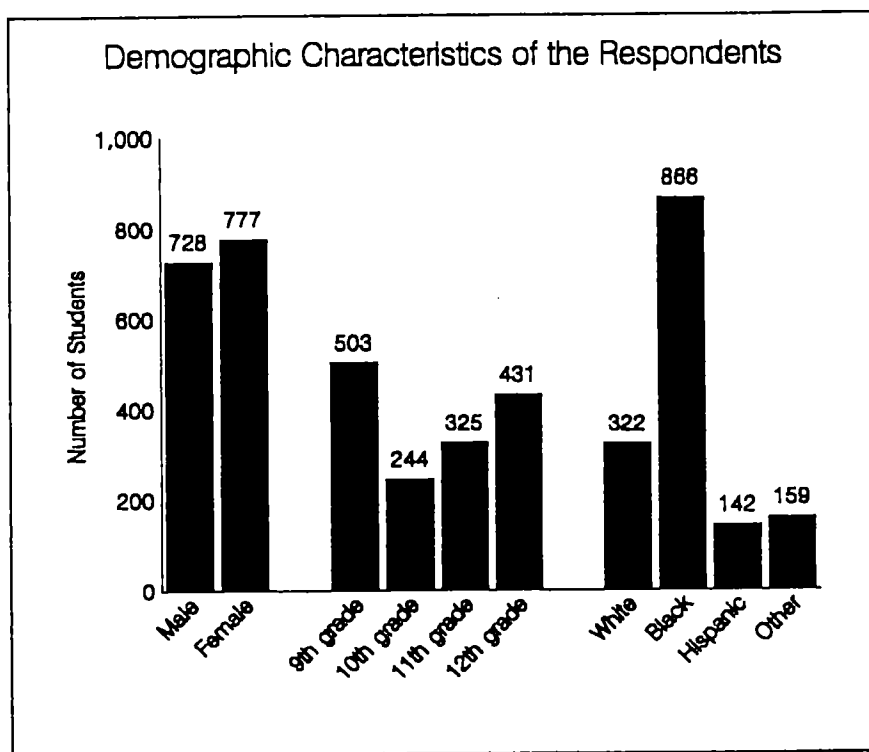
YRBS results can be used by SEAs and LEAs to 1) monitor progress in achieving 26 national health objectives for the year 2000; 2) monitor progress in achieving National Education Goal 6; 3) focus comprehensive school health education teacher training and instructional programs; and 4) support comprehensive school health programs in their jurisdictions.

School District of Philadelphia Youth Risk Behavior Survey

Executive Summary

The 84-item, multiple choice Youth Risk Behavior Survey (YRBS) was administered to 1505 students in 11 public high schools in Philadelphia during the spring of 1993. Survey administration procedures were designed to help protect the privacy and confidentiality of all participating students. Student participation was voluntary.

The results should not be generalized to other students in Philadelphia. Nonetheless, the results provide an important description of the priority health-risk behaviors of the survey participants.



SCHOOL DISTRICT OF PHILADELPHIA

1993 YOUTH RISK BEHAVIOR SURVEY RESULTS: HIGHLIGHTS

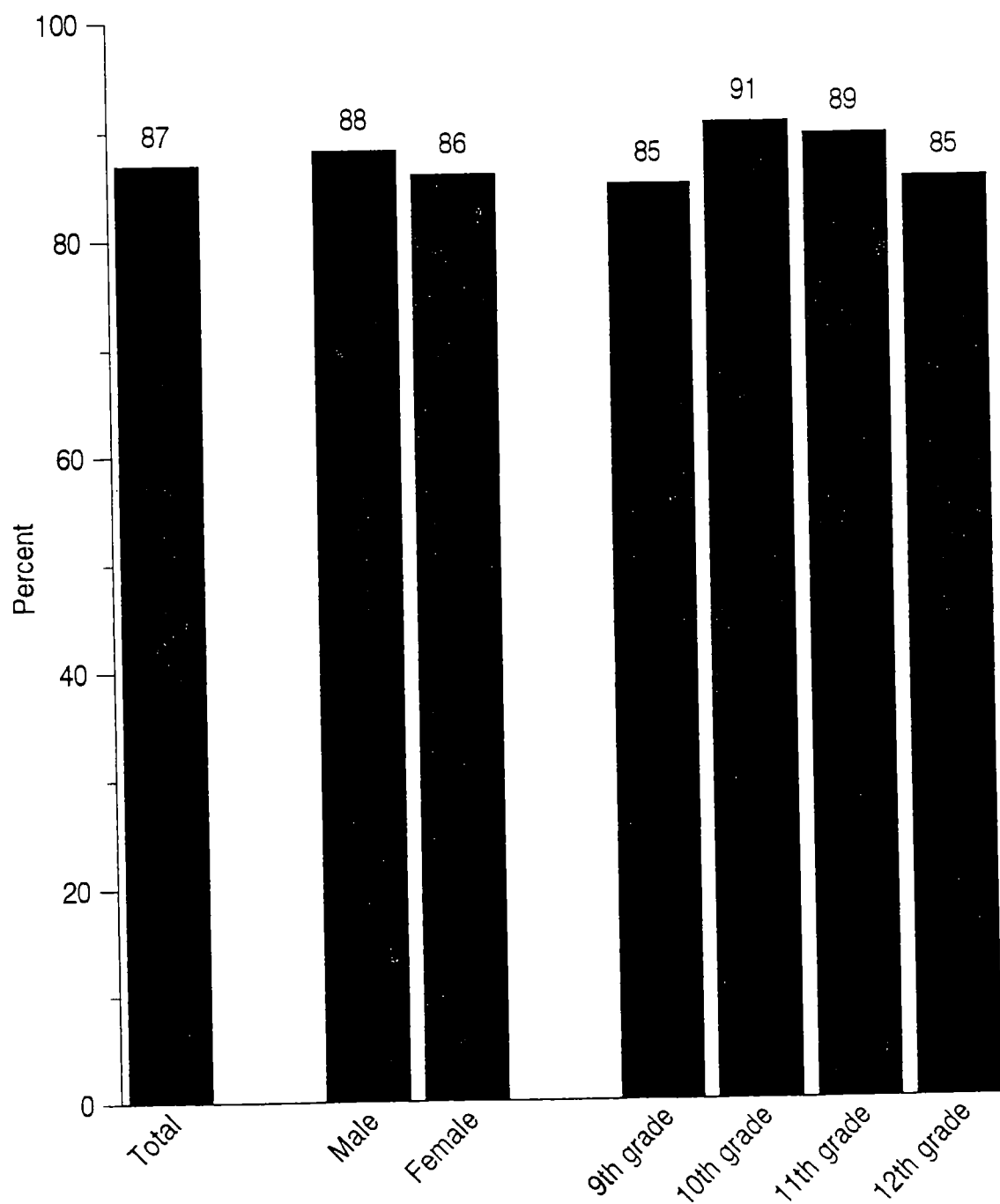
SAMPLE:

- * 1505 HIGH SCHOOL STUDENTS PARTICIPATED IN THE SURVEY**
 - 728 - MALES; 777 - FEMALES**
 - 16 AND 17 YEAR OLDS REPRESENTED 46% OF THE POPULATION**
 - BLACK STUDENTS REPRESENTED 57% OF THE POPULATION**

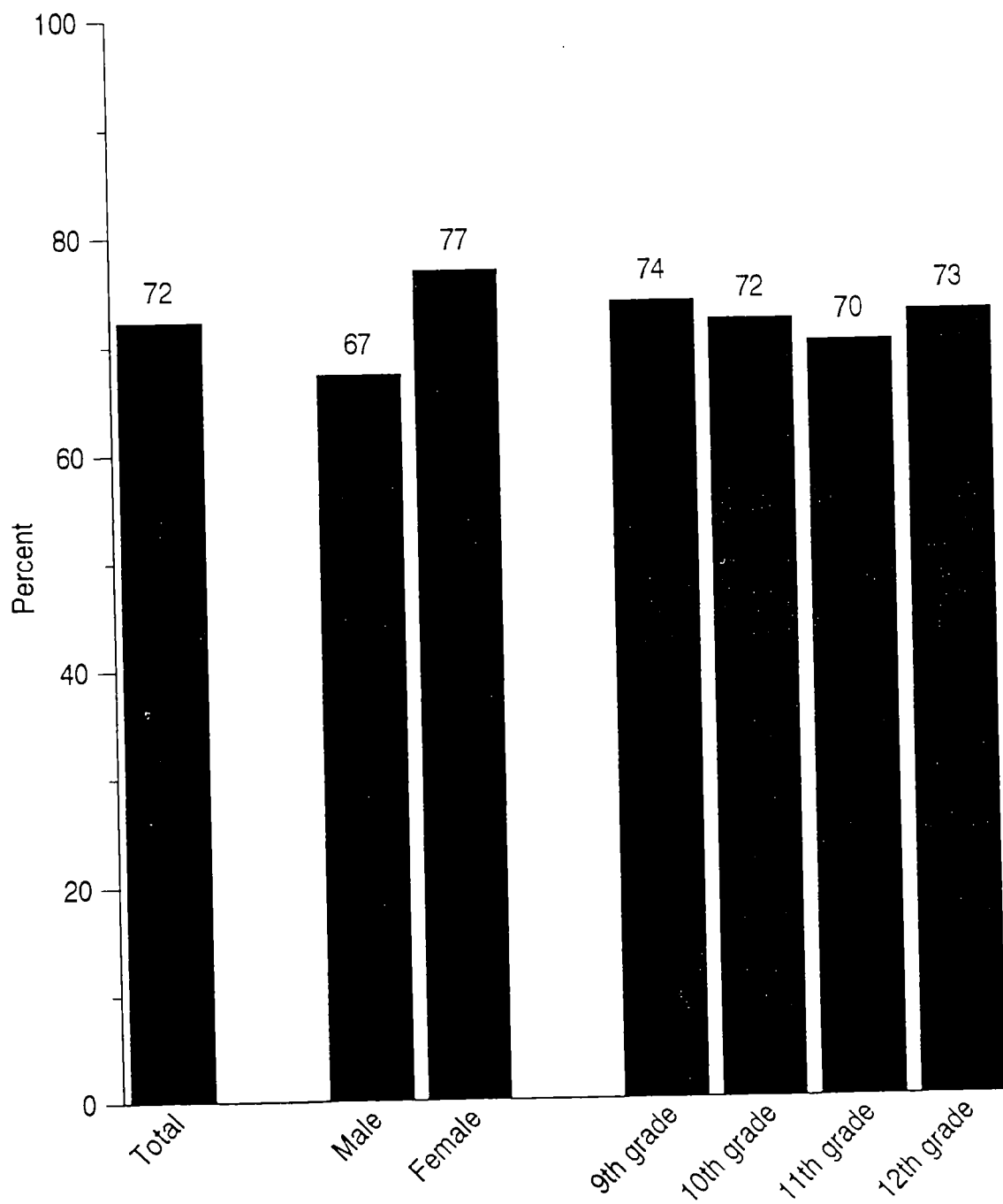
SEXUAL RISK-TAKING BEHAVIOR:

- * 71% OF ALL STUDENTS REPORTED HAVING HAD SEXUAL INTERCOURSE**
 - HIGHEST RATE REPORTED AMONG 18 AND OLDER STUDENTS - 86%**
- * 26% REPORTED HAVING SEXUAL INTERCOURSE PRIOR TO AGE 13**
 - MALES HAVE HIGHEST RATE OF 42%; FEMALES 11%**
- * 36% OF ALL STUDENTS REPORT HAVING HAD SEXUAL INTERCOURSE WITH 4 OR MORE PEOPLE**
 - MALES ARE HIGHER THAN FEMALES (53% VS. 21%)**
 - BLACKS REPORTED THE HIGHEST RATE AMONG RACES - 47%**
 - 21% OF THE 15 OR LESS AGE GROUP REPORTED HAVING MULTIPLE PARTNERS**
- * 42% OF ALL STUDENTS REPORTED USING CONDOMS OR WHOSE PARTNER USED CONDOMS**
 - MALES - 53%; FEMALES - 33%**
 - BLACK MALES - 64%; WHITE MALES - 33%**
- * 9% REPORTED USING OR WHOSE PARTNER USED BIRTH CONTROL PILLS**
- * LESS THAN 50% OF FEMALE HIGH SCHOOL STUDENTS ENGAGING IN SEXUAL INTERCOURSE USE CONDOMS OR BIRTH CONTROL PILLS**
- * 40% OF 18 OR OLDER FEMALES REPORTED BEING PREGNANT ONE OR MORE TIMES AND 20% OF ALL STUDENTS REPORTED BEING PREGNANT OR GETTING SOMEONE PREGNANT ONE OR MORE TIMES**

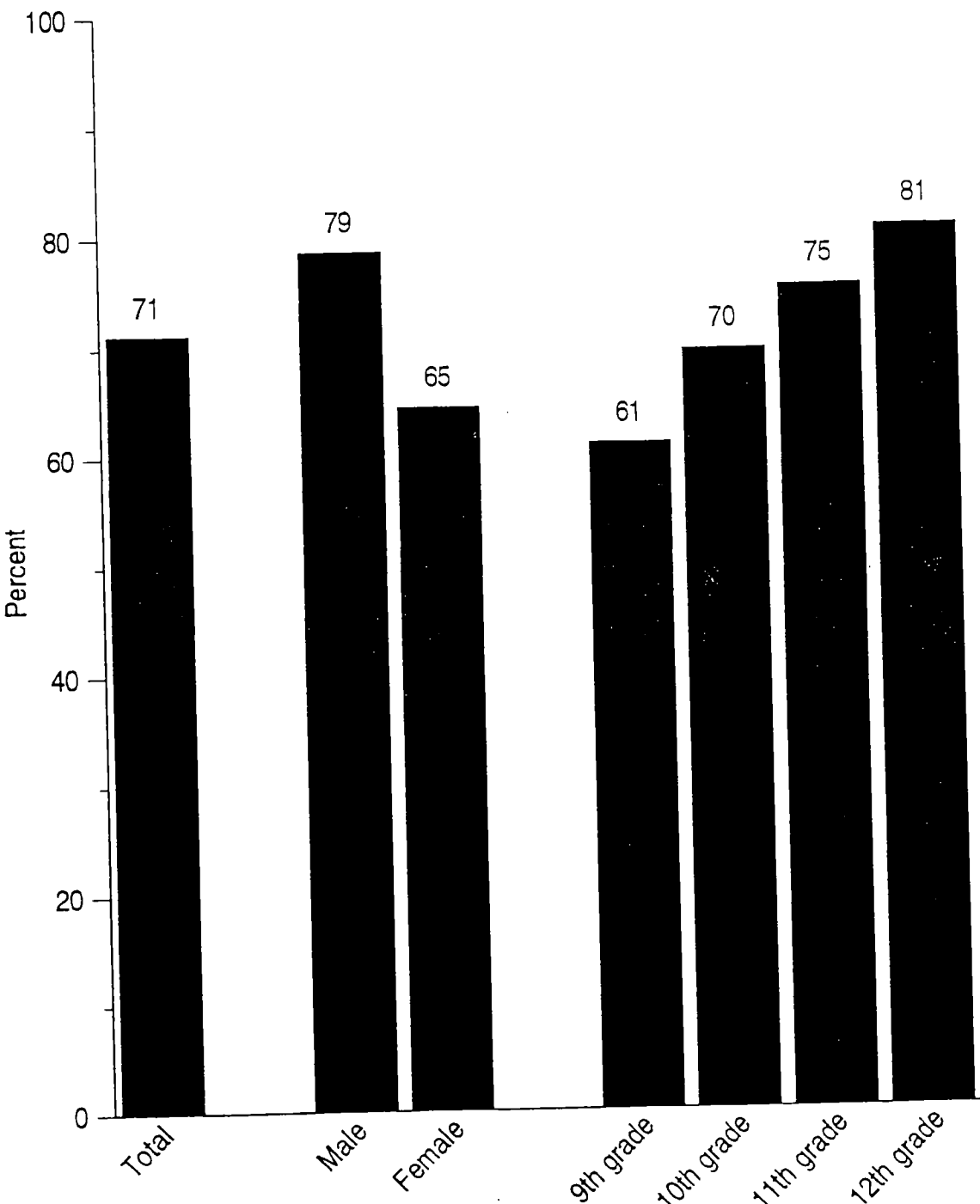
Percentage of respondents who were taught about AIDS/HIV infection in school.



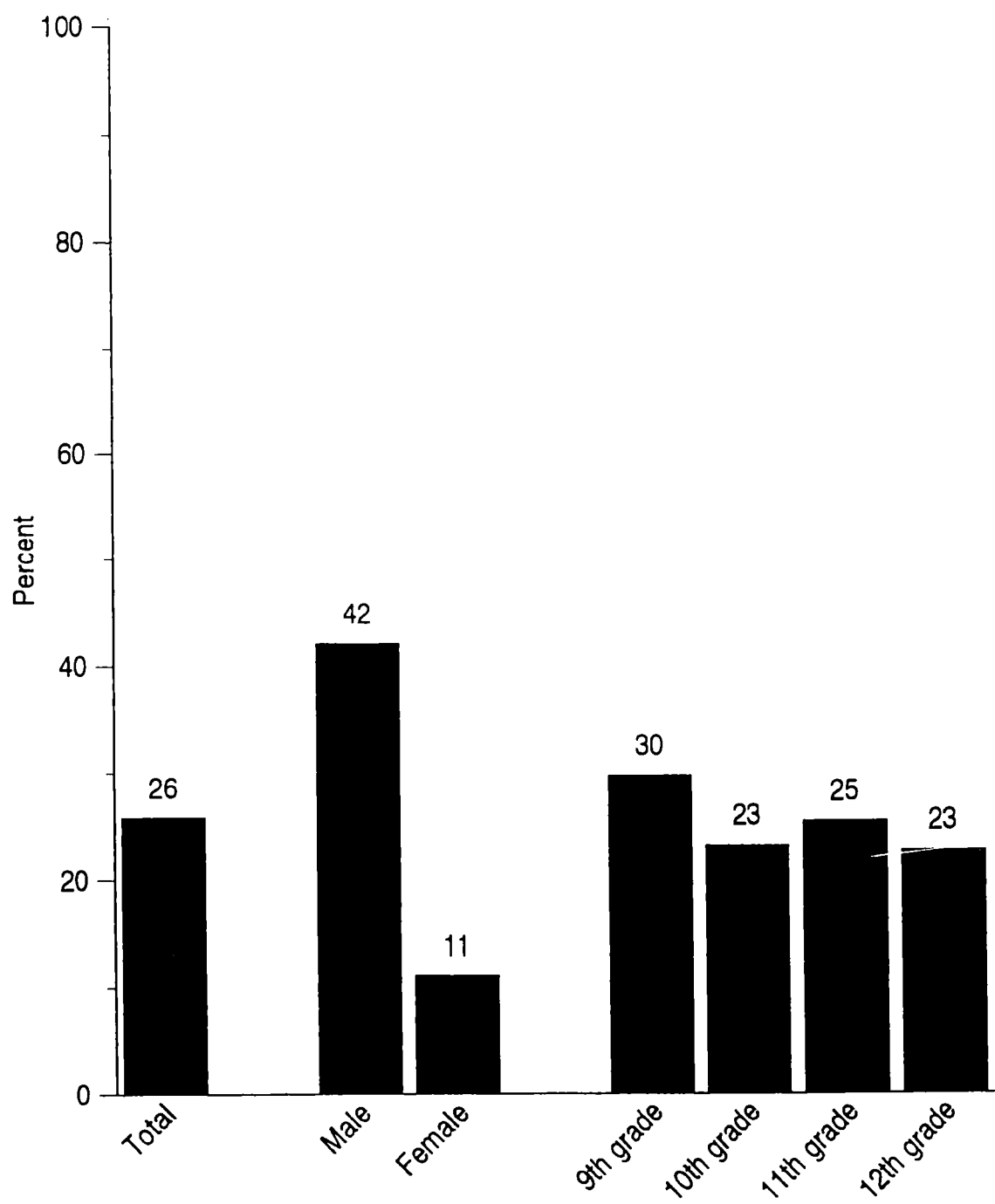
Percentage of respondents who ever talked about AIDS/HIV infection with their parents or other adults in their family.



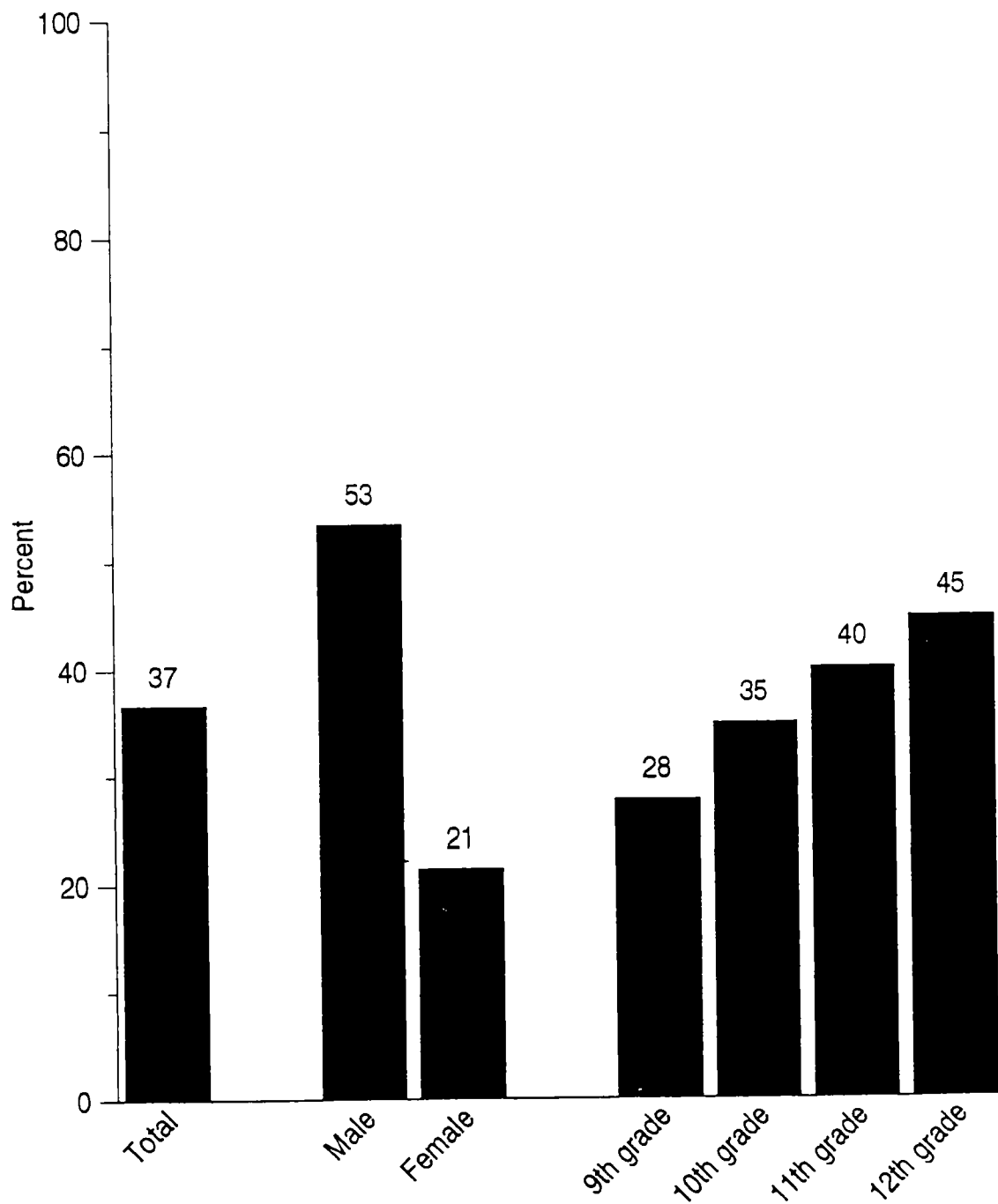
Percentage of respondents who ever had sexual intercourse.



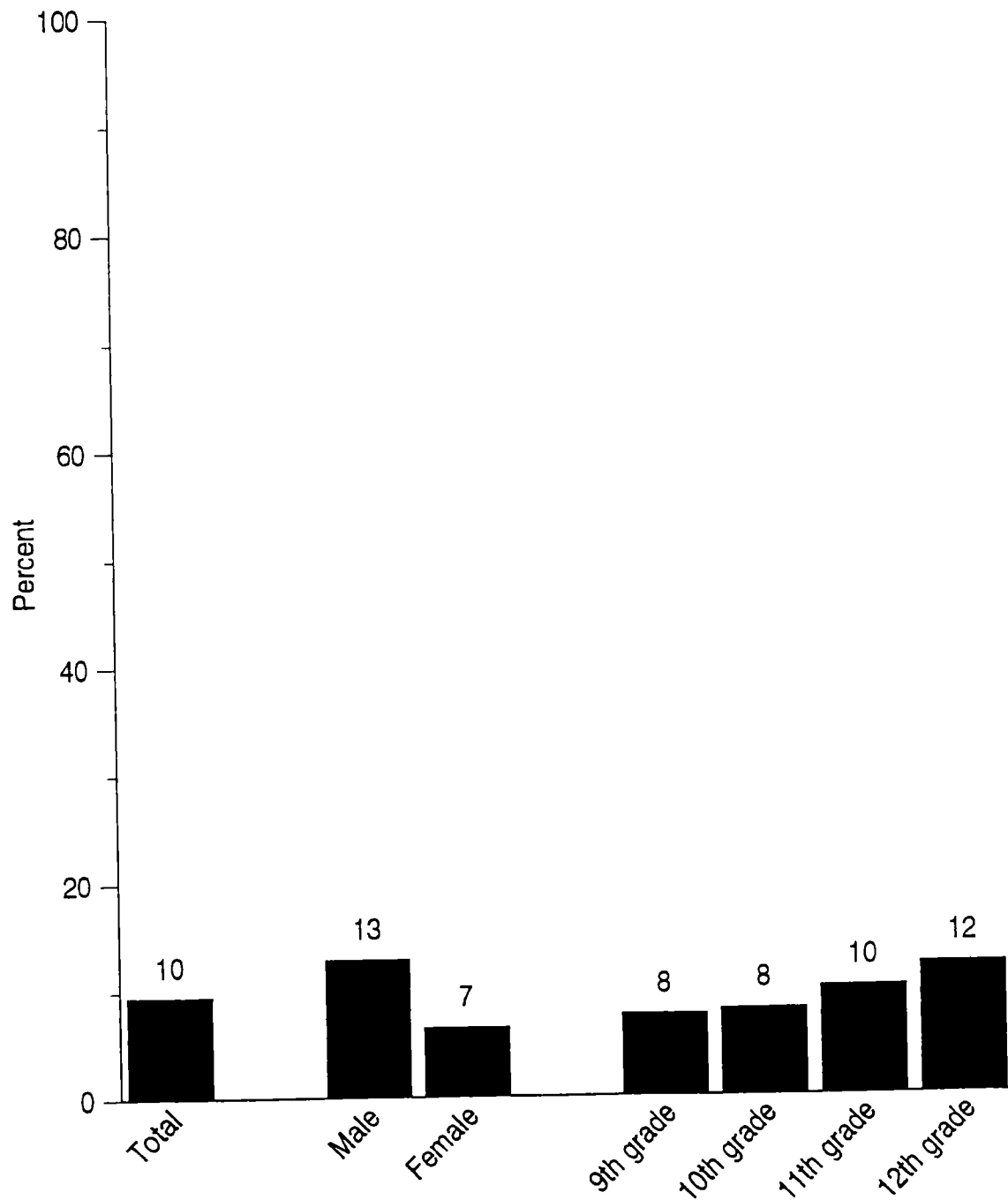
Percentage of respondents who had sexual intercourse for the first time prior to age 13.



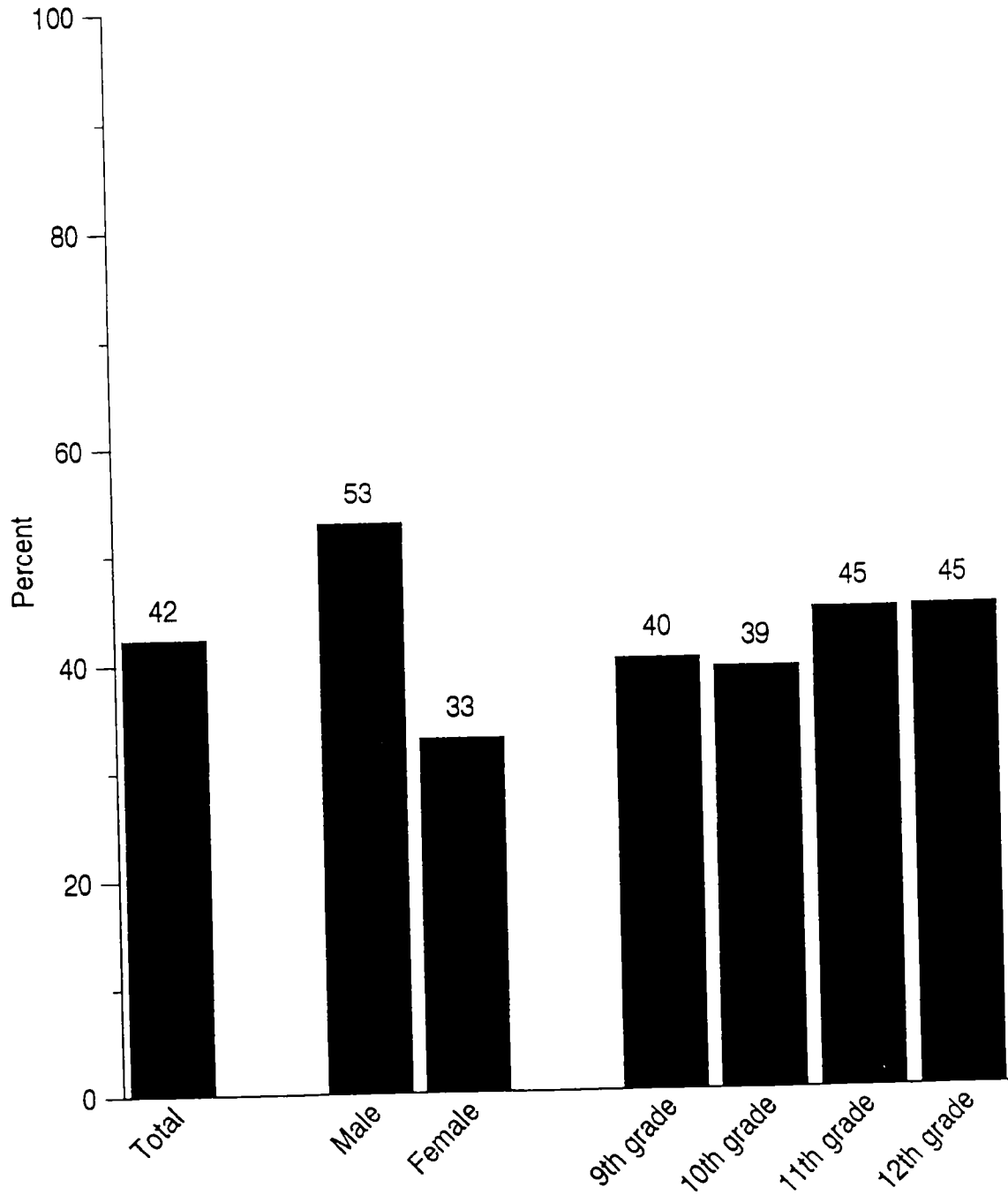
Percentage of respondents who had sexual intercourse with four or more people during their life.



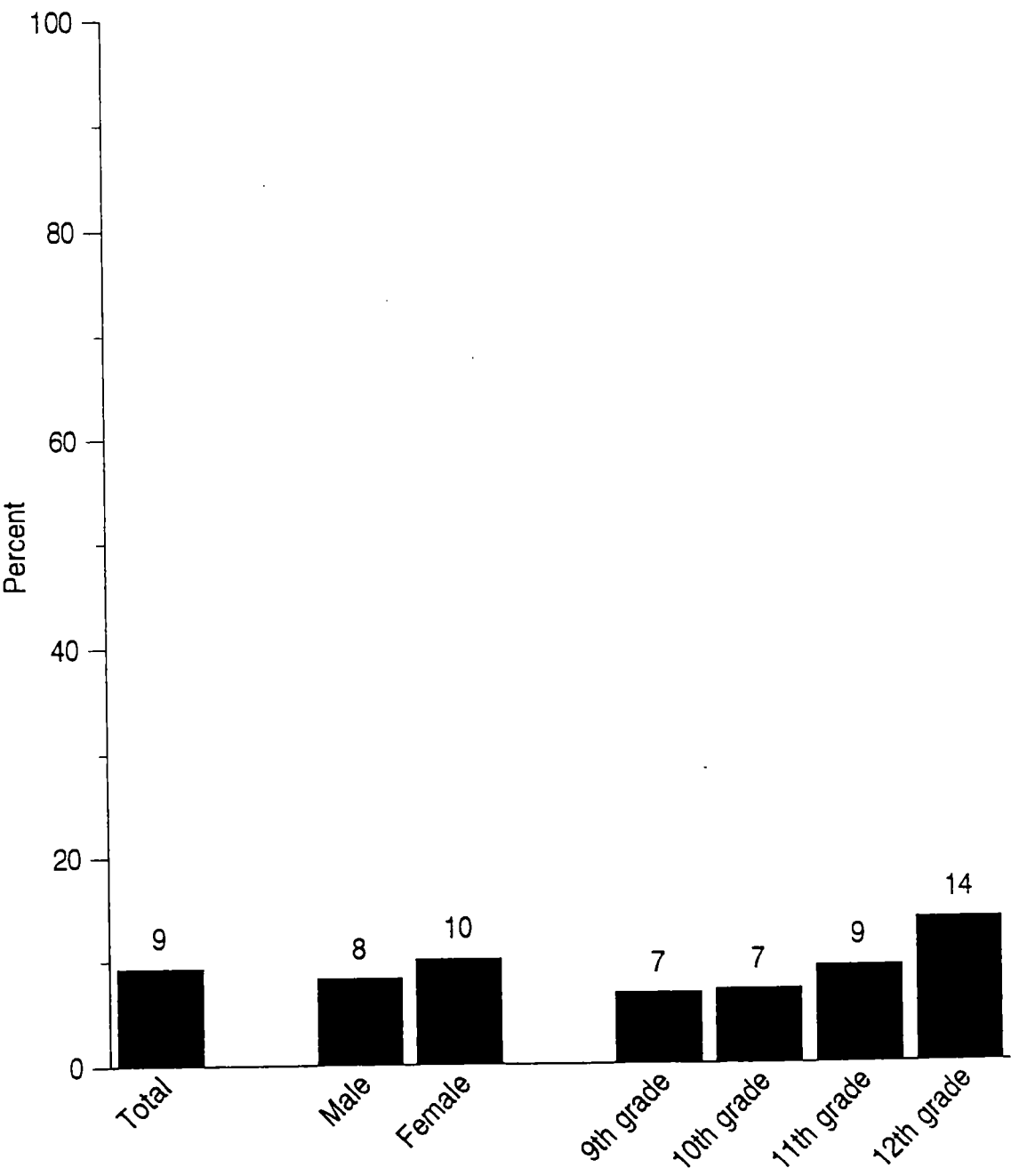
Percentage of respondents who drank alcohol or used drugs before last sexual intercourse.



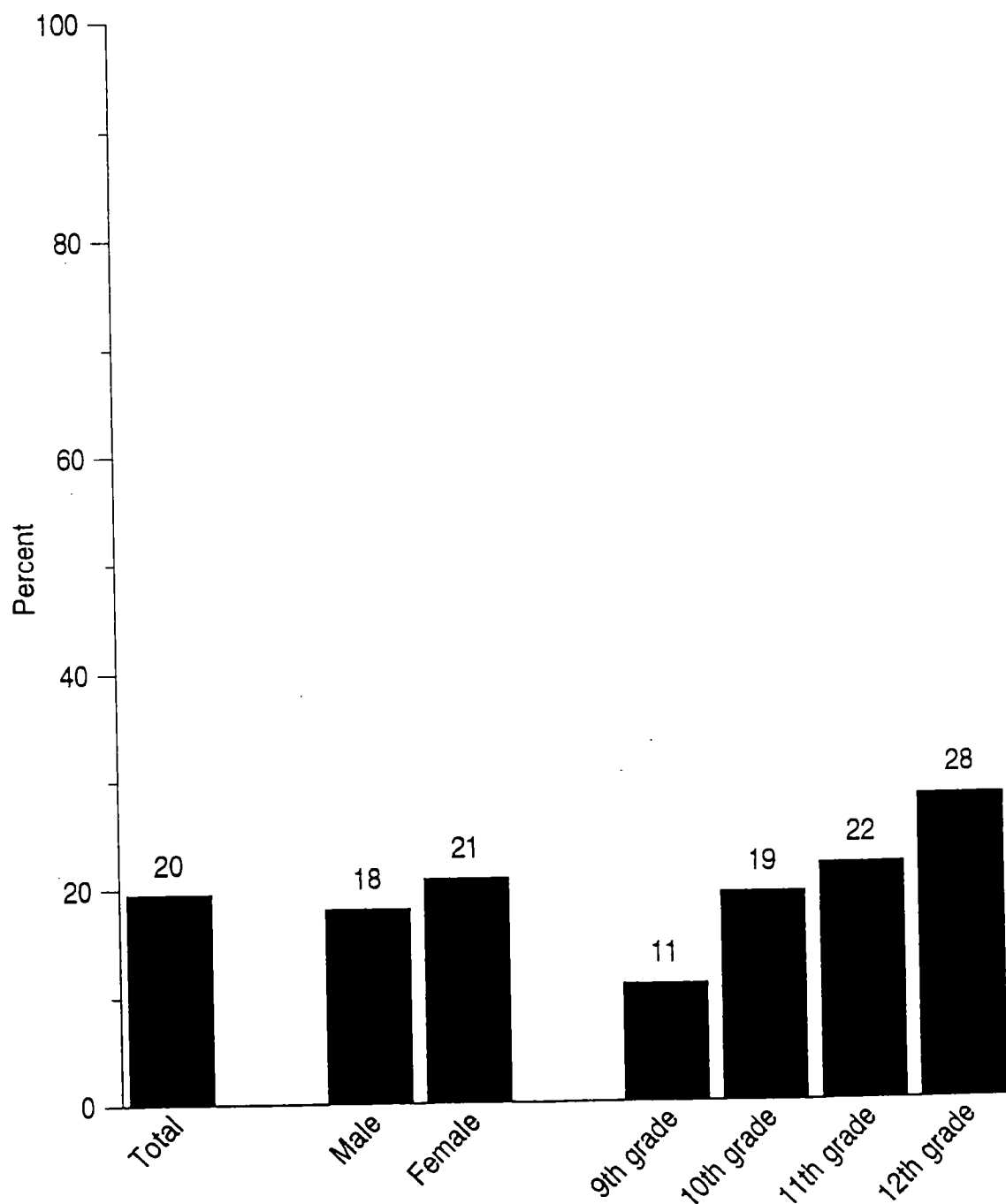
Percentage of respondents who used or whose partner used a condom during last sexual intercourse.



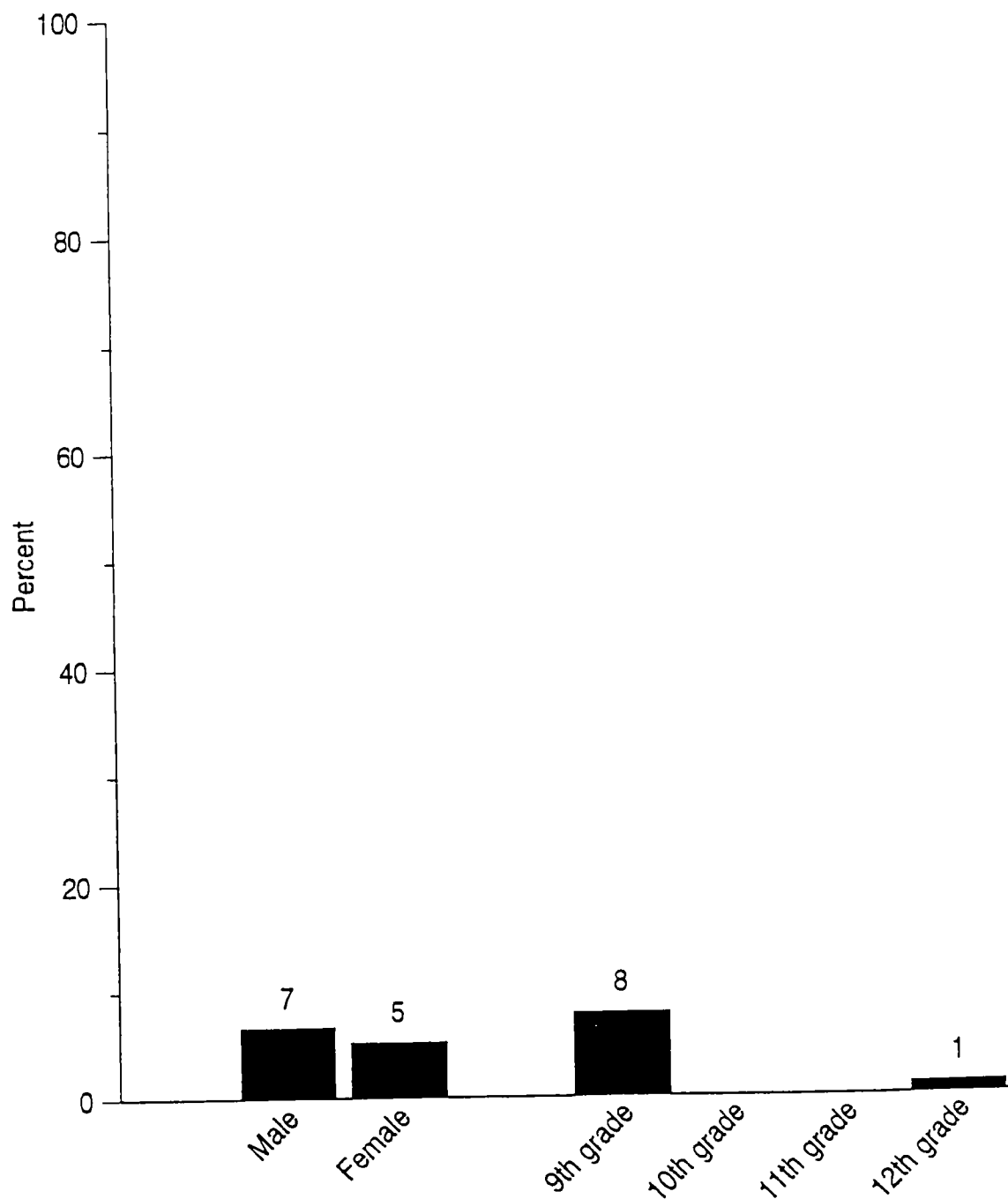
Percentage of respondents who used or whose partner used birth control pills to prevent pregnancy during last sexual intercourse.



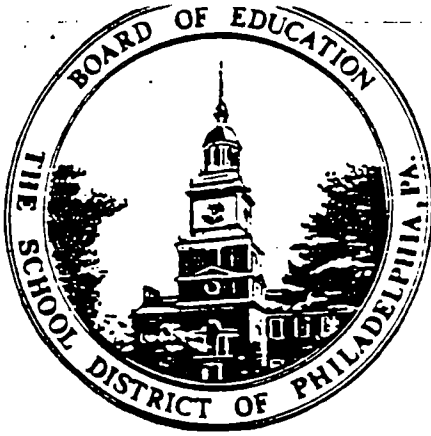
Percentage of respondents who had been pregnant or gotten someone pregnant one or more times.



Percentage of respondents who had ever been told by a doctor or nurse that they had a sexually transmitted disease*.



*such as genital herpes, genital warts, chlamydia, syphilis, gonorrhea, AIDS, or HIV infection
Total Philadelphia YRBS Results



No. 236

Section STUDENTS

Title AIDS/HIV INFECTION
SCHOOL DISTRICT OF
PHILADELPHIA

Date Adopted November 18, 1985

Date Revised September 1, 1987

December 17, 1990

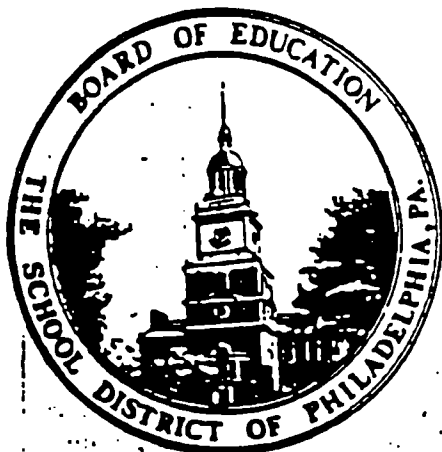
Guide	236. AIDS/HIV INFECTION	Source
1. Purpose	1.1 The Board of Education is committed to the provision of a healthful environment for its students and employees. 1.2 In fulfillment of that commitment, the Board has and shall continue to seek guidance from appropriate medical, educational, legal and government authorities. This policy statement is the result of such guidance.	"Statement of Philosophy Mission and Goals" Sept.1983
2. Definition	2.1 AIDS is an acronym for acquired immune deficiency syndrome. As used in this policy, AIDS includes <u>all</u> levels of infection, from asymptomatic to AIDS Related Complex (ARC) to full blown or "classic" AIDS, caused by the AIDS virus. This virus has been designated by scientists and medical authorities as the Human Immunodeficiency Virus (HIV).	Center for Disease Control MMWR, 10/31/86 Surgeon General's Report on Acquired Immune Deficiency Syndrome
3. Authority	3.1 This policy shall apply to all students and employees in all programs conducted by the School District of Philadelphia. 3.2 School District Management for this disease shall be the responsibility of the Director for Health Services.	24 PS13-1302
4. Admission	4.1 Each case shall be considered on an individual basis consistent with the recommendations of the Center for Disease Control.	MMWR 8/30/85

236. AIDS/HIV INFECTION

	4.2 A student or employee with AIDS shall be admitted to the classroom or program provided such admission has been approved by a Screening Committee consisting of the Director for Health Services who shall serve as chairperson, a physician named by the Superintendent, and a physician named by the Commissioner of Health of the City of Philadelphia. The Committee shall consult with the attending physician, the child's parent or guardian, and, if necessary, with educational personnel in the proposed placement. 4.22 Decisions shall be based both on the student's susceptibility to other diseases and the student's likelihood of presenting risk of infection to others. 4.23 The Screening Committee may make limited waiver of the physician-patient privilege a condition of admission to the extent necessary to protect the patient and others. 4.24 Periodically, the Screening Committee shall review each case to determine current status and make revisions, if necessary, in the original decisions. 4.3 An employee with AIDS shall be admitted to his/her place of employment in accordance with provisions of this section.	PL94-142 Reg.300.5 (b) 7(11) Rehabilitation Act Sec. 504 PA. Dept. Education "AIDS Advisory" 10/18/85
5. Identification and Confidentiality	5.1 The identity of students or employees with AIDS shall be confidential except to the limited extent provided in Section 4.23. 5.2 All files that include listing of names and other confidential information of those with AIDS shall be kept under strict security by an official named by the Superintendent.	24 P.S. 14-1409
6. Placement	6.1 First consideration should be given to returning the student or employee to the regular assignment. Any decision for an alternative placement must be supported by specific data.	24 P.S. 13-1310 24 P.S. 13-1371

236. AIDS/HIV INFECTION

- | | | |
|----------------------|---|---|
| | <p>6.2 Students diagnosed as having AIDS and unable to attend school as determined by medical examination shall be considered for homebound instruction.</p> <p>6.3 A student with AIDS may be excused from school attendance if the parent or guardian seeks such excuse based upon medical or psychological advice of those treating the student.</p> <p>6.4 A student may be excused from school attendance by the Board upon satisfactory evidence of urgent reasons which prevent the student from attending school or application to study. Such an excuse must be approved by the Pennsylvania Department of Education prior to the exclusion.</p> | <p>24 P.S.
14-1417</p> <p>24 P.S.
13-1329</p> |
| <p>7. Education</p> | <p>7.1 The mandatory <u>elementary</u>, middle, junior high and senior high school courses of study in health education shall be expanded to include instruction about AIDS.</p> <p>7.2 The Division of Health Services shall develop appropriate administrative guidelines to implement this policy. The guidelines of the United States Center for Disease Control shall be the major reference.</p> | |
| <p>8. Evaluation</p> | <p>8.1 The Director of Health Services shall periodically report to the Superintendent regarding the effectiveness of this policy and make recommendations for revision in response to developments in medical research and treatment.</p> | |



No. 123

Section PROGRAMS

Title ADOLESCENT SEXUALITY

SCHOOL DISTRICT OF
PHILADELPHIA

Date Adopted June 24, 1991

Date Revised October 28, 1991

Guide		Source
1. <u>Purpose</u>	123. ADOLESCENT SEXUALITY 1.1 The Board of Education reaffirms its policy to provide comprehensive human growth and development instruction to all public school students. In accordance with School District policy and state law, such instruction should be part of the public school program and should be shared by the public schools, home, and community. The primary purposes of such instruction are to promote more wholesome family and interpersonal relationships; to help young people understand their sexuality at all levels of development; and, to develop healthy habits and moral values regarding human sexuality. 1.2 The Board recognizes that the expression of human sexual behavior can be the source of many of life's most meaningful experiences as well as its most painful problems; and, the Board of Education firmly asserts that abstinence from sexual activity during adolescence promotes good health and a healthy lifestyle. 1.3 The Board of Education firmly believes that successful pursuit of the mission of promoting a healthy lifestyle for all adolescents depends upon the cooperation of a broad spectrum of the Philadelphia community, including schools, families, religious institutions, health care providers, social service agencies, businesses, government, and media.	Board of Education Policy #120, Rev. 12/17/90.

123. ADOLESCENT SEXUALITY

Educa-
tional
Supple-
ment
to The
Home Rule
Charter

2. Authority

2.1 Pursuant to its authority under the Educational Supplement to the Home Rule Charter, the Board adopts the following policy objectives in order to promote a healthy lifestyle for all children.

2.1.a. To enable and encourage students to abstain from sexual intercourse until ready to enter marriage or another mutually monogomous relationship.

2.1.b. To reduce high risk sexual behavior leading to teen pregnancy, sexually transmitted diseases and HIV infection.

2.1.c. To assure a safe, equitable and positive school experience for lesbian and gay students.

2.1.d. To assure that all programs and activities take into consideration the broad spectrum of ethnic and cultural diversities, as well as mental and physical disabilities.

3. Delegation
Of Respon-
sibility

3.1 The Superintendent shall direct the development and acquisition of curricula which comprehensively promote healthy behavior and which shall be taught in all grade levels, pre-kindergarten through grade twelve. Such curricula shall focus on behavioral outcomes and will also utilize more innovative and effective methods to convey the message that abstinence is the most effective way of preventing pregnancy, sexually transmitted diseases and HIV infection; a voluntary parental education component, designed to enhance the frequency and effectiveness of parents' communication with their children; and, a mechanism for monitoring the efficacy of the curricula.

3.2 All school staff share in responsibility for understanding and promoting healthy adolescent behavior; therefore, the Administration will develop and maintain a comprehensive plan for staff education on adolescent health.

123. ADOLESCENT SEXUALITY

- 3.3 The Superintendent is empowered to develop additional partnerships with health care providers that expand and maximize access to in-school comprehensive health care for all children, which will have a positive and lasting effect on the lives of the children of Philadelphia.
- 3.4 The Board believes that the effectiveness of the curricula to promote healthy lifestyles and to prevent pregnancy, sexually transmitted diseases and HIV infection is enhanced for sexually active students by facilitating their access to condoms outside of school. Toward that end, the Board supports the School District's involvement in city-wide efforts to maximize access to condoms.
- 3.5 The Board of Education directs the Superintendent to immediately initiate the design of a pilot, educationally-based program, permitting the in-school availability of condoms and the counseling of students in the use of same, utilizing established non-School District health care and social service providers, in partnership with participating schools. Such programs shall commence not later than the Fall of 1991.
- 3.6 The phased-in pilot program of condom availability in schools shall apply only to students in grades nine through twelve. Moreover, every policy builds on already existing policy; and Policy #103 requires "equal opportunity for all students"
- 3.7 A component of the phased-in pilot program shall be specifically for the education of parents, designed to enhance the frequency and effectiveness of parents' communication with their children about sexuality.

Board of
Education
Policy
#103, Rev.
12/17/90.

123. ADOLESCENT SEXUALITY

4. Recognition of Parental Authority

4.1 Parents or guardians of students in schools taking part in the phased-in pilot program shall have the absolute right to veto their child's or children's participation in the program.

5. Evaluation and Research

5.1 The Board of Education directs the Superintendent to develop program evaluation criteria that will be used to evaluate the efficacy of all programs initiated under this policy, as well as their impact on adolescent sexual behavior.

5.2 The Administration will monitor the phased-in pilot program and such other programs so initiated; and, it shall apply those program evaluation criteria developed to evaluate program efficacy.

5.3 The Superintendent shall report to the Board of Education on such evaluations at such times as requested by the Board; and, prior to implementation of the program evaluation criteria, the Administration shall fully apprise the Board of the structure and objectives of same.



No. 102

Section **PROGRAMS**

Title **MULTICULTURAL-**
MULTIRACIAL-
GENDER EDUCATION
SCHOOL DISTRICT OF
PHILADELPHIA

Date Adopted **January 24, 1994**

Guide	102. MULTIRACIAL-MULTICULTURAL-GENDER EDUCATION	Source
Definition	1. Multiracial-Multicultural-Gender Education is an educational process designed to foster knowledge about and respect for those of all races, ethnic groups, social classes, genders, religions, disabilities, and sexual orientations. Its purpose is to ensure equity and justice for all members of the school community, and society as a whole, and to give those members the skills and knowledge they need to understand and overcome individual biases and institutional barriers to full equality.	School District of Philadelphia Policy 104 Non-Discrimination
Goals	2. The School District of Philadelphia envisions a society that will ensure respect for all cultures, dignity for all communities and justice for all people. The School District of Philadelphia expresses its commitment to achieving this goal by recognizing that Multiracial-Multicultural-Gender Education is indispensable in attaining this objective. To move us toward this goal, the School District is committed to: 2.1 Pursue academic excellence for all children 2.2 Assist students to develop the necessary social and linguistic skills needed to communicate effectively in a multilingual, global society 2.3 Teach students to respect their own cultural heritages and to appreciate other peoples from their neighborhood, city, state, nation, and the world 2.4 Enable students to develop a deep multicultural understanding that reflects sensitivity toward all 2.5 Foster opportunities for students, staff, parents, and other community members to engage in cooperative decision-making and problem solving and to develop a deep multicultural understanding that reflects sensitivity to the diversity present in a multicultural society 2.6 Empower students to recognize and work to overcome injustices caused by bias and historical exclusion and to become active citizens and leaders in the quest for a just society	School District Policy 101 Philosophy, Mission, and Goals Section 4.2 Dec. 1990

POLICY GUIDES	102. MULTIRACIAL-MULTICULTURAL-GENDER EDUCATION	Source
Philosophy	3. The School District of Philadelphia affirms its commitment to Multiracial-Multicultural-Gender Education. In seeking to ensure educational equity and justice for all, Multiracial-Multicultural-Gender Education will be infused throughout all aspects of the educational process. This process will: 3.1 Integrate multiple perspectives in all curricular areas 3.2 Utilize the variety of skills and knowledge that students and adults from diverse backgrounds bring to teaching and learning 3.3 Incorporate learning activities to foster knowledge of, acceptance of, and respect for the diverse cultures and histories that make up the fabric of our school communities 3.4 Foster among children the development of interpersonal and intergroup skills that will prepare them to live harmoniously in a multiethnic/multicultural/multilingual society 3.5 Facilitate the practices necessary to assist all children to become effective and successful learners regardless of race, ethnicity, social class, gender, religion, disability or sexual orientation 3.6 Ensure that staff throughout the District receive appropriate, ongoing opportunities for training and staff development in multicultural understanding 3.7 Ensure that the commitment to Multiracial-Multicultural-Gender Education is reflected in the diversity of all levels of staffing in the School District of Philadelphia 3.8 Respect and value parental and community input and participation in the educational process 3.9 Extend training in Multiracial-Multicultural-Gender Education to parents and community members that reflects multi-racial-multicultural-gender equity. 3.10 Implicit in this statement is the requirement that each staff member accept responsibility for the accomplishment of these goals.	Commonwealth of Pennsylvania Statement of Principals Regarding Educational Equity 1993 Improving America's Schools Act of 1993

POLICY GUIDES	102. MULTIRACIAL-MULTICULTURAL-GENDER EDUCATION	Source
Implementation	4. Academic excellence and equity represent, in part, an institutional commitment to enable the school community, including faculty, staff, and students, to reach its fullest human and intellectual potential. The achievement of these goals and objectives requires the School District to: 4.1 Make an institutional commitment to teach to all children in every school, a curriculum informed by the principles of gender-equity, multiracial and multicultural knowledge and perspectives, including but not limited to the history and experiences of women, racial, ethnic, and religious minorities, as well as lesbian and gay people and disabled people. 4.2 Seek equitable allotments for this activity from the District's resources for the ongoing development of appropriate curriculum, instruction, and assessment, as well as the ongoing evaluation of administrative policies, procedures, and performance standards. 4.3 Enhance and develop all school-based educational activities/programs/experiences including but not limited to curricula, instructional materials, after-school programs, community partnerships, professional staff development, support services, library acquisitions, as well as assessment, testing and evaluation instruments to reflect the School District of Philadelphia's commitment to a school environment that reflects multiracial-multicultural-gender equity. 4.4 These activities are subject to staff evaluation, assessment, and reporting on an annual basis to the Board of Education.	Regulations of the State Board of Education Chapter 5: Curriculum 1993 Commonwealth of Pennsylvania Annex A Title 22, Education Part XIV, Chapter 235 Code of Professional Practice and Conduct for Educators 1992 Commonwealth of Pennsylvania Statement of Principals Regarding Educational Equity 1993

- (iv) All students produce, perform or exhibit their work in the visual arts, music, dance or theater, and describe the meanings their work has for them.

(7) Career Education and Work

- (i) All students explore the multiple purposes of work and the range of career options, including entrepreneurship, and relate them to their individual interests, aptitudes, skills, and values.
- (ii) All students assess how changes in society, technology, government, and the economy affect individuals and their careers and require them to continue learning.
- (iii) All students understand and demonstrate the importance of relating their academic and vocational skills (for example interviewing, creative thinking, decision-making, problem-solving, understanding and giving oral and written instructions) to their ability to seek, obtain, maintain, and change jobs.
- (iv) All students completing a vocational-technical education program exhibit the skills required to succeed in a particular occupation for which they have prepared.

(8) Wellness and Fitness

- (i) All students develop knowledge of injury prevention and treatment and the ability to respond appropriately in emergency situations.
- (ii) All students recognize and demonstrate the ability to apply dietary guidelines to meet nutritional needs at various stages of life.
- (iii) All students demonstrate their knowledge of the benefits associated with physical fitness and good personal health habits including health promotion and disease prevention.
- (iv) All students identify the advantages of avoiding, and develop the skills to avoid, tobacco, alcohol and substance use.
- (v) All students demonstrate individual development in motor fitness and physical fitness, including aerobic fitness and skills in lifetime sports and outdoor activities, to promote lifelong physical activity.

- (vi) All students demonstrate leadership skills and the ability to work cooperatively in team sports or other developmentally appropriate group activities.

(9) Home Economics

- (i) All students demonstrate their knowledge of principles of consumer behavior as a foundation for managing available resources to provide for personal and family needs.
- (ii) All students demonstrate their knowledge of basic child health and child care skills.

10

22 § 5.219

STATE BOARD OF EDUCATION

Pt. 1

(1) The aptitude of the student for the applicable vocational-technical education program.

(2) Other factors to assure fair access of students to the vocational-technical education programs that do not unfairly penalize students who have not achieved high grades in academic subjects but who otherwise qualify for and are likely to succeed in the program.

Source

The provisions of this § 5.218 adopted July 23, 1993, effective July 24, 1993, 23 Pa.B. 3549.

Cross References

This section cited in 22 Pa. Code § 5.213 (relating to high school education); and 22 Pa. Code § 6.2 (relating to standards and reports).

§ 5.219. Special education.

(a) Under Chapter 14 (relating to special education services and programs), eligible students as defined in § 14.1 (relating to definitions) shall be provided an education which approximates as nearly as possible the curriculum of the school district under this chapter.

(b) Under Chapter 14, gifted students as defined in § 342.1 (relating to definitions) shall be provided an education that enables them to participate in acceleration or enrichment, or both, as appropriate.

(c) The educational program provided to exceptional students shall be in accordance with their Individualized Education Programs under § 14.32 (relating to IEP), even if the Individualized Education Program of a student does not otherwise meet all the requirements of this chapter.

(d) Planned courses for exceptional students shall conform to the requirements established for planned courses in §§ 5.3 and 14.38 (relating to definitions; and planned courses) as they relate to planned courses.

Source

The provisions of this § 5.219 adopted July 23, 1993, effective July 24, 1993, 23 Pa.B. 3549.

§ 5.220. HIV/AIDS.

(a) Instruction regarding prevention of human immunodeficiency virus (HIV) infection/acquired immunodeficiency syndrome (AIDS) shall be given for primary, intermediate, middle school and high school education and shall follow the requirements of subsections (b) and (c).

(b) Educational materials and instruction shall be determined by the local school district and be appropriate to the age group being taught. The program of instruction shall include information about the nature of the disease, the lack of a cure, the ways the disease is transmitted and

Ch. 5

CURRICULUM

22 § 5.221

how infection can be prevented. The school district may omit instruction in the elementary grades on the transmission of the disease through sexual activity. Programs discussing transmission through sexual activity shall stress that abstinence from sexual activity is the only completely reliable means of preventing sexual transmission. Programs shall stress that avoidance of illegal drug use is the only completely reliable means of preventing transmission through shared drug paraphernalia.

(c) A school district shall excuse a pupil from HIV/AIDS instruction when the instruction conflicts with the religious beliefs or moral principles of the pupil or parent or guardian of the pupil and when excusal is requested in writing. Prior to the commencement of instruction, a school district shall publicize that detailed curriculum outlines and curricular materials used in conjunction with the instruction are available to parents and guardians during normal school hours or at teacher-parent conferences. Curricular materials, if practical, shall be made available by the school district for home instruction use by a parent or guardian of a student excused from the district's HIV/AIDS instruction.

Source

The provisions of this § 5.220 adopted July 23, 1993, effective July 24, 1993, 23 Pa.B. 3549.

SCHEDULING AND LEARNING OPTIONS**§ 5.221. Scheduling.**

(a) Kindergarten programs shall provide each kindergarten student with at least 2 1/2 hours of instruction each day for the full school term unless the school district obtains prior Department approval for an alternative kindergarten program.

(b) A school district shall obtain approval of the Department prior to scheduling 1/2-day sessions other than in kindergarten under subsection (a).

(c) A school district shall obtain approval of the Department prior to establishing a new school or changing school organization.

(d) Planned courses offered in summer school may be designed as credit or noncredit offerings.

Source

The provisions of this § 5.221 adopted July 23, 1993, effective July 24, 1993, 23 Pa.B. 3549.

SCHOOL DISTRICT OF PHILADELPHIA
BOARD BUDGET REVIEW COMMITTEE

DIVISION OF SCHOOL HEALTH SERVICES

“

Optimal Health For All Children:

”

Their Right, Our Mission

JANUARY 18, 1994

School District of Philadelphia

Board of Education

Organizational Unit: Student Services
Program: School Health Services

Budget Review

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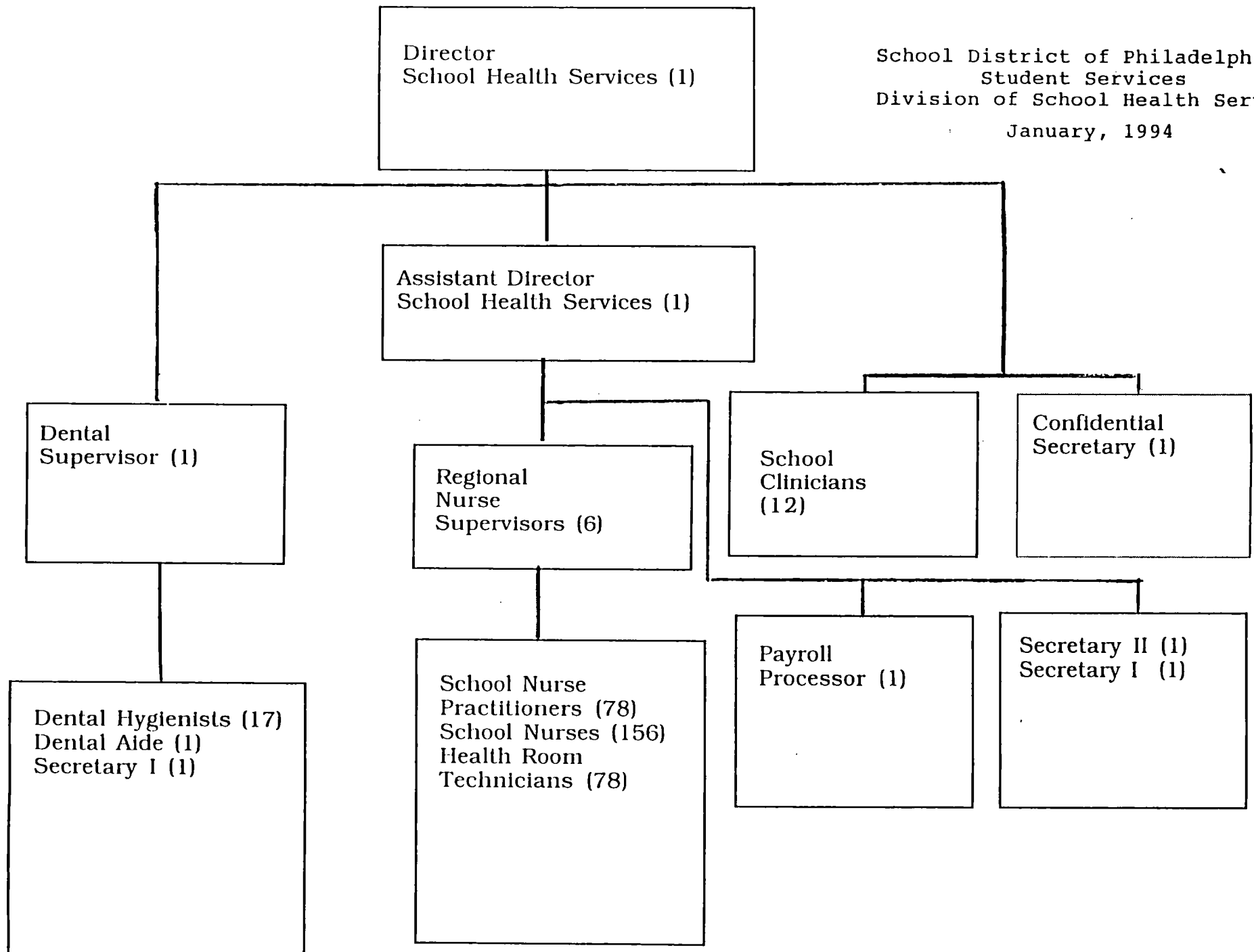
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School District of Philadelphia
Student Services
Division of School Health Services
January, 1994



School Nurse Service (01-07-038)

I. Statement of Function

Pennsylvania law mandates school nurse services for each child in public, parochial and private school. The nurse:pupil ratio may not exceed 1:1500. School nurses function as public health professionals by providing:

1. prevention of illness and injury (monitoring immunizations, environmental health hazards and disease surveillance),
2. case finding (screenings and health assessments to identify problems that impede learning),
3. identification of risk factors (documentation and statistics, dialogue with school and community groups),
4. facilitation of access to health care (referrals to primary care providers, community agencies and financial resources),
5. follow-up (to ensure that student health needs are met), and
6. health promotion (health counseling, instruction in self-care, and education of parents/school staff on health issues).

Nurses are case managers for Protected Handicapped Students, health consultants and core members of the IEP (Individual Educational Plan) and SST (Student Support Teams). They provide care for illnesses and injuries that present during school hours. Due to the increasing number of students attending school who suffer severe handicaps and conditions, school nurses must provide more frequent services and monitoring to maintain the students in school and must have caseloads smaller than 1500. The six regional nurse supervisors are members of the regional management team and are certified rating officers for all nursing staff and provide support to all the schools in each region including high schools. The Assistant Director is responsible for assuring the highest standards of professional practice by orienting new staff, providing on-going staff development regarding developments in the field, and by linking with various professional societies and health care providers.

II. Description of Program

A. Certified School Nurses: A Certified School Nurse is a Baccalaureate prepared professional nurse who has a minimum of 24 post-baccalaureate credits. Some school nurses are Nurse Practitioners. There are 234 Certified School Nurse positions budgeted in this activity for the current school year. This is 27 fewer than the prior school year, in spite of an increase in enrollment.

Certified School Nurses responsibilities are carried out within the framework of a public health model by nurses who are knowledgeable about educational theories, nursing theories, and community health needs. Certified School Nurses promote, protect, and maintain the health of the student population as a whole and the school community, including staff, while at the same time caring for and guiding individual children and their families. School Nursing is a specialty practice which includes:

Primary prevention, which includes health promotion and specific prevention, e.g., monitoring immunization status and health counseling.

Secondary prevention, which includes early diagnosis, prompt treatment, and disability limitations, e.g., screenings, case finding, and referrals for further evaluation.

Tertiary prevention which focuses primarily on rehabilitation, e.g., development of appropriate care plans for students with special needs.

Certified School Nurses address the overall health of entire school communities, and are the **only** health professionals who see, assess and provide service to **all** school-age children, rich or poor, insured or uninsured.

In pursuit of the goal of a healthy community, Certified School Nurses use every opportunity to provide the education and information that children, parents and staff, i.e., entire school communities, need in order to make responsible and informed decisions about personal and community health matters. Some of the services they perform include:

- conducting health programs and assemblies
- developing school plans for health emergencies
- making classroom presentations on health issues at the invitation of the classroom teacher
- identification of health and safety hazards and working with others to correct situations
- teaching sound health and safety habits
- teaching and promoting self care
- assisting families in securing health benefits
- connecting families with quality health care
- empowering children and their families to recognize and utilize quality health care facilities.

Additional responsibilities of Certified School Nurses are many. They include completion of screening programs for growth, vision, hearing, scoliosis, tuberculosis, and physical assessments which are mandated by the Commonwealth of Pennsylvania. Care of illnesses and injuries is also a responsibility of Certified School Nurses. These are highly visible functions which are easily quantified and are reported to the Commonwealth annually (see Appendix).

School nurses also provide professional service in other areas beyond the state mandate. Some examples included::

- monitoring and referring for care over 2,200 pregnant students.

- participating in the identification and reporting of over 900 cases of suspected child abuse.
- developing innovative ways to prevent accidental or violence related injuries, such as "Prom Safety Nights" and linkages with area trauma prevention programs.

It is significant that these programs, as conducted by Certified School Nurses, are continuing, on-going programs which include linking families to care. This distinguishes them from "one shot" screening programs and makes them far more valuable to the children and their families.

Tertiary prevention responsibilities of Certified School Nurses include their role as manager of health care within the school health program by participating in interdisciplinary conferences to plan a child's IEP. The School Nurse applies principles of delegation to effectively and efficiently meet handicapped students' health needs while at school. Another example of a tertiary prevention activity is to provide health education for handicapped students and their families in such areas as the nature and extent of their handicap, self-care activities, and coping strategies.

The student health record created by the school nurse is often the only **cumulative** health record that will exist in the school life of a child.

B. Industrial Nurses: Industrial Nurses were responsible for first aid and safety programs at Randolph and Swenson Skills Centers and Kennedy AVTC. These positions did not require certification as a school nurse and were not mandated. All three Industrial Nurse positions were abolished.

The majority of students who attend the Skills Centers are shared time students who receive mandated school nurse services at their home school. During 92/93, for those students who were enrolled full time at the Skills Centers, a Certified School Nurse was assigned part-time to the center in addition to the Industrial Nurse.

C. Regional Nurse Supervisors: There are six Regional Nurse Supervisor positions budgeted in this activity. Each Regional Nurse Supervisor is certified as a Supervisor of School Health Services and is the official rating officer for all nursing staff in their region. The size of staff and number of schools varies from region to region (see Tables I & II). Their responsibilities include high schools and non-public schools.

The Regional Nurse Supervisor is the only Nursing professional assigned to the region and is, therefore, the only person who can assess the true nursing requirements of schools and children in the region. With limited resources it is essential that the allotment of school nurses be based, to the extent possible, on true nursing and health needs.

Examples of ways in which the Regional Nurse Supervisor supports ALL schools and ALL nursing staff are by:

- insuring that all programs are implemented in accordance with federal, state and local regulations and/or policies
- providing staff development programs for school and regional administrators on current health issues.
- providing staff development for nurses and health room technicians.
- providing consultative services to outside agencies who wish to establish linkages with the School District.
- developing educational and health promotion programs for parents.
- establishing collegial relationships with community health care agencies, providers, schools of nursing and medicine thereby establishing a pool of expert professionals who are knowledgeable about school health.
- representing the Division of School Health Services, the Region, and the School District on inter-agency task forces, boards and/or committees.
- advising the Director and Assistant Director of School Health Service and the Regional Superintendent on trends and related matters which will require future policy development or intervention.
- participating in policy development for the Division of School Health Services and the Region.
- establishing regional "emergency plans" which deploy skilled nurses to meet the complex nursing needs of children in the absence of assigned school nurses.
- performing nursing assessments at early intervention agencies to determine nursing needs and prepare school staff for the entry of transitional students.
- collaborating with other regional and divisional administrators to coordinate and synchronize services to children.
- scheduling school physician and consultant services
- monitoring progress of school health programs and school based activities and assist wherever and whenever a stumbling block is identified

D. Assistant Director: There is one Assistant Director budgeted in this activity. The Assistant Director is certified as a Supervisor of School Health Services.

The Assistant Director is responsible for program development and implementation across all regions. In collaboration with the Director, Regional Nurse Supervisors, other administrators, and health services staff, the Assistant Director establishes standards and criteria for School Nursing Practice.

The Assistant Director is a nursing consultant to the Director and drafts all procedures for Certified School Nurses insuring that they meet all professional standards.

The Assistant Director is responsible for developing and/or recognizing creative ways to increase utilization of the professional skills and talents of Certified School Nurses and Regional Nurse Supervisors.

The Assistant Director is responsible for staff development, formal and informal, of all school health staff. This includes orienting new nurses, providing current information to Regional Nurse Supervisors, arranging formal inservice programs, and clarifying roles and responsibilities to individuals or groups as necessary.

The Assistant Director participates in or arranges staff development programs for other disciplines and/or agencies.

The Assistant Director establishes Ad Hoc Committees of Certified School Nurses to insure that procedures and forms are state of the art and effective in the field. Committees are chaired by Certified School Nurses, supervised by a Regional Nurse Supervisor, and guided by the Assistant Director.

The Assistant Director supports School Based Management by developing guidelines which provide a foundation for informed decision making.

The Assistant Director conducts second level formal conferences with staff when performance is being questioned and issues remain unresolved after meetings which were conducted by the Regional Nurse Supervisor.

The Assistant Director serves on the Pennsylvania School Nurse Advisory Committee.

The Assistant Director acts in place of the Director and/or any Regional Nurse Supervisor should any be absent or not available.

The Assistant Director is responsible for allotting the number of Certified School Nurses to each region based upon a city wide needs assessment.

The Assistant Director prepares the annual request for reimbursement which is submitted to the Commonwealth of Pennsylvania.

III. Program Evaluation

During the 1992-1993 school year, Certified School Nurses were successful in identification and resolution or management of many health problems which may impact on a student's ability to function at optimal levels in a classroom.

Puretone audiometer screenings were completed on 128,946 students in kindergarten through grade 3, grade 6 and eleventh grade. Of those

2,514 students were referred for further evaluation and/or care. Appointments for evaluation and care were kept by 70.2% (1,765) as a result of school nurse involvement.

Scoliosis screening was done for 30,456 students in sixth and seventh grades. Referrals were made for 558 students, of whom 75% (418) went to their physician.

The vision screening program resulted in 200,804 students having access to Snellen and near vision screening. Referrals were made for 17,329 students and 62% (10,726) of those appointments were kept.

Following physical examinations done by School Physicians, Certified School Nurses successfully encouraged 2,213 parents to keep appointments for further evaluation of health problems. That is 64% of those who were referred (3,459).

School Nurse Practitioners did physical examinations on 2,519 students and referred 1,564 for further evaluation. The problem resolution rate for these referrals was 81%.

Certified School Nurses facilitated access to private health care providers for 36,574 students for physical examinations. This involved contacting parents, making sure they had a source of health care and, if not, connecting them with one.

Certified School Nurses facilitated administration of medication during school hours for over 1800 students enabling them to stay in school and benefit from the educational program.

Health Fairs to provide good health were held in schools under the leadership of School Nurses.

Nursing assessments were completed on 115 students in response to requests for special transportation for medical reasons.

Certified School Nurses provided individual health counseling for 147,501 students with health problems.

Certified School Nurses made visits to 255 homes.

Nurses participated in the development of 1507 IEPs for students with complex health needs.

School nurses rendered care in 450,574 instances to ill and injured persons, including 15,317 employees.

In public schools alone, Certified School Nurses did nursing assessments of, and developed and managed health care plans for, 9,652

students with special chronic health needs. The conditions ranged from asthma, diabetes, seizure disorders and sickle cell trait, to kidney failure.

The policy and procedure manual for School Health Services complies with all professional standards. With guidance from the Assistant Director, many of the procedures have addressed the health needs of children well in advance of mandates to do so. This is the direct result of input from Certified School Nurses and Regional Nurse Supervisors.

Case management resulting in problem resolution is a time consuming process. Certified School Nurses, with the support of the Assistant Director have implemented a screening referral day in the first 90 days of school to identify students who teachers suspect may have a sensory problem. This early identification system increases the problem resolution rate.

The addition of a nursing assessment to the process for receiving Homebound Instruction has reduced the time required to obtain approval, prevented excess amounts of time spent on homebound, and confirmed the necessity for the service. In one high school, attendance of pregnant teens has improved dramatically because the school nurse has intervened.

Participation on committees established by Assistant Director and supervised by the Regional Nurse Supervisor provides a mechanism for staff involvement in policy development. It also allows Certified School Nurses who serve as chair to gain recognition from their peers.

A Breast Cancer Summit was held, in collaboration with the American Cancer Society and the Department of Education for all nursing staff in September.

A one day, Saturday, conference for School Nurses was held at LaSalle University. All workshops and one plenary were conducted by Philadelphia Certified School Nurses. This conference was unique because it was planned and implemented by administration and the bargaining unit working together.

Staff development programs or presentations have been done this year on Chapter 15 and on confidentiality.

IV. Impact of Budget Reductions (See Tables I-VI)

There are 27 fewer Certified School Nurses in Philadelphia Schools today than there were one year ago. There are also three fewer Industrial Nurse positions. Although the total impact of that reduction has yet to be felt, some problems have arisen which are clearly a result of the reduction.

Coverage for nurses who are on long term absences for reasons ranging from sabbatical to extended sick leave is much more difficult, and often impossible, to achieve. (The number of long term substitute nurses

has remained constant and continues to be fewer than needed). In the past, the Office of School Nurse Service and Regional Nurse Supervisors, were able to temporarily reassign appointed school nurses to these 'uncovered' assignments. Lower case ratios give us this flexibility. While we recognize that these temporary reassignments impacted on the school from which the nurse service was taken, it was a viable, legal option. In one region, we were able to staff two schools with medically fragile students for the entire 92/93 term.

There are increasing numbers of students coming to school who have health problems and health needs which require the presence of a full time school nurse in the building. Examples of these are students who have fragile tracheostomies, urinary catheters, cardiac monitors, nebulizers, glucose monitors, or students who need to have medication administered through a naso-gastric tube or who require ambulatory peritoneal dialysis. In accordance with all legal requirements these students are often attending their neighborhood school with related services, or they may be assigned to a school which has the specialized education program which will meet their educational needs.

In the past, the level of nurse service made it possible for Nurse Supervisors to have the flexibility to reallocate nursing staff in accordance with the needs of each of these new students. This year, reallocations have been more difficult and are, at this point, not even possible.

The impact of reductions has been described by one elementary school principal in the December 1, 1993 issue of the Philadelphia Inquirer. She said that time spent administering first aid has decreased the amount of time she has available to perform other functions. She has less time to be a Principal.

At one middle school, for example, due to the combined circumstances of long term absence, lack of long term substitute service and reduced staffing levels, the students are daily being deprived of a comprehensive program. Nurses are pulled from other schools, one or two days/week compounding the problem because of a loss of nurse service at the schools from which they are being temporarily reassigned.

When nurse service to another middle school was reduced from 5 days a week to 4 days in September, 1993, the principal and faculty took a ~~we~~ re in this together position and responded in a professional manner. However, when it became necessary to further reduce nurse service from 4 days to 3, the principal wrote:

"The absence of our nurse will severely affect the following:

- daily tube feedings
- daily administration of medicine
- attendance to seizure prone students

- support of the student assistance program
(Mrs. X is our team leader)
- support of the Health Academy
(Mrs. X is liaison)
- completion and update of IEP and MDT reports for
157 special education students "

School Nursing is much more than the visible. The impact of the reduction of 27 certified school nurse positions can be measured and felt in many other ways.

A survey of 13 elementary schools scattered across the city revealed that, in those schools, on the days the Certified School Nurse was in the building, 81% of students who were seen for illness or injury were assessed by the nurse and treated or counseled and returned immediately to their classrooms. Only fourteen(14)percent were sent home. In those same schools when the nurse was not there, 53% of students were returned to their classrooms. Forty-four (44%) were sent home. (See Tables V & VI). The reduction of 27 positions, which translated into 4860 fewer staff days will necessarily impact on student attendance and time spent on the task of learning.

The impressive problem resolution rates described in the evaluation section above are a result of intensive case management, health counseling, client advocacy and family empowerment activities performed by expert school nurses on behalf of children and their families. It is anticipated that these activities will be severely curtailed in every school where nurse service has been reduced, as proportionately less time will be available to address the day to day and increasingly complex health problems of school children and their families.

On average, each school nurse on each day during the 92/93 term, provided individualized health counseling to 3 children. During 93/94 it can be anticipated that 15,259 students will not receive the health counseling they need, when they need it, because there will be no Certified School Nurse.

The impact of abolishing the Industrial Nurse positions has been felt severely by the students enrolled in the high schools to which the Skills Centers are attached organizationally. The number of full time students enrolled at the Skills Centers is included in the enrollment of the high school. The school nurse allotments were based on the total organizational enrollment. The principals of both high schools have directed that their Certified School Nurses spend a disproportionate amount of time at the Skills Centers at the expense of the main building. The ultimate impact of this action is to replace a lower salaried individual (Industrial Nurse) with a higher salaried individual (Certified School Nurse) and to decrease the level of professional service available to all parties.

The impact on the Regional Nurse Supervisors of the reduction of 27 Certified School Nurses and 3 Industrial Nurses is compounded by the reduction of other regional staff. On each occasion when regional administrative offices have been closed, the nurse supervisors have had to absorb responsibility for all public schools, including high schools, all parochial and all private schools within the newly structured boundaries.

As stated earlier, the reduced level of nursing staff has made it difficult, if not impossible, for Regional Nurse Supervisors to reallocate School Nurses based upon the nursing needs of school children and their families.

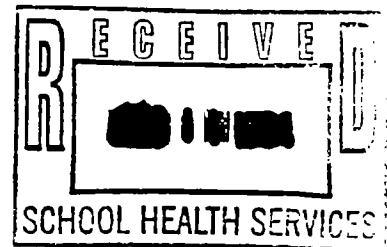
At the regional level, nurse supervisors are working more closely with Regional Superintendents in areas of attendance and parental involvement. Of necessity they are working longer hours to ensure a timely response to parents and staff.

The impact on the Assistant Director has been to spend more time to enhance and promote the professional skills and talents of all health services staff and to increase the amount of time needed to assist School Principals who are managing their schools without adequate levels of nurse service.

The domino effect of these reductions can be seen in Tables I - IV. One hundred and fifty one (151) schools have less nurse service this year because there are twenty seven (27) fewer School Nurse positions and no Industrial Nurses.. Allotments are now more closely tied to numbers of children and the presence of medically fragile children in a building. The complex needs of school communities can no longer be given consideration when nurse allotments are made. This means fewer health programs which address a myriad of public health problems, from pediculosis to T.B. to lead to violence to teen pregnancy. There will be less intensive monitoring of environmental hazards, fewer opportunities to teach self care and to empower children and their families to take responsibility for their own health.

THE WEST PHILADELPHIA
COLLABORATIVE PROGRAM
FOR CHILD HEALTH

January 3, 1994



Herbert Hazan
Director of Health Services
School District of Phila.
21st & the Parkway
Philadelphia, PA 19103

Dear Mr. Hazan:

We are writing in support of increasing the number of school nurses in the Southwest Region. We are deeply concerned that the decrease in school nurses from 34 last year to 29 nurses this year will be detrimental to the health of these children and youth.

We have had the pleasure of working with the School District since the West Philadelphia Collaborative Program for Child Health was founded in 1989. The Collaborative and the School District have enjoyed great success in several efforts to improve the health of youth. The initiatives developed by the Collaborative (such as the Adolescent Care Network, Hospital School Information Exchange, Keeping Teens Healthy Project and Health Fairs) have all had a visible impact on both students and school staff in the Southwest Region.

The Region's Nurse Supervisor, Acting Nurse Supervisor and school nurses have been vital to the success of these initiatives. For example, the Hospital School Information Exchange was developed in response to school nurses' requests for medical information about students hospitalized at CHOP. School nurses in their role as case managers have effectively utilized discharge information from CHOP to ensure students' prompt return to school and access to ongoing care.

This type of partnership with school nurses is precisely what is needed to confront the many problems facing young people in the Southwest Region. We urge the School District to support the integral role of school nurses in disease prevention and health promotion by increasing the number of school nurses in the Southwest Region.

Sincerely,

Anthony L. Rostain
Anthony L. Rostain, M.D.

Ann O'Sullivan
Ann O'Sullivan, Ph.D., CRNP

Maryann Measure
Maryann Measure, M.S.S.

Donald F. Schwarz
Donald F. Schwarz, M.D.

Peter B. Vaughan
Peter B. Vaughan, Ph.D., ACSW

TABLE I

	NUMBER OF SCHOOLS		
REGION	PUBLIC	NON PUBLIC	TOTAL
SOUTHWEST	40	21	61
SOUTHEAST	48	32	80
CENTRALWEST	36	22	58
CENTRALEAST	47	21	68
NORTHWEST	45	36	81
NORTHEAST	46	43	89
SUB TOTALS	262	175	376
SKILLS CENTERS	3	0	3
GRAND TOTALS	265	175	379

TABLE II

NUMBER OF NURSES			
REGION	92/93	93/94	DIFFERENCE
SOUTHWEST	34	29	-5
SOUTHEAST	42	37	-5
CENTRALWEST	35	31	-4
CENTRALEAST	45	40	-5
NORTHWEST	46	43	-3
NORTHEAST	59	54	-5
SUB TOTALS	261	234	-27
SKILLS CENTERS	3	0	-3
GRAND TOTALS	264	234	-30

TABLE III

REGION	NUMBER OF SCHOOLS LOST SESSIONS						TOTAL NUMBER			SESSIONS
	LOST 3 OR MORE		LOST 2		LOST 1		SCHOOLS LOST SESSIONS			NON
	PUBLIC	NON	PUBLIC	NON	PUBLIC	NON	PUBLIC	NON	ALL	PUBLIC
	PUBLIC		PUBLIC		PUBLIC		PUBLIC		SCHOOLS	CLOSED
SOUTHWEST	4	1	10	0	9	0	23	1	24	3
SOUTHEAST	0	2	14	0	11	1	25	3	28	0
CENTRALWEST	3	0	8	3	6	2	17	5	22	2
CENTRALEAST	1	1	10	3	16	2	27	6	33	5
NORTHWEST	3	0	7	2	3	4	13	6	19	0
NORTHEAST	6	0	7	4	4	1	17	5	22	0
SUB TOTALS	17	4	56	12	49	10	122	26	148	10
SKILLS CENTERS	3	0	0	0	0	0	3	0	3	0
GRAND TOTALS	20	4	56	12	49	10	125	26	151	10

TABLE IV

NUMBER OF SCHOOLS WITH FT* SERVICE						
REGION	PUBLIC		NON PUBLIC		ALL	
	92/93	93/94	92/93	93/94	92/93	93/94
SOUTHWEST	7	4	1	0	8	4
SOUTHEAST	8	7	1	0	9	7
CENTRALWEST	11	9	0	0	11	9
CENTRALEAST	18	15	0	0	18	15
NORTHWEST	15	14	2	2	17	16
NORTHEAST	15	15	3	3	18	18
SUB TOTALS	74	64	7	5	81	69
SKILLS CENTERS	3	0	0	0	3	0
GRAND TOTALS	77	64	7	5	84	69
*FT=full time						

TABLE V

School Loc #	Days	Pupils	Other	Illness	Injury			Immediate Return to Class	Sent Home	Sent to Hospital	Immediate Return to Class %	Sent Home %	Sent to Hospital %	
840	2	20	0	5	13			10	10		0	50%	50%	0%
830	3	8	0	7	1			0	8		0	0%	100%	0%
138	4	6	0	5	1			1	5		0	17%	83%	0%
147	3	19	0	11	8			15	4		0	79%	21%	0%
134	1	21	0	10	11			15	6		0	71%	29%	0%
130	2	23	0	10	13			19	4		0	83%	17%	0%
121	3	20	0	20	20			6	14		0	30%	70%	0%
820	3	12	0	12	0			0	12		0	0%	100%	0%
727	2	6	0	6	0			0	6		0	0%	100%	0%
219	2	20	0	13	7			7	6		0	35%	30%	0%
445	6	7	1	7	7			6	4		1	75%	50%	13%
424	3	16	0	9	7			8	8		0	50%	50%	0%
439	2	7	0	3	4			4	3		0	57%	43%	0%
841	2.5	24	2	14	12			15	10		1	58%	38%	4%
747	3	15	0	18	3			12	3		0	80%	20%	0%
729	2	18	0	8	10			13	5		0	72%	28%	0%
0														
TOTALS	43.5	242	3	158	117	0	0	131	108	2		53%	44%	1%

PUPILS RETAINED IN SCHOOL/IMMEDIATE RETURN TO CLASS
WHEN THE CERTIFIED SCHOOL NURSE IS NOT PRESENT

TABLE VI

School Loc #	enrollment	Days	Pupils	Other	Illness	Injury	Accident Incident Report	Notice to Parent	Immediate Return to Class	Sent Home	Sent to Hospital	Immediate Return to Class %	Sent Home %	Sent to Hospital %
840	760	3	39	2	15	24	1	6	33	6	0	80%	15%	0%
830	520	2	16	0	9	7	0	2	10	6	0	63%	38%	0%
138	600	1	4	0	3	1	0	1	4	0	0	100%	0%	0%
147	472	2	14	0	11	3	0	4	12	1	0	86%	7%	0%
134	1064	4	65	4	38	31	0	18	58	7	0	84%	10%	0%
130	746	3	51	5	48	8	0	48	46	10	0	82%	18%	0%
121	455	2	17	2	12	7	0	4	17	2	0	89%	11%	0%
820	509	2	14	3	12	4	0	1	17	1	0	100%	6%	0%
727	898	3	58	0	42	16	0	16	51	7	0	88%	12%	0%
219	550	3	27	0	21	6	1	22	17	3	0	63%	11%	0%
445	601	10	45	10	24	26	0	11	45	0	0	82%	0%	0%
424	785	2	18	3	15	6	0	1	18	3	0	86%	14%	0%
439	494	1	4	0	2	2	0	1	3	1	0	75%	50%	0%
841	525	2.5	79	9	46	42	0	58	66	20	2	75%	23%	2%
747	406	2	27	0	13	14	0	6	21	6	0	78%	22%	0%
729	516	3	24	0	16	8	0	9	20	4	0	83%	17%	0%
TOTALS	9901	45.5	502	38	327	205	2	208	438	77	2	81%	14%	0%

PUPILS RETAINED IN SCHOOL/IMMEDIATE RETURN TO CLASS
WHEN THE CERTIFIED SCHOOL NURSE IS PRESENT

Medical Services (01-07-037)

I. Statement of Function

The Pennsylvania School Code mandates that each school child receive complete medical examinations. In Philadelphia this is done at the entry level of the particular school's organization. Approximately 50,000 students will receive examinations under this mandate. Approximately eleven thousand will be performed by school physicians. In addition, each physician provides medical back-up for several nurse practitioners. Two physicians provide physical examinations (approximately 6000/year) for students needing working papers for after-school and/or summer employment. All physicians participate in examining youngsters for Special Olympics activities.

II. Description of Programs

There are ten physicians budgeted in this activity. Each physician has several areas of responsibility:

A. Physical examinations - The standard American Academy of Pediatrics unclothed physical is performed (unless the child and/or the parents object). Each physician is usually scheduled to see four children each hour, during their normal work day, which is three hours. Physicians function as itinerant workers.

B. Medical Consultants - When the school to which a physician is assigned is staffed by a School Nurse Practitioner, then the physician acts as a consultant/auditor. The physician reviews child health records to determine the practitioner's adherence to standard protocols and appropriateness (accuracy) of findings. The physician also provides ongoing staff development for the School Nurse Practitioners.

C. Medical Clearances - In addition to these areas, physicians clear students for participation in the Special Olympics and two members of the staff provide, on an extra-curricular basis, physical examinations students need for employment certification.

D. Private Physicians - Parents are given an option to have their children examined by their own physician or source of health care, or by the school physician. If they choose the former, they supply a record of that physical so that the child's health record can be maintained in an up to date fashion.

III. Program evaluations

School physicians examined a total of 16,616 children during the 1992-93 school year. Of that number, 3,805 were found to have

problems. The problems included, but were not limited to, heart murmurs, hernias, otitis media, scoliosis, enlarged tonsils, and suspected abuse. Three hundred and forty six (346) were not referred for follow up, mostly because the problem was found to already be under a physician's care. Of the 3,459 children who were referred for follow up, 2,213 actually completed the referral. Therefore, 64 % of the health problems discovered by school physicians were resolved. (As a measure of quality, it is worthwhile noting that in only 1.04% of the referrals did the family's own physician disagree with ours.)

IV. Impact of Budget Deductions

From September through December, 1993, school physicians examined a total of 4,318 children. For the same period in 1992, the total was 5,842. Extrapolating this difference through the end of the current school year indicates that more than 3,000 fewer children will receive physical examinations this year than last.

Dental Services (01-07-036)

I. Statement of Function

Pennsylvania law mandates a program of dental examinations for school children. The School District's dental program provides dental screenings, referral and instruction in oral hygiene and nutrition to approximately 180,000 students in elementary and middle public, parochial and private schools within the boundaries of the School District of Philadelphia. The program's major goal is to achieve dental health through prevention and health promotion. Services are provided by dental hygienists, each of whom is assigned a case load of students/schools within a specific geographical area. Classroom presentations include dental health and nutrition, education, and instruction in good techniques and practices of oral hygiene. The Dental Supervisor is responsible for assuring the highest standards of professional practice by orienting new staff, providing on-going staff development regarding developments in the field, and by linking with various professional societies and dental health care providers. The supervisor is the official rater of all dental hygienists.

II. Description of Programs

There are 17 Dental Hygienists budgeted in this activity. Each is responsible for the following activities within an assigned geographic area:

A. Dental Evaluations - Using a mouth mirror and explorer, Dental Hygienists determine the presence of dental diseases (caries, gingivitis, periodontal disease, infections, malocclusion, dental injury, poor oral hygiene, lack of dental follow-up. DMF and def rates are tabulated.¹

B. Referrals for Treatment - Parents are informed of their child's dental status via note, phone call, conference, and will receive referrals for corrective and preventive treatment, and facility information. School nurses and other support staff may also be used to assist with referrals.

C. Classroom Education - Includes teaching the following to establish lifetime habits: oral hygiene and plaque control techniques (brushing, flossing); nutrition education (especially as it relates to dental health, with specific emphasis on dentally safe snack choices); the importance of regular dental care, both preventive treatment (prophylaxis, sealants, etc.) and corrective treatment (fillings, endodontics, etc.) Dental health education materials will be given to students and teachers. Emphasis is placed on integrating dental health with other areas of the curriculum

D. Parent/Staff Education - Includes all appropriate dental health education, and can be done in groups or individually as requested. Education materials are provided. Seven thousand individual parent conferences were held; there were three thousand meetings with other school staff.

E. Special Projects - Includes Health Fairs, Assemblies, Career Fairs, Sugarless Wednesday Program (Nutrition Program), Smile Contest, Pregnant Student Education Program. Education materials are provided.

F. Dry Brush-In - Includes brushing demonstration and brushing technique practice utilizing supplied kits for third graders. Approximately 15,000 toothbrushes are supplied via this activity.

G. Toothpaste/Toothbrush Company Programs - Education materials provided are used in four grade levels. Toothbrushes and kits are used in two grade levels and in special education classes. Another 38,000 toothbrushes are distributed in this activity.

H. Plaque Control Program - The Oral Hygiene Index (OHI) is calculated and reported for two grade levels.²

¹ Follow-up - A sample of students in need of correction will be rescreened to determine if treatment was given.

² DMF refers to the number of decayed, missing or filled permanent teeth; def refers to the number of decayed, indicated for extraction or filled deciduous (baby) teeth.

2. Oral Hygiene Index (OHI) refers to the scoring system that is based on the quantity of oral debris and calculus present at the time of the evaluation.

III. Program Evaluations

During the 1992-93 school year 99,556 children were screened; 24,519 were found to require referrals for corrections (24.6%). A sample of eighty schools were selected for follow up visits by the Dental Hygienists. Five thousand seven hundred (23%) of the 24,519 were re-screened. Of these, 1,540 were found to have completed treatment, while another 737 were still under treatment, but not completed. The total of these last two figures represents a 40% follow up rate.

IV. Impact of Budget Reductions

The last School dentist= position was abolished at the end of the 1992-93 school year. Consequently, we have applied to the Commonwealth of Pennsylvania for permission to modify our school dental program. We have received approval. This modification means that we will be applying for reimbursement under a different formula, i.e., instead of \$.80/child average daily membership (ADM), we will be eligible for reimbursement at the rate of \$2.00/child actually "reached" by the program. In order to realize additional revenue in this way, we added two middle school grades (5 and 7) to the elementary grades already being covered (K-4). In order to do this, however, we had to curtail our activities in the preschool program,

since these were not reimbursable.

Administration (01-07-013)

1. Statement of Function

This is the central administrative unit of School Health Services. It provides direction and leadership to the other units -- Dental, Medical and Nursing -- as well as certain support services, such as payroll, personnel, purchasing, supplies distribution, etc. The Director of School Health Services is responsible for the development of policies and procedures governing the delivery of school health programs and services to more than 275,000 public, private and parochial Philadelphia school students. The Director works closely with City, State, Federal and private health officials and agencies in connection with ongoing and special health programs; and, in programs aimed at preventing child abuse and improving reporting in this area, disease prevention, health promotion and in implementing the School Board's policy on adolescent sexuality. The Director is the School District's Compliance Officer in regard to services for Protected Handicapped Students, and provides leadership and support to schools in the establishment and operation of expanded school-based health programs, including on-site clinics and school-linked services.

II. Program Description

A. Policy Development - The Director, School Health Services (SHS), is responsible for identifying emerging health issues and for developing and recommending policies that address those issues.

B. Development & Dissemination of Procedures - The Director oversees the preparation of, procedures which guide school health and other school staff in the implementation of policies and in dealing with specific health matters.

C. Program Initiation and Implementation - The Director, SHS, is responsible for initiating and/or implementing a number of programs aimed at improving the health status of children.

D. Working with Other Public and Private Agencies - The Director, School Health Services, interacts on a regular basis with public and private health and related agencies and individuals regarding specific and general health issues.

III. Program Evaluation -

A. Policy Development - The Director has developed and recommended policies to address a variety of issues from childhood immunization to HIV infection. The School District of Philadelphia was first in Pennsylvania to adopt a school entry immunization requirement. As a result, the percentage of children enrolled in school who are fully immunized has gone from 75% to 98%. The School District of Philadelphia

was one of the first to adopt a policy regarding students and staff with AIDS. That policy spared this School District the controversy that many others experienced.

B. Development and Dissemination of Procedures - The Division of School Health Services has an up to date procedure manual. In addition, when health-related procedures require action by other school staff, such procedures are disseminated through the appropriate office(s). This includes the recently revised and re-issued first-aid procedures.

C. Program Initiation & Implementation - School nurse practitioners, school-based health clinics, school-linked health programs, EPSDT screens (by private providers and school nurses), staff development on child abuse prevention, identification and reporting and implementation of Board Policy 123 are all examples of activities in this area. Looking at just the area of school based health clinics, the school district of Philadelphia was first in Pennsylvania with these programs. The system-wide goals call for one in every region by 1995. We now have seven in operation. Except for space these have been implemented at little or no cost to the School District.

D. Working with Public & Private Agencies - as a member of various boards and advisory committees, the Director, School Health Services, has an opportunity to interact with various public and private agencies and individuals. The net effect of this has been to increase the involvement of organizations, institutions and individuals external to the School District in school health and related programs. Examples of such linkages:

School-Based Health Clinic

<u>Physician/Health Care Organization</u>	<u>School</u>	<u>Type of Relationships</u>	<u>Approximate Value to School District (\$/yr)</u>
Covenant House	J.B.Kelly	School-Based	\$150,000
Greater Phila. Health Action	Bartram H.S.	School-Based	200,000
Greater Phila. Health Action	Franklin	School-Based	200,000
Misericordia Hospital	Huey	School Based	180,000-200,000
Quality Community Health Care	Meade*	School--Based	250,000
Spectrum Health Services	Sulzberger	School-Based	200,000
St. Christopher's Hospital	Stetson*	School-Based	250,000
St. Christopher's Hospital	Clemente**	School-Based	<u>250,000</u>
Total:			\$1,680,000 - \$1,700,000

*To begin serving students in January, 1994

**To begin serving students in September, 1994

School-Linked Health Services

<u>Physician/Health Care Organization</u>	<u>School</u>	<u>Type of Relationship</u>	<u>Approximate Value to the School District (\$/yr)</u>
Albert Einstein Medical Center	Bethune	School-linked	\$7 - 10,000
Albert Einstein Medical Center	Roosevelt M.S.	School-linked	7 - 10,000
Albert Einstein Medical Center	Wagner M.S.	School-linked	7 - 10,000
Albert Einstein Medical Center	Cramp	School-linked	7 - 10,000
Albert Einstein Medical Center	McClure	School-linked	7 - 10,000
Stuart Cooler, M.D.	Clymer	School-linked	7,000
Stuart Cooler, M.D.	Hackett	School-linked	7,000
Stuart Cooler, M.D.	Moffet	School-linked	7,000
Stuart Cooler, M.D.	Potter-Thomas	School-linked	7,000
Stuart Cooler, M.D.	Sheppard	School-linked	7,000
Stuart Cooler, M.D.	Willard	School-linked	7,000
Stuart Cooler, M.D.	Harrison	School-linked	7,000
Germantown Hospital	M.L.King H.S.	Possible School-Linked	7 - 10,000
Hahnemann University Hosp.	W. Penn H.S.	School-Linked	7,000
Lankenau Hospital	Shoemaker	Possible School-Linked	7 - 10,000

School-Linked Health Services(continued)

<u>Physician Health Care Organizations</u>	<u>School</u>	<u>Type of Relationship</u>	<u>Approximate Value to the School District (\$/yr.)</u>
Medical College of Pa.	Gratz H.S.	School -Linked	\$20,000
Nelson Medical Group	Barratt M.S.	School-Linked	10,000
Nelson Medical Group	Audenreid H.S.	Possible School-Link Center	10,000
Phila. Dept. of Public Health	Vaux M.S.	School-Linked	20,000
Phila. Dept. of Public Health	Fitzsimons M.S.	School-Linked	7,000
St. Christopher's Hospital	Edison H.S.	School-Linked	20,000
Village Community Health Care	Blaine	School-linked	7,000
			Total: \$186,000 - 207,000

Health Resource Centers - Policy 123

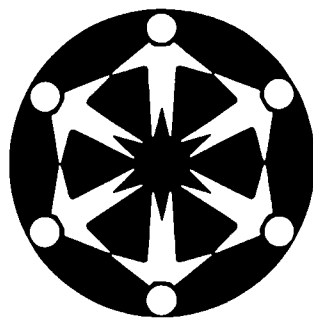
<u>Physician/Health Care Organizations</u>	<u>School</u>	<u>Type of Relationship</u>	<u>Value to the School District (\$/yr)</u>
Albert Einstein Medical Center	Central	Health Resource Center	\$36,000*
Children's Hosp. of Phila.	UCHS	Health Resource Center	36,000*
Covenant House	M.L. King H.S.	Health Resource Center	36,000*
Medical College of Pa	Gratz	Health Resource Center	36,000*
Phila. Child Guidance Clinic	WPHS	Health Resource Center	36,000*
Phila. College of Osteopathic Medicine	Lamberton	Health Resource Center	36,000*
Spectrum Health Services	Overbrook	Health Resource Center	36,000*
St. Christopher's Hospital	Edison	Health Resource Center	<u>36,000*</u>
Total:			\$288,000

*Excludes cost of condoms. During 1992-93, 35,000 distributed @ 5 cents each: Cost: \$1750

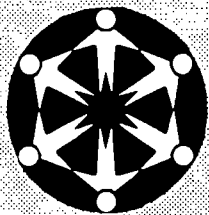
Executive Summary

PARTNERS

for a Healthy Community



Health Assessment for Northwest Philadelphia and Adjoining Suburbs



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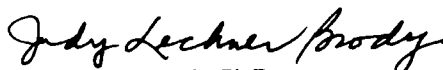
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PREFACE

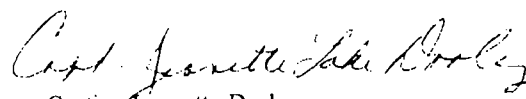
This document, *The Northwest Philadelphia and Adjoining Suburbs Community Health Assessment*, pulls together, for the first time, much useful information on these neighborhoods. Through synthesis of many interviews with community and medical leaders and through focus groups on key areas of concern, it puts a human face on the many statistics. It digs below the surface and explores the nuances and subtleties of the health problems faced by this region and the possible approaches to improving the health of its people. This community health assessment will serve as a base line resource to all of the region's varied community groups and service providers. We recommend that those who are curious or concerned about the health of the community read this document carefully.

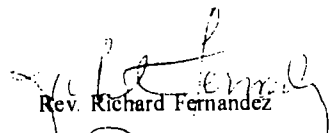
This assessment marks the beginning of an important process which is supported by the C.H.A. Advisory Committee. The information and recommendations in this report will serve as a reference point for the beginning of a community dialogue. We pledge ourselves to active participation in that dialogue and urge all who share our concern for the health, vitality and future of our neighborhoods to join us.

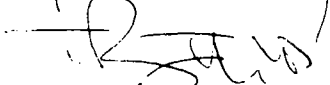
The C.H.A. Advisory Committee

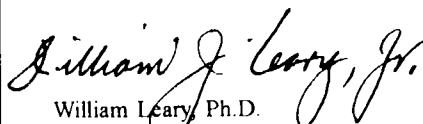

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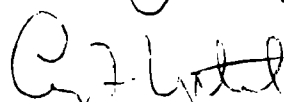

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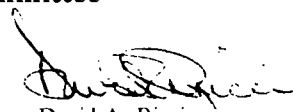

Rev. Richard Fernandez

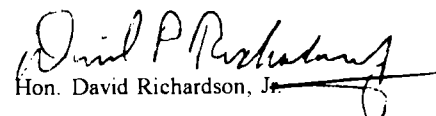

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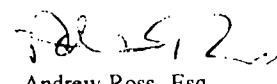

William Leary, Ph.D.

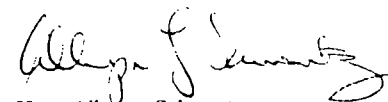

Cary F. Leptuck

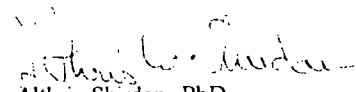

Robert J. Patterson, M.D.

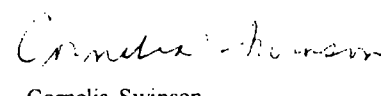

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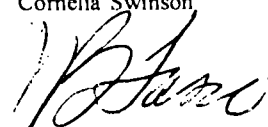

Hon. David Richardson, Jr.

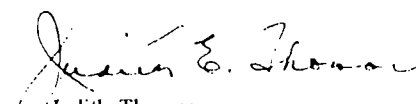

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Partners for a Healthy Community
Health Assessment for Northwest Philadelphia and Adjoining Suburbs

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Acknowledgements

More than 800 residents in the Northwest Philadelphia neighborhoods and adjoining suburban communities participated in various phases of this project. We can't begin to acknowledge our indebtedness to all of them here. Their willingness to take the time out of their busy schedules to share information provided most of what is valuable in this report. Their directness about the problems and their optimism about solutions challenged us to do the same.

The project was a large undertaking that couldn't have been accomplished without the enthusiastic collaboration of many individuals and agencies. The project was directed and the report was written by David B. Smith, Ph.D. and Joan Apt. A special note of appreciation to Jeff Flood and the Delaware Valley Hospital Council for their assistance in obtaining data to complete the small area vital statistics profile section of the report. Marjorie Baker of the Regional Planning Commission, Francine Axler and Gary Feit of the Philadelphia Health Management

Corporation, Warner Tillack of the Philadelphia Department of Health, John Orris of the State Health Data Center, Scott Snyder of the Temple University Social Science Data Library, and Paul Rappaport, Director of the Temple University Cochran Research Center, were all of invaluable assistance in pulling together various data components.

The qualitative section presented equal challenges in scheduling interviews, organizing focus groups and synthesizing taped transcripts. Barbara Needham of The Germantown Hospital and Medical Center and Louise Clark of Chestnut Hill Hospital Healthcare were invaluable in keeping the interviews on track and assisting in the organization of the focus groups. Special appreciation is due Ethel Branch-Cooper, President of the Morton Homes Tenant Council; Joseph Jacavino, Ph.D. and Cathy Balsley, Ph.D. of the Philadelphia Public Schools; Denise Floyd of the Child Health Watch and Sue Endy of the Parents' Place for help in this phase of the project. Ahema Asare, a graduate student in Temple's Graduate Program in Health Services Administration, was of invaluable assistance in this phase of the project as

were the many individuals in different Philadelphia schools that assisted in recruiting students to the adolescent focus group.

While the report itself reflects the words and thoughts of many people in this community, several groups helped make that voice come alive. A special note of appreciation is due the technical advisory group members Roger Lukoff, Kathleen Kennedy and Lisa Finkelstein for their review and help in organizing the project. We are particularly indebted to the policy advisory group in guiding the broader outlines of this project and in formulating its final recommendations. This group was especially able to provide insight, direction, focus and life to this report and to help us all awake to common dreams.

COMMUNITY SUMMARY

What can we do to improve the health of the people in this community? Answering the question involves collecting information to create a picture of the current health status of the community. It also entails identifying the resources that are currently available for prevention and treatment. Ideas were generated about what changes in programs and services would actually result in improved health for individuals living in this area. The executive summary focuses on the results of this creative thinking. This report is a summary of a two hundred page qualitative and statistical report on the area. Copies of this larger planning and program development resource document are available at the hospital and local public libraries in the region.

Seven priorities were identified through the analysis of health statistics, in-depth interviews, and focus groups involving more than one hundred people in the community. These priorities were selected because they offer both practical first steps and promise the greatest long term gains in the overall health of the

community. Success will require the development of a collaborative community partnership that must also address the racial and socioeconomic divisions and inequities that shape stark differences in health.

One. Reduce the risks of premature deaths from heart disease and cancer by pooling hospital community service program resources to develop new community wide collaborative strategies.

Two. Expand collaborative efforts to support the frail elderly in their homes through churches and neighborhood associations and other concerned groups.

Three. Focus on the schools and churches as hubs of community health education and promotion, screening, treatment, counseling, mental health treatment, career placement and avoiding child abuse.

Four. Support parents, caregivers and children with systems that simplify services and supply information.

Five. Develop a mechanism in the

community to address the interrelated problems of drug and alcohol abuse, crime, violence and unemployment, housing, child abuse and other social problems through collaborative efforts with neighborhood associations, block and tenant councils, schools, police and churches. Develop technical training and career placement programs for targeting youth from the community.

Six. Expand a collaborative approach to primary care, preventive care, health promotion and hospital service.

Seven. Advocate that the managed care programs are coordinated with community health needs and existing programs, and provide education and choice for participants in the program.

The information and process used in establishing these priorities were as follows:

The Community Picture: The project involved the compilation and analysis of census data, vital statistics, communicable disease rates, crime rates, hospital discharge and household survey data. The

analysis provided a view of the health status of the community, and of resources and their use by the varied populations within it.

Interviews with Professionals and Community Leaders: Seventy five people were interviewed in depth for the assessment. They included physicians, school officials, social workers, health educators, neighborhood association representatives, political and business leaders. Interviews lasted from 45 minutes to two and a half hours and dealt with both priorities and strategies for community health improvements.

Focus groups: Four groups were selected which were particularly important to identify both health needs and the ways that resources are used to meet those needs. Representatives of these groups met together to discuss their perspectives on needs and priorities. These groups included caregivers of young children; adolescents; primary care physicians; and a group of men in a rehabilitation program with personal experience with drug abuse, crime and violence in the community.

Many of the problems identified through the assessment are impacted by things going on outside this community. Of particular importance is the debate over health care reform and its as yet uncertain outcome. Yet, as the health care reform debate unfolds in Harrisburg and in Washington D.C., we have a unique opportunity to shape and influence what happens. We believe there is a great wealth of underused potential for improving the health of residents in this region. Coordinated action by schools, churches, neighborhood associations, businesses, government, health providers and health insurers can have a positive impact. This coordinated action has been largely lacking, but will become essential as a new system emerges.

As one of the people interviewed for the project observed, "If we organized a war the way we organize health care, we'd all be dead." It is time to organize for the health care war. This document is an invitation to participate.

A Picture of the Community

What can we do to improve the health of

the people in this community? The Northwest region is, in fact, a geographic region that does not think of itself as a single community. However, in a narrow economic sense, it is a health community because the cost of providing health services and promoting health will be borne by this region as a whole. Under the pending proposals for Health Reform, health insurance premium rate costs per person will be based on this region, not on neighborhoods. The cost of duplication and redundancy will be shared by all. The service areas of hospitals and medical practices also include residents of all these neighborhoods. The quality of medical services would suffer for all in this region if health care was organized by neighborhoods. We are also a community in an ethical sense. We share the problems of our neighbors, and ultimately they will be solved best by a joint effort.

To answer the question of improving health for community residents, we begin with a brief history of the area. Then we will summarize basic demographics and vital health statistics of the area, followed by a summary of health care resources and the social issues which affect them.

History

Nothing ever happens that did not begin in the past and presses hard against the future."

T.S. Eliot

Perhaps in no area of the United States are the tensions of the past and the potential for the future more concentrated than in the Northwest section of Philadelphia. Germantown's urban village tradition began with the initial migration of Germans at the end of the 17th century. After it was incorporated into the City of Philadelphia, it continued to function with its own government through the 19th century. Many of the early residents of this urban village were transients on the way to farming areas in Lancaster County. The pattern of migration continued, bringing the Irish and Italians in the 19th century. The major influx of African Americans began during the 1920's as the cotton industry declined in the south. The more recent influx of Asians in the 1980's reflected the end of the Vietnam war and the end of racial quotas on immigration. The general pattern of migration has flowed from North Philadelphia to

Germantown to Mt. Airy and then to the suburbs. Chestnut Hill was a planned community constructed in the latter half of the 19th century.

Neighborhoods are important here and the strength of local neighborhood associations throughout the region is a sign of this. They are clearly a key to making an effective link between the health care system that may be imposed from the outside, and meeting the needs of people in the community.

"I am constantly in awe of the time and energy and creativity that people put into their communities," says one study

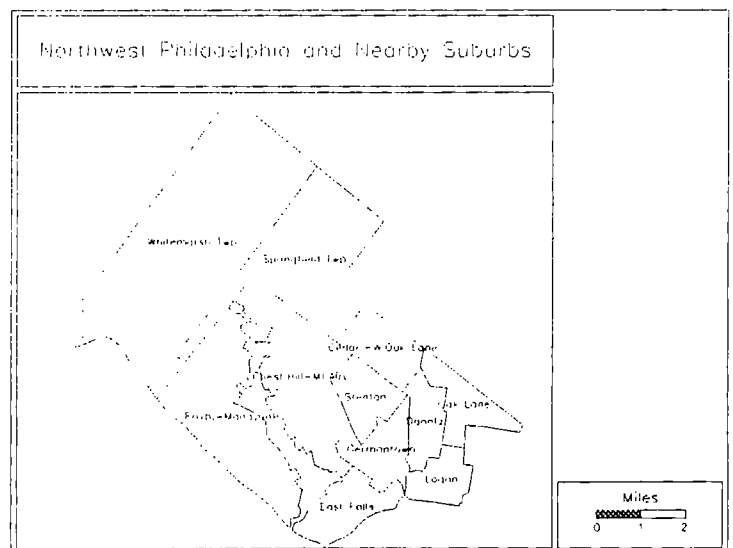


Figure 1

Northwest Philadelphia and Nearby Suburbs

<u>Zip</u>	<u>Name</u>	<u>1990</u> <u>Total Population</u>	<u>1980</u> <u>Total Population</u>	<u>Change</u>	<u>Percent</u> <u>Change</u>
19118	Chstnt Hill, Erdhm, Wyndmr	19,531	20,574	(1,043)	-5.1%
19119	Mt. Airy	29,789	31,669	(1,880)	-5.9%
19126	Oak La, Chltnhm	21,884	23,794	(1,910)	-8.0%
19127	Manayunk	6,045	6,493	(448)	-6.9%
19128	Roxborough	36,727	39,275	(2,548)	-6.5%
19129	East Falls	13,205	13,114	91	0.7%
19138	East Germant'n	37,383	41,293	(3,910)	-9.5%
19141	Logan	38,482	40,306	(1,824)	-4.5%
19144	Germantown	46,738	51,163	(4,425)	-8.6%
19150	Wadsworth	27,675	29,050	(1,375)	-4.7%
Total Northwest Phila		277,459	296,731	(19,272)	-6.5%
19444	Lafayette Hill	8,337	8,145	192	2.4%
19075	Oreland	7,397	7,903	(506)	-6.4%
19031	Flourtown	4,275	4,512	(237)	-5.3%
Suburban Total		20,009	20,560	(551)	-2.7%
Regional Total		297,468	317,291	(19,823)	-6.2%
Philadelphia		1,585,577	1,688,210	(102,633)	-6.1%

Figure 2

participant. "It is just amazing to have people come in here who have work to do in their real lives and they are here volunteering their time, blood and sweat to keep neighborhoods together and safe and functioning and it is really amazing to me."

Demographics

The "community" examined in this report includes Northwest Philadelphia and the nearby suburbs in Montgomery County. The neighborhoods and zip codes are

shown in Figures 1 and 2, along with population figures from the 1990 and 1980 censuses. The region includes approximately 300,000 people.

Over the past decade overall population declined 6.2%. Germantown and East Germantown had the highest decrease, while the suburbs of Lafayette Hill, Oreland and Flourtown had the lowest.

Figure 3 shows the changes in population adjusted by age. In the last ten years, statistics show an overall decrease in the

Population by Age Group 1980, 1990, 1993 and Forcasted to 1998

Age Group	Region	1980	1990	1993	1998	Percent Change	Forcasted Percent Change
						1980 to 1990	1990 to 1998
Under 15	Northwest Philadelphia	63,624	55,638	56,640	56,125	-12.6%	0.9%
	Nearby Suburbs	3,862	3,514	3,788	3,823	-9.0%	8.8%
15 to 44	Northwest Philadelphia	135,997	128,886	126,524	122,510	-5.2%	-4.9%
	Nearby Suburbs	8,495	8,214	7,959	7,731	-3.3%	-5.9%
45 to 64	Northwest Philadelphia	58,890	54,602	55,731	60,059	-7.3%	10.0%
	Nearby Suburbs	5,495	4,339	4,410	4,688	-21.0%	8.0%
64-84	Northwest Philadelphia	34,127	33,646	32,911	31,249	-1.4%	-7.1%
	Nearby Suburbs	2,471	3,534	3,682	3,739	43.0%	5.8%
85 Plus	Northwest Philadelphia	4,093	4,687	5,274	6,026	14.5%	28.6%
	Nearby Suburbs	237	408	492	581	72.2%	42.4%
Total	Northwest Philadelphia	296,731	277,459	277,079	275,969	-6.5%	-0.5%
	Nearby Suburbs	20,560	20,009	20,331	20,563	-2.7%	2.8%
Region Total		317,291	297,468	297,410	296,531	-6.2%	-0.3%

Source: 1980, 1990 U.S. Census, 1998 NDS/Equifax

Figure 3

population under age 65. Children under 15 decreased most dramatically (12%) in the Northwest.

Of most significance for health care planning is the dramatic increase of people over 65 living in the suburbs - over 43%. The population over age 85 increased by 14% in Northwest Philadelphia. This is the group of older elderly who require the most health care. The inadequacy of services available to this rapidly growing population was a major theme in this health assessment. The population over age 85 in Lafayette Hill, Oreland and

Flourtown almost doubled, a population that includes some 360 nursing home residents.

Under the age of five, females make up 49% of the population. By age 20, they outnumber men in all age groups. Overall, 55% of the population is female, and 75% of the population over 85 is female.

Race and Ethnicity

The racial make up of the neighborhoods in the study is still strongly segregated, even slightly more segregated than ten years ago. The region is still more

integrated than the City of Philadelphia as a whole and most other major metropolitan areas. The Spanish and Asian language speaking residents, still a small group, is primarily located in the area around North Philadelphia.

Race, according to many interviewed for the study, still matters. A hospital administrator said, "I am not sure that either of the hospitals have recognized the significant income, cultural and racial changes that have occurred in the last ten years. It is an issue that has to be wrestled with before people can begin to design systems for these communities."

Fear of the encroachment of African Americans into white suburbs is not uncommon. A Chestnut Hill minister observes, "I have met people who are frightened of the possibility of African Americans moving in, and some eager to have them. Germantown Avenue symbolizes change. People sense that change is going on and it is out of their control. An African American man who drives a car through Chestnut Hill at 11:00 pm is asked 'Where are you going?'." Another minister observes, "Many

physicians have terrible biases and are very insular. Nursing homes operate like plantations: Black service workers and white patients."

Income and Education

The great discrepancies in income education and opportunity in this community add to the challenges of healthcare delivery. One person recalls a discussion with a physician concerned about the "Chicken Bone Syndrome." When he took on Medical Assistance patients he was afraid that the chicken bones left in the waiting room might make him lose some of his private pay patients.

As indicated in Figure 4, median household incomes range from a high of \$150,000 in one part of Chestnut Hill, to a low of \$9,450 in one part of Germantown. The federally defined poverty threshold for a family of four was \$13,924 in 1991. The highest concentrations of children living in poverty were in Germantown and Stenton, where, in several census tracts, 50% of the children were living in poverty. Poverty is, however, distributed everywhere, as are the homeless and people living in the streets. The percentage of college educations and

proportion of residents never completing high school correspond to the income variations in the region.

2000 national goals are related to these indicators, as are many report card measures for managed care plans. While the measures are an important piece of the

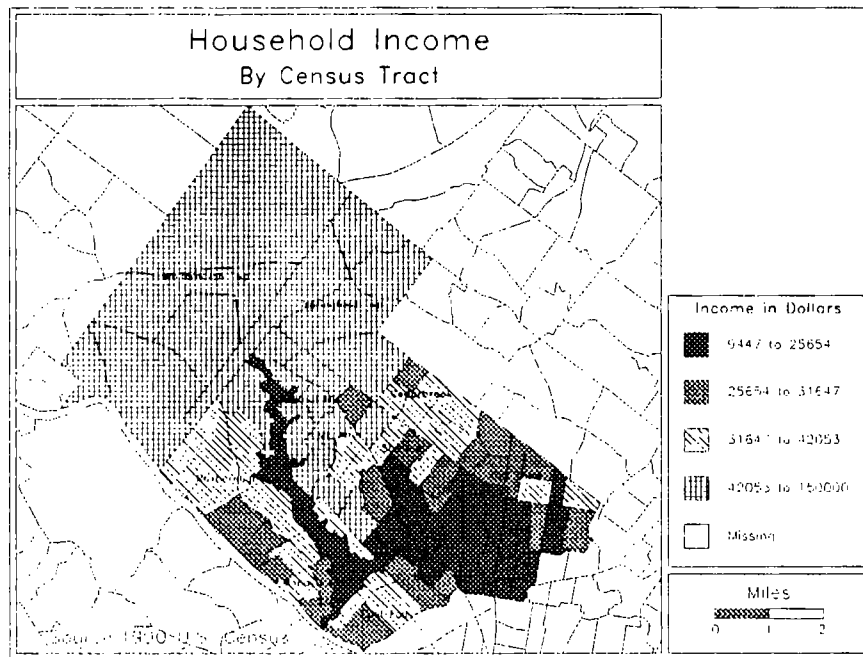


Figure 4

Vital Statistics

Part of the community profile is the information kept in public health records about births and deaths in the population, and the incidence of various health conditions. This information provides standard indicators of the health of a population. Most of the Healthy People

health picture of a community, they do not tell us what to do to improve the community's health.

Births

The birth rate in Philadelphia has increased slowly over the past 20 years. The 1990 rate for whites was 14.9 per 1,000 people while the rate for nonwhites was 22.9, both slightly below the national averages.

Teen Pregnancy

As shown in Figure 5, the rate of teenage pregnancy increased in 1990 and 1991 after decreasing for fifteen years. The highest rates were in Logan and Ogontz, where one out of every 12 children was born to a teen mother in 1990.

Prenatal Care

Early prenatal care, considered a critical factor in reducing infant health problems and death, varies greatly throughout the community. For white women, timely prenatal care use has increased from 74% to 82% in the last twenty years. For

African American women however, a period of increase from 1971 to 1984 has now been turned around. Only 49% of African American women are receiving care in the first trimester. Both white and nonwhite women are below the Healthy People 2000 goal of 90% for first trimester care. Teen mothers have the lowest rates of adequate prenatal care.

Low Birth Weight

After reaching a low of 10.3% in 1984, the incidence of low birth weight infants has increased to 11.6% in 1992. The rise coincides with the crack cocaine epidemic

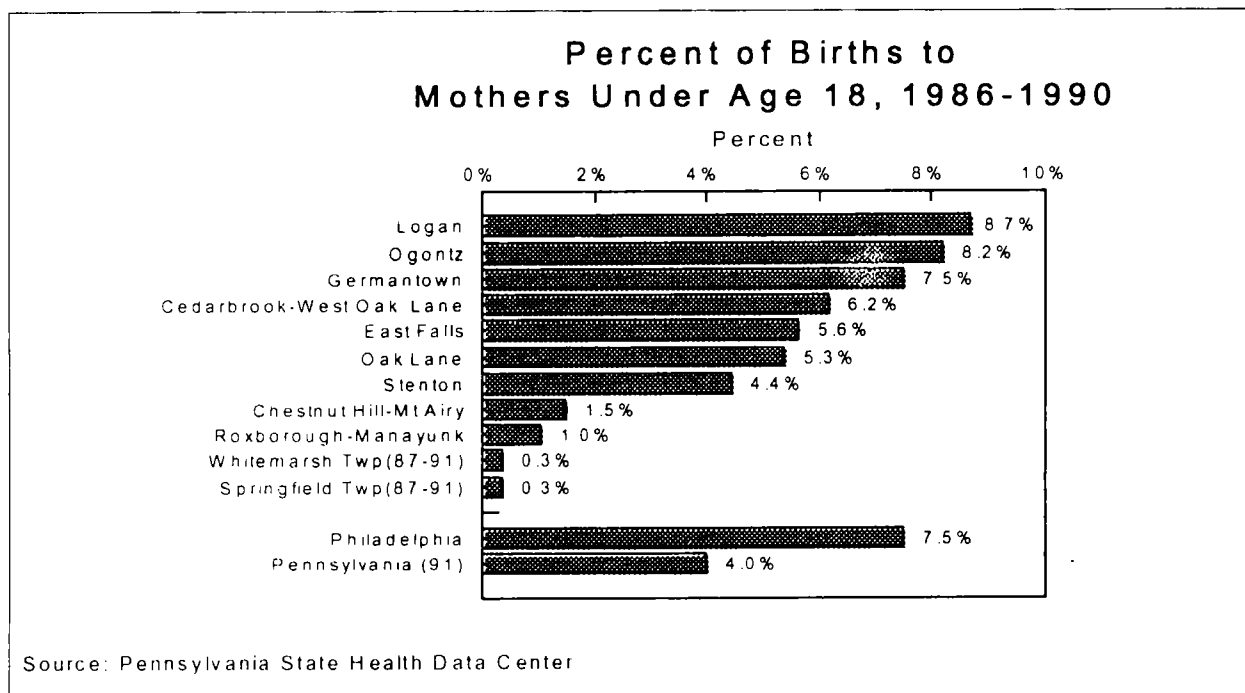
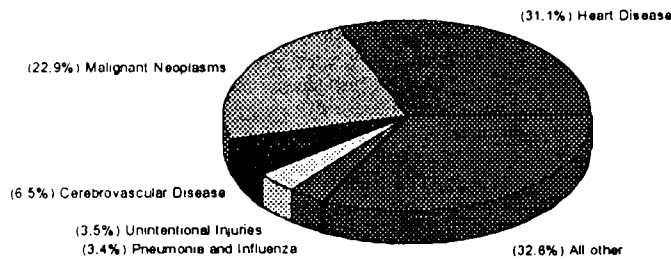


Figure 5

Major Causes of Death in Northwest Philadelphia and Nearby Suburbs, 1987-1991



Source: PA State Health Data Center

Figure 6

which began in Philadelphia in 1985.

African American women are twice as likely as white women to have low birth weight babies. The rate was 6% for whites and 14% for nonwhites, but both are above the 5% target goal for Healthy People 2000.

Infant Mortality Rates

Infant mortality rates in the community have dropped dramatically in the past twenty years, from 27 per 1,000 live births in 1970 to 16 in 1990. The rates are still far above the Healthy People 2000 goals of 7 deaths per 1000 live births for whites and 11 for African Americans.

Deaths

As shown in Figure 6, the leading cause of death for this community, as it is for the country as a whole, was heart disease. Forty six percent of the deaths in this region were from heart disease. The second most frequent cause of death was cancer, followed by cerebrovascular disease, then accidents and pneumonias.

The highest age adjusted death rates were in Logan and Germantown and the lowest rates were in the nearby suburbs of Whitemarsh and Springfield as shown in Figure 7.

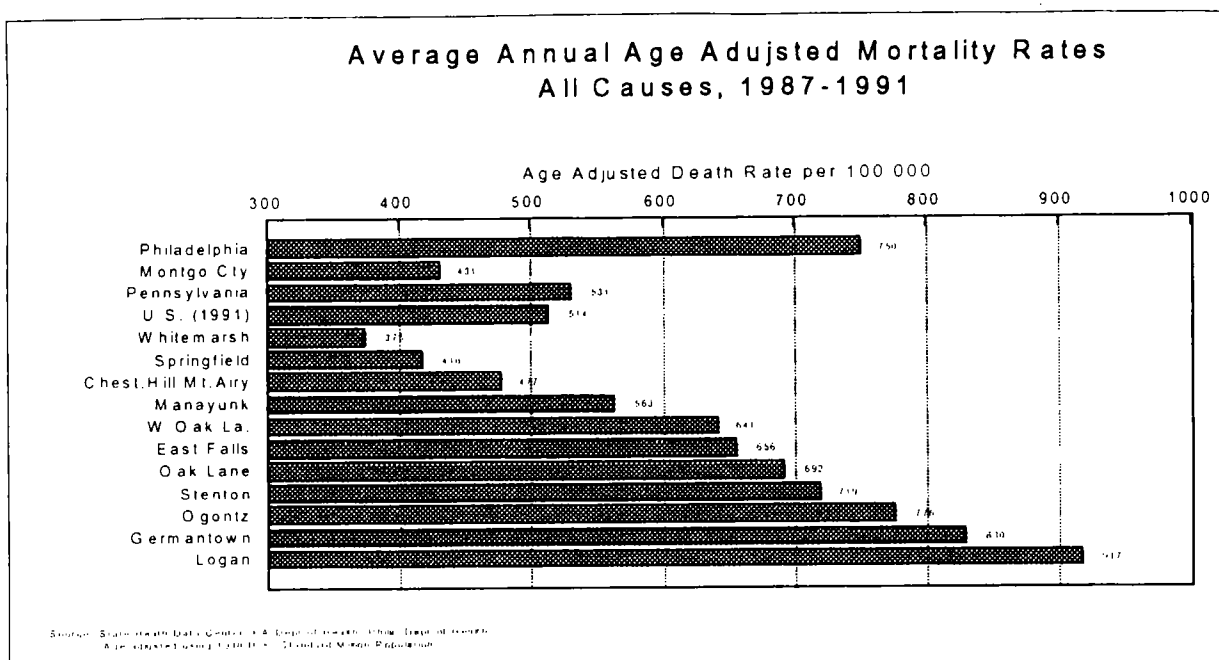


Figure 7

Among different age groups, causes of death vary greatly. For children under five, almost half of the deaths occur around the time of birth. Birth defects and congenital anomalies contribute, as well as accidents.

In the 5 to 24 age group, 29% of deaths were due to homicide. This is double the rate for the state. In the 25 to 44 age group, most causes either stayed level or declined. As shown in Figure 8, HIV became the leading cause of death, followed by cancers and accidents, homicide, heart disease and suicide.

Years of potential life lost under age 65 measures the impact of deaths occurring at younger ages. A large percentage of these deaths before age 65 are preventable. Years of potential life lost emphasizes deaths at early ages by not including deaths over age 65. It also weighs the deaths of younger people more heavily. It is a useful measure for setting health priorities, guiding prevention programs and planning intervention strategies.

Figure 9 shows years of potential life lost for the community. Years lost from homicide, cancer, heart disease and HIV

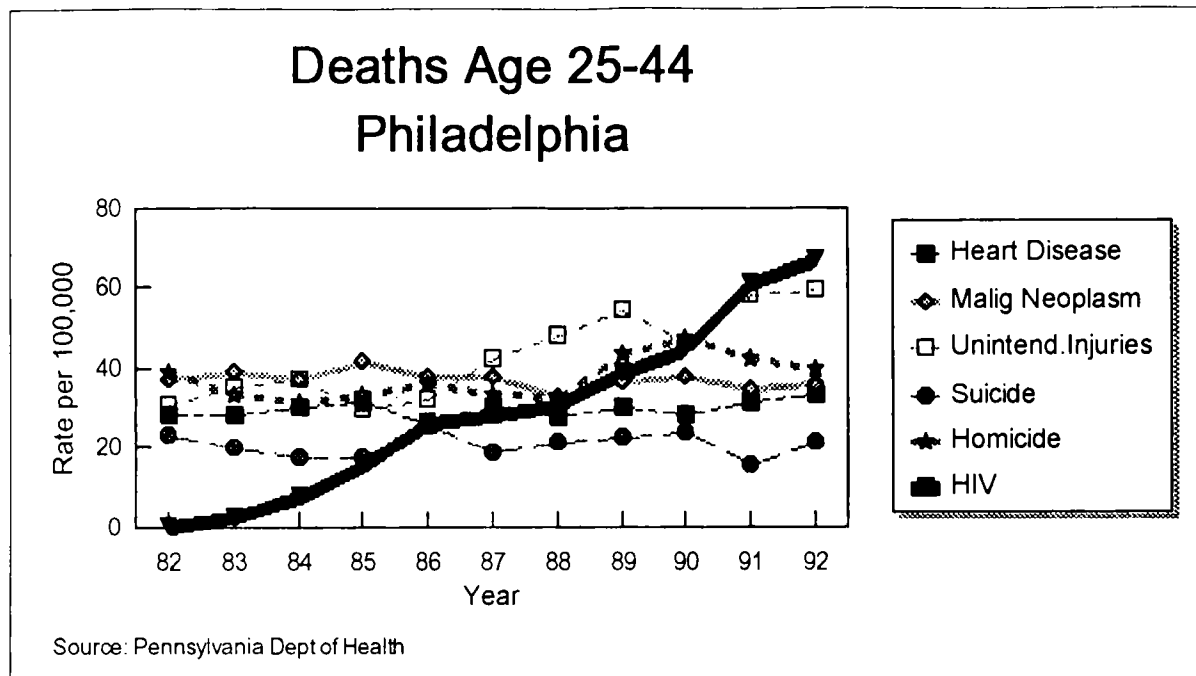


Figure 8

are all above the national average. Based on statistics from Philadelphia, these figures are all higher for African American males as opposed to white males.

Summary Comparison

Assessments are comparative. People, no matter how healthy, sometimes get sick and eventually die. The Healthy People 2000 initiative provides a way of comparing how well we are doing. Using these general indicators of health, we compared the neighborhoods in Northwest Philadelphia and the nearby suburbs to the

Healthy People 2000 goals and to Philadelphia and Montgomery counties.

The data in Figure 10 shows these comparisons. The suburbs of Springfield and Whitmarsh had the lowest overall death rates with the exception of breast cancer deaths. Logan, Germantown and Ogontz had the highest death rates, percent of births to mothers under age 18, inadequate prenatal care and low birth weight babies.

The comparison shows that one of the great challenges in health care delivery will

**Years of Potential Life Lost under 65 per 1,000 persons under age 65
By Selected Causes of Death
Northwest Philadelphia and Nearby Suburbs, 1987-1991, Philadelphia, United States, 1990**

Cause of Death	<u>All Races</u>	<u>All Races</u>	
	<u>Total</u>	<u>Total</u>	<u>U.S.</u>
	<u>NW Philadelp and Suburbs</u>	<u>Philadelphia</u>	
Homicide	8.8	12.5	3.7
Malignant Neoplasm	11.5	11.6	8.5
Heart Disease	8	9.1	6.3
Non intentional Injuries	8.8	10.6	9.8
HIV	4.9	6.4	3.0
Suicide	2.7	3.9	3.1
Cerebrovascular Diseases	1.7	1.9	1.1
Pneumonia	1.3	1.3	0.8
All Causes	80.4	93.7	56.2

Source: Philadelphia data, State Health Data Center

Figure 9

be the variations in health within the region. It also points to areas where dramatic improvements in health and preventable deaths could be made with the right programs adapted to the needs of specific neighborhoods.

Health Care Resources

The neighborhoods statistically show an above average supply of physician and hospital beds. For other categories of health care professionals there are some deficits compared to the state averages, but

overall the neighborhoods seem to have average or above average resources. See Figure 11.

Identifying the health care resources in the area is not a very specific process. People may seek services throughout the Philadelphia Metropolitan Area, not just in their neighborhood. In addition, physicians limit the size, nature and insurance mix of their practices. Despite the large physician/patient ratios in Philadelphia, for example, access may be limited by neighborhood and the ability to pay.

Healthy Community 2000
Age Adjusted Death Rates per 100,000 and Other Selected Indicators, 1987-1991

	Montgomery County	Philadelphia County	hestnut Hill- Mt. Airy	Stenton Manayunk	Roxborough	East Falls	Germantown	Cedarbrook	Ogontz	Logan	Oak Lane	Springfield	Whitemarsh	althy People 2000 Goal
DEATHS PER 100,000														
TOTAL DEATHS	417.8	719.8	477.2	719.1	563.1	656.3	829.6	641.4	776.4	917.0	692.2	417.9	374.8	
STROKE	22.7	34.3	28.8	39.7	19.6	21.6	43.1	32.3	43.1	52.0	39.2	21.9	20.7	20.0
SUICIDE	9.7	12.3	10.9	14.1	10.4	11.7	7.9	7.0	7.0	8.9	5.9	10.6	14.8	10.5
LUNG CANCER	31.5	52.0	29.3	50.3	43.4	41.9	47.9	32.8	45.6	48.9	38.8	32.7	19.3	42.0
BREAST CANCER	25.1	29.3	25.7	22.2	29.7	29.7	30.6	27.7	26.2	29.4	27.4	38.9	26.5	20.6
CARDIAC	120.5	193.7	117.6	159.9	167.5	173.6	191.8	153.9	190.9	229.5	182.5	119.6	114.6	100.0
HOMICIDE	2.8	30.2	9.3	31.9	2.0	17.9	47.8	24.4	38.3	38.3	28.5	0.0	0.0	7.2
DEATHS FROM INJURIES	22.7	37.9	20.7	40.1	29.4	31.9	41.2	25.1	39.1	42.7	31.5	15.5	17.9	29.3
INFANT MORTALITY (88-90)	7.2	16.7	7.6	15.3	7.9	18.8	20.7	16.7	18.6	17.6	18.3	8.6	6.9	7.0
INCIDENCE PER 100,000														
AIDS INCIDENCE	7.0	41.6	34.5	41.5	12.9	30.3	53.5	59.6	58.5	58.5	29.7	0.0	0.0	
PERCENT OF CASES														
BIRTHS<18 (%)	1.3	7.4	1.5	4.4	1.0	5.6	8.7	6.2	8.2	8.7	5.3	0.3	0.3	
INADEQUATE PRENATAL (%)	2.7	13.2	5.0	12.9	3.9	10.4	14.5	10.3	16.1	16.1	9.9	6.5	4.7	
LOW BIRTH WEIGHT (88-90)(%)	5.3	11.7	7.6	12.8	6.7	11.0	14.9	12.9	15.4	13.3	10.6	4.2	4.2	5.0
POVERTY<18 (%)	3.6	30.0	7.1	22.7	5.5	36.1	36.2	10.8	23.6	33.4	11.9	1.7	1.4	

Source: Pennsylvania Department of Health, 1993

Figure 10

There are 33 acute care hospitals in Philadelphia, with 5.1 beds per 1,000 population, which is above the state average. In Northwest Philadelphia there are five hospitals with a total of more than 1,300 beds, similar to the state average.

The nursing home resources present a very different picture. There are far fewer nursing home beds per elderly resident in Philadelphia than there are in the rest of the state. The Pennsylvania Department of Health cited a shortage of 7,865 nursing homes beds in Philadelphia County, and 231 in Montgomery County. Alternatives to nursing home care, such as boarding

homes, hospitals and homecare are also limited by low reimbursement rates. This lack of resources for the elderly is a major health concern for the community.

Need for Ambulatory Care

Patterns of hospital discharges can provide clues for the need for ambulatory resources or for patterns of high risk behavior.

A set of thirteen "Avoidable Hospital Conditions" developed to test the impact of the lack of insurance coverage was applied to the Northwest Philadelphia and nearby suburban data (Weissman, et al 1991).

Health Care Professionals in Philadelphia and Montgomery County

HEALTH CARE PROFESSIONALS	Phila. <u>Rates</u>	Montg. <u>Rates</u>	Penna. <u>Rates</u>	Phila. +/(-) <u>from State</u>	Montgo. +/(-) <u>from State</u>
Active Physicians (D.O. & M.D.)	450.4	482.9	264.6	185.8	218.3
Active OB/GYN Physicians (D.O. & M.D.)	23.0	27.1	13.4	9.6	13.7
Active Primary Care Phys. (D.O. & M.D.)	109.2	139.7	81.6	27.6	58.1
Certified Emergency Medical Technicians	140.7	132.0	207.5	-66.8	-75.5
Certified Paramedics	11.4	30.9	34.9	-23.5	-4.0
Licensed Dentists	77.8	119.7	72.9	4.9	46.8
Licensed Practical Nurses	286.8	265.6	404.6	-117.8	-139.0
Licensed Nurse Practitioners	9.8	24.8	12.2	-2.4	12.6
Licensed Occupational Therapists	15.4	44.1	19.0	-3.6	25.1
Licensed Physicians Assistants	5.2	11.1	7.8	-2.6	3.3
Licensed Physical Therapists	18.5	72.1	37.1	-18.6	35.0
Licensed Registered Nurses	720.6	1,711.1	1,233.6	-513.0	477.5

* Rates per 100,000 population

Sources: Pennsylvania Medical Society, 1993; and Bureau of Professional and Occupational Affairs, 1993

Figure 11

Inadequate ambulatory care often results in the higher use of inpatient services. The United Hospital Fund identified conditions which indicate that there had been inadequate primary care. A panel of clinicians judged that the hospital admissions for these types of discharges can be reduced with adequate primary care. Germantown, Logan, East Germantown, Manayunk, Oak Lane, and East Falls had the highest rates of avoidable hospitalization rates (Figure 12) and the highest use of the inpatient setting for admissions that could have been avoided with adequate ambulatory care (Figure 13). Improved ambulatory health services in these areas has the potential of decreasing overall health care costs and improving health outcomes.

Priorities: Problems and Needs

The profile of the community and the areas for improvement in the health of this community were drawn from health statistics and from personal interviews with both health service providers and consumers. Race continues to matter in this

community both in the statistics compiled and for the people we listened to.

Improving the health of this region means addressing these divisions and inequities. Death rates are too high in areas where prevention can have an impact: cancers, heart disease, homicide and HIV, for example. Services to the elderly are badly needed, even in the more affluent neighborhoods. Teen pregnancy rates, low birth weights and prenatal care are part of a constellation of factors that produce poor health outcomes for children.

Based on this picture, seven priorities have been developed for the region. The approach to these priorities must be guided by strong principles that reflect our national beliefs and our sense of ourselves as caring individuals. The guiding principles developed by the advisory group are as follows:

Universal Access: Every child and adult should have access to health care without financial or other barriers.

Comprehensive Services: Every individual should have access to a full range of

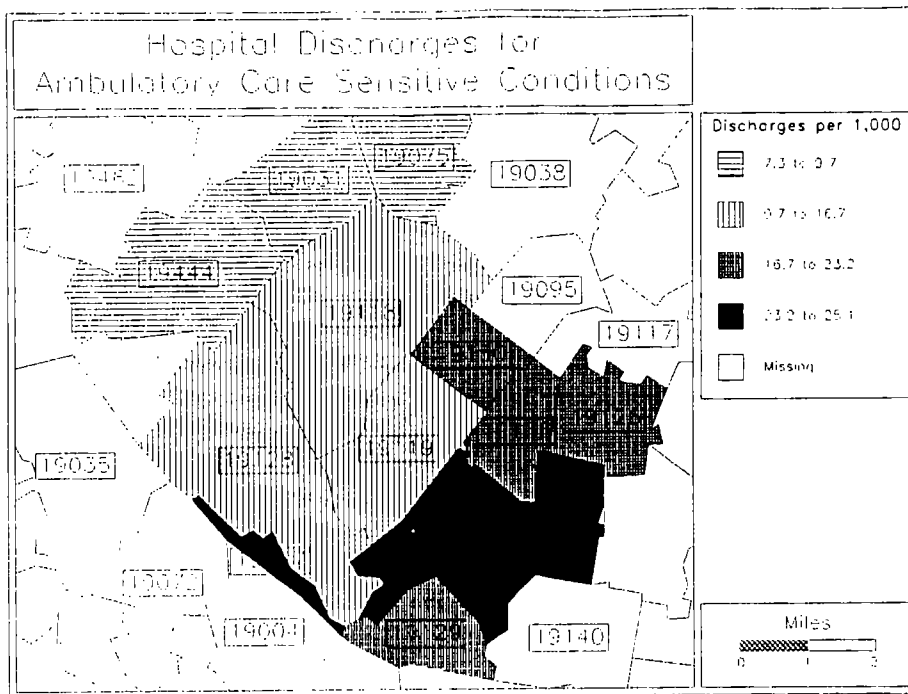


Figure 12

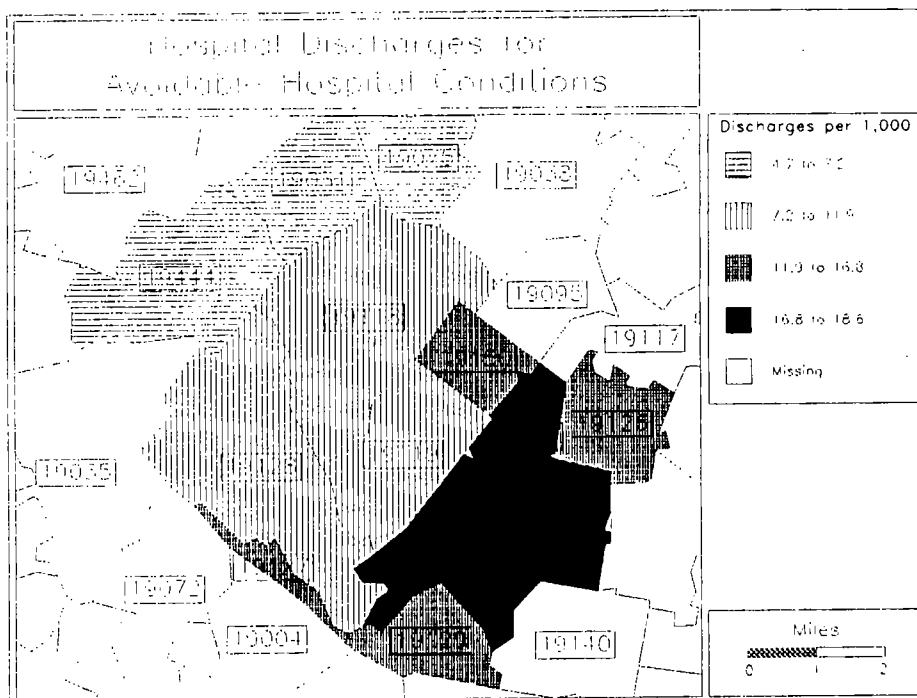


Figure 13

services, including health promotion, prevention, primary, dental care, specialty care, mental health and long term care.

Equality of Care: There should be a single system providing care based only on need.

Effective Integration of All Human

Services: The boundaries between health and social service agencies, schools and the criminal justice system and religious organizations should be blurred to improve the health of the community.

Personal Responsibility and Choice: Each individual and family should assume responsibility for protecting and promoting their health. To do this they need full information and choice of providers, medical plans and treatments.

Local Community Responsibility:

Working within the framework of federal and state reform, local communities should shape the effective design of high quality systems of care that serve the needs of their citizens.

The statistical health profile of the

Northwest community provides a skeleton for answering the question: **What can we do to improve the health of this**

community? The seventy five individual interviews and the focus groups help fill in the picture. They provide a picture of these needs in raw human terms, the numbers translated into the impact of health and health service delivery problems in daily lives. In addition, it is the experience of both health and human service providers, and of the people who need their services, that can point to solutions. Setting the priorities is only the first step; we must now move to understanding how these priorities can be addressed and we must work together to solve them.

The following section explores each priority and includes summaries of the individual comments about those areas. Addressing the priorities in one area will have a positive impact on the others.

The priorities are:

1. Community wide collaborative strategies;
2. Supporting the frail elderly;
3. Schools and churches as the hub of community health;

children;

5. Targeting drug and alcohol use, crime, violence, unemployment and other social problems;
6. Expanding collaborative approaches to primary care and hospital service; and
7. Advocating that managed care programs meet community needs.

PRIORITY 1: Reduce the risks of premature deaths from heart disease and cancer by pooling hospital community service program resources to develop new community wide collaborative strategies.

Problem: Seventy percent of all deaths in this region are caused by heart disease and cancer. Both of these conditions are strongly affected by individual behavior that can be supported through education, screening and support services.

Over 25% of the adult population (more than 56,000 people) continue to smoke, contributing to deaths from both heart disease and lung cancer. The smoking rate is much higher in the lower income areas, which also have the highest rates of lung cancer.

About 36% of the women above age 50 in

the region failed to have annual mammograms. Only 56% of adults get regular physical exercise. Many people are not taking advantage of pap smears and colorectal cancer screenings. (Figure 14).

Needs: Almost every health service provider and most health insurance plans have screening and health promotion efforts designed to have an impact on these problems. However, the health promotion motivation for these efforts tend to get confused with marketing efforts. Dealing with the problem means putting aside the healthcare marketing war and tackling the real enemy. Health promotion efforts need to be combined.

The new ways of financing health care and the increasing consumer resistance to health promotion will call for new strategies. Different approaches should emphasize the following features:

1. Environmental engineering: Changing the environment can change behavior. Eliminating vending machines, enforcing the prohibition against tobacco sales and changing restaurant and cafeteria menus can encourage healthy choices.

Risk Behaviors, Screening and Access to Care in the Northwest Region

	<u>Northwest Region</u>			<u>City of Philadelphia</u>
	<u>Total</u>	<u>Non Poor</u>	<u>Poor*</u>	
<u>Personal Health Behaviors of Adults</u>				
Adults who smoke cigarettes	25.2%	24.5%	30.9%	31.6%
Of these, adults who have tried to quit in last year	45.8%	45.3%	41.3%	49.5%
Adults who had exercised in the last month	63.3%	68.9%	45.4%	58.9%
Adults who always or nearly always wear seat belts	73.1%	75.3%	68.0%	68.8%
<u>Absence of Preventive Screening in Adults</u>				
Adults who had no blood pressure reading in the last year	13.4%	11.7%	15.0%	16.9%
Adults who did not have their cholesterol checked in the last year	46.3%	48.8%	32.7%	48.3%
Adults age 50 or older who did not have a test for colorectal cancer in the past year	48.6%	42.9%	63.2%	61.5%
Adult women who did not have a breast exam in the last year	28.4%	26.3%	29.4%	32.0%
Adult women who did not have a PAP smear for cervical cancer in the last year	29.0%	26.1%	36.2%	33.9%
Adult women age 40 and older who did not have a mammogram in the past year	46.4%	46.9%	46.9%	47.6%
<u>Health and Access Problems</u>				
Persons whose health rated "fair or poor"	14.2%	13.0%	33.8%	17.7%
Persons without a regular source of care	11.2%	14.0%	11.0%	11.3%
Persons without health insurance	9.1%	6.9%	18.5%	8.8%
Persons with no ambulatory visits in last year	13.4%	17.0%	11.1%	15.0%
Persons who did not see a dentist in last year	37.5%	37.1%	56.6%	39.8%
Persons who had a medical emergency in last year	17.8%	18.1%	17.7%	18.5%
Adults who did not have health insurance in the last year	8.2%	6.0%	18.0%	8.6%
Adults who did not seek care because of cost	11.1%	10.2%	13.6%	12.8%
Adults who belong to an HMO	34.2%	35.5%	35.6%	31.2%
Households in which illness caused a major financial problem in the last year	8.2%	5.3%	16.5%	8.4%
Households having a family member with a chronic illness	11.5%	10.9%	14.6%	11.8%

Source: 1991 Philadelphia Health Management Survey

*Poor defined as 150% of Federal Poverty Level based on family size and income for 1990.

Figure 14.

2. Downstream interventions: Individuals with chronic conditions, such as high blood pressure or asthma, have more motivation to change their behaviors. Interventions with this population can reduce overall costs of medical care.

3. Diffusion: Centering health promotion and screening efforts around one physical location may not be the right approach. Convenient locations--work place, schools, churches--may work best. Making use of people who are often real sources of community education--bartenders, beauticians--may be important networks to use.

4. Social reinforcement: Community wide efforts seem to be effective. Some school based health promotion programs that involve the whole community, as opposed to just the kids, seem to have promise.

PRIORITY 2: Expand collaborative efforts to support the frail elderly in their homes through churches and neighborhood associations and other concerned groups.

Problem: No one wants to live or die in a nursing home or hospital. This approach to

dealing with the frailty of aging is also the most expensive approach. And yet the alternative of a dignified and independent period of aging among neighbors and family is not always available. This must be a high priority in the community.

The population of elderly in this healthcare community continues to grow. By 1998, there will be 7,000 people over the age of 85. Eleven percent of the households have a chronically ill family member living there. Access to nursing homes and personal care for the medically indigent are seriously lacking. There is a shortage of 8,000 nursing home beds and long waiting lists for public home care services.

"We have sixty homebound people in our parish," says one minister. "It has taken 8 years to get the parish to make contact with all of them."

Need: While the problem of supply of and access to home care is not totally in the hands of the community, much more could be done by churches and neighborhood associations to help the elderly live where they want most to live - in their own homes. Health providers need to help

facilitate and promote these activities. Job training and placement to develop personnel to provide in-home care is also part of the picture.

"An outreach component is important," says a rabbi. "It would be good to do screening here at the synagogue."

"I would put additional dollars into a good neighbor system," says a geriatrician. "Something that would provide everybody who needs it with somebody who would check in on them, to do errands, take them to appointments or just fix little things."

Family members who care for elderly relatives in the home are a tremendous community resource. Yet they often struggle for a modest amount of support to help them do this work. "Affordable respite care is something that doesn't exist," says a primary care physician. "The people that really need it can't afford it."

"We see 90 year-old parents being cared for by 70 year-old children who are not healthy either," says a public health nurse. "The lack of support for these caregivers is costly, because nursing homes and

hospitalizations are the alternative." A nursing home administrator comments, "There is no lack of private pay nursing home beds. If you have \$30,000, you can have a bed. If you are on medical assistance, you can't."

"The Philadelphia Council on Aging has a full range of services," comments one provider. "But the waiting lists are extensive. It could be months and then they get help only two days a week."

A hospice worker laments about the whole system. "By all the Gallup polls, when people are asked where they would like to die 90% of them say 'at home'. They don't want to be in a hospital. So why is this happening?"

PRIORITY 3: Focus on the schools and churches as the hubs of community health education and promotion, screening, treatment, counseling, mental health treatment, avoiding child abuse and career placements.

Problem: A wide range of health concerns can be prevented by education, screening efforts and programs to support individual

responsibility. Finding ways to deliver these services to those most in need is a challenge. For those individuals most in need, there are significant barriers to receiving services in conventional locations. Among the barriers are transportation, payment, and a notable suspicion of establishment care. Poverty is highly correlated with incidence of poor health and high risk behavior, making it difficult to separate the need for improved health from the issue of income. Employment services, therefore, become part of health promotion efforts.

Need: The strong neighborhood identification in these areas made many feel that community schools and churches should be used as the hub of many local services. School based clinics should be major components of such efforts, reaching a highly vulnerable teen population on their own turf. The parish nursing concept provides a promising low cost vehicle for programs and should be explored further. Both could provide screening, health promotion, parenting support and counseling to school aged children, their families and neighbors. These school related activities should include assistance

in job placement. Hospitals should recognize employment as part of the health care picture and support these activities.

Teenagers validate the value of school based efforts. "We have a program called SITE," says one teenager. "It is very confidential. No one sees you go in there. They didn't have it when I was pregnant. I hear it is very nice."

"We don't specifically have a counselor, but we have a person and you can tell this person anything," says another. "She listens. The school needs more of these people. We need somewhere where we can get together and talk and no one is going to judge you. Not with trained psychologists. Just people who are ready to listen."

A principal confirms these comments. "The school is the only organization that is serving children effectively. It should be the center and focal point of services. The school yard is where programs are sold. A school has to begin to be seen as a place where you can get help."

Churches as well as schools can be centers

for informational and outreach programs and various health care screening activities. A minister described these activities as part of his mission. "Part of it," he says, "may not be a lack of specific knowledge about disease but a lack of a larger perspective. We exploit the earth and have lost our sense of relationship to the earth and I think we have got to find ways to increase our sensitivity that we are part of something larger. There is a connection between caring for your body and caring for the earth."

PRIORITY 4: Support parents, caregivers and children with systems that simplify services and supply information.

Problem: School officials, physicians, neighborhood association leaders and ministers all focus on this concern. "We're in serious trouble with our children," was a common refrain. While there was not a great deal of agreement on the cause, family disintegration was a key concern. The issues included the abandonment of women by men, the lack of discipline and structure in the home.

The traditional family with one wage earner and one caregiver has, for all practical purposes, ceased to exist in this region. Medical and other services for children have not responded fully to these changes. Services have in fact become more fragmented and complex. The most vulnerable families, the medically underinsured, have the most complex system to work through. Foster parents are among those who face a complex system while struggling to get basic services for the children in their care.

Often problem parenting is associated with single parents and lower income families. But a business leader in Chestnut Hill comments, "The children here are almost forgotten. The atmosphere when I first came here was very negative towards children. I don't think there is anything here that talks about drugs, alcohol, teen pregnancy. All that is 'hush-hush' and put under the rug."

Basic health supports for children, such as vaccinations, are not satisfactory. By age two only 31% of Philadelphia children were up to date with immunizations, compared with 71% statewide. Vaccination

rates for measles in some Philadelphia neighborhoods compare with those of third world countries.

Needs: As parents talked about the challenges of getting health care for their children, many specific needs were expressed. Local access is a major part of the issue. "I can't keep going down to CHOP (Childrens Hospital of Philadelphia); because the emergency room is hell, and it is just too far and we're too frantic with the baby in the car screaming," says one mother. "This is my neighborhood, and I need somewhere up here where I can take her."

Finding ways to pay for services is another part of the complexity of the system. "Some doctors in the community don't take all the cards. If you're in the community you should take everything," says a frustrated parent.

"Sick-child day care services are needed for working families," says a physician. "The child has to go somewhere, and there is a lot of pressure on the family to get them well so the parents can go back to work."

Many parents felt a need for help in getting through the complexities of the system. "I would benefit from learning how to better work the system, understanding the Medical Assistance card, WIC and a lot of stuff that I have never done," says one parent. "I didn't get a good orientation in this area." Parents, like many providers, feel overwhelmed with paperwork. "Paperwork for schools and day care centers needs to be cut down. The forms are redundant and ask information they don't need to know."

A private school official says, "The most crying need is for good after school care during the first 10 to 12 years of a child's development. There is only so much fuel in the tank. The parenting isn't happening." A community activist says, "There needs to be a walk-in, multipurpose center, including services for parents and children and respite care for the parents."

The system for parents of foster children is even more complex than those for biological parents. "The system is horrible," says a foster mother. "They need to do something about it. You can't even find out if these kids have had their shots."

Foster parents in the parent focus group put the following items on their wish list: Simplification of the system, better coordination among agencies, flexible hours for health services, more efficient telephone scheduling and consultation, and day care for sick kids.

In the focus group for teenagers, one suggestion was to provide educational programs for their parents. "If the parent tries to talk to you, they should get some facts. They have to learn what is going on. They have to learn what is going on about sex, because they are stammering and embarrassed and you are not going to want to hear what they say. I want to say, like, get it over with. It's the 90's."

PRIORITY 5: Develop a mechanism in the community to address the interrelated problems of drug and alcohol use, crime, violence, unemployment, housing, child abuse and other social problems through collaborative efforts with neighborhood associations, block and tenant councils, schools, police and churches. Develop technical training and career placement programs targeting youth from the community.

Problem: Drug and alcohol abuse, violence and poverty are major influences on the mental and physical health of people in the community. They are also problems associated with enormous costs, including costs to the health care system. While crime rates seem to have leveled off and even declined in recent years, concern has continued. Twenty-nine percent of all people who died between the ages of 5 and 24 died from homicide. Ten percent of hospital admissions in Philadelphia are directly related to alcohol abuse, although many more admissions for accidents, violence and other medical conditions are also alcohol related. There are almost 11,000 prisoners from Philadelphia in Pennsylvania prisons, at a cost of \$15,000 each per year. The bulk of these incarcerations are for drug related crimes.

But statistics don't show the pain and waste of ruined lives, not only of those caught in the cycle but of their children and families, as well. A group of men involved in a drug rehabilitation program told vivid stories.

"I had lost my family to drugs at one time. My father tried to kill me. I could walk

down the street and my mom would not speak to me."

"My addiction took me to living in the streets. It took me back and forth to prison numerous times. It took me to doing things I never thought I would do - living out of trash cans, robbing and stealing every day. In the end, my addiction lasted about 14 years."

"I started doing crack and mixing all the drugs together. I got so bold I'd walk into stores and stick them up in daylight. Gas stations, stabbing my father, stabbing my brother; I even stuck my Mom up."

Needs: The complex interrelatedness of these problems makes it difficult to find an intervention point. It is clear from the voices interviewed for this study that there are things that work and points of attack. It is something that requires coordinated efforts from individuals, families, schools, health care providers, social services and police. Both the men in the rehab group and high school students had ideas for things that could help avoid or break the cycle:

"My parents always supported me, but I still did what I did. But they stuck with me through my ins and outs and today they will go to bat for me. I would call the people in my rehab program my family. Without them I wouldn't be where I am today."

"In our high school there is a group who call themselves Straight Edge: No smoking, no drinking, no casual sex and no drugs. It does include spending time listening to hard core music and doing skateboards."

"We had an assembly with people who had been affected by drinking. These people were a mess, they were shaking. It made me think, this could be me! Actually seeing what it can do, first hand, might spark something."

"I came from a functioning family. The younger brothers and sisters looked up to me and it got to a point where my older ones looked up to me. I always was proud of my mother. She got two masters degrees. I wanted to pattern myself after my Mom. I went to private school. The fantasy in my head was that I could do drugs socially. You use drugs. You get

caught up in the grips. I came to realize the type of help that I needed wasn't going to let me run loose and let me run wild. Now, since I've been clean, I'm in a life like I never experienced. I'm having fun, I'm in school, I'm getting ready to graduate."

"The community has to stand up. If everybody is together at the march, there will be nobody on the corner selling drugs. You can't just do it in one day. The police can't do it. You have to keep standing out there on the corners the way the moms' did. You have to stay out on the corner."

"Drugs are about money. There are no other jobs. No training programs. The investment in this community should go into business development, housing, job training programs, housing for recovering addicts. Give us an abandoned house for a dollar and we'll do the rest. Our program is self sufficient."

"I had been on drugs about 25 years. I lost my home. I lost my wife. I lost jobs. If I didn't come to this program, I don't know what would happen."

"The most important thing is giving back what we learned. That continues to help us and keep in mind where we came from. That's why I work the crisis team, because every time someone comes in here off the street for help, I get in touch with where I came from."

"All of us in this room have in common, most recovered addicts in this world have in common, is we have a God in our lives. No matter who we chose, as long as we keep a power greater than ourselves, we stand a chance. Any time I find a difficulty in my life I pray. If you take a step you take a thousand steps."

PRIORITY 6: Expand a collaborative approach to primary care, preventive care, health promotion and hospital service.

Problem: Managed competition in health care without community involvement and influence will not work. People in the communities who were experiencing it now say it is not working.

There is a lack of primary care physicians and ambulatory care which results in the

higher usage of inpatient hospital services. Germantown, Logan, East Germantown, Manayunk, Oak Lane and East Falls had the highest rate of avoidable hospitalizations. An increased distrust of public health clinics was mentioned by many as a barrier to primary care, as was a lack of money to pay for care.

Physicians are especially nervous about managed competition and health care reform. Health care has begun to be defined from a different perspective - that of the purchasers of services. Doctors no longer see the patients as their own, but rather as belonging to the insurance companies.

The change and extent of this control can cause many frustrations, "My husband's company changed and he went with the HMO. You get piles of books and stuff when you change. I can't wait to get back on Blue Cross/Blue Shield. I don't have time to go through all that paperwork " A parent adds, "They sent me a booklet with 35 pediatricians in my area, but none of them were accepting any new patients." A doctor complains, "I have built a very old-fashioned practice. We are in the city but

we have a small town style. People love it. But we are under so much pressure to take more managed care contracts. We can't figure out how to honor all these different kinds of contracts."

Needs: The needs expressed by physicians and consumers interviewed in the study were varied, but all pointed toward collaborative efforts.

One need is to educate consumers about their own health and about the use of the health care system. One physician says, "They are often desperately under-educated about their illness. We have young people come in who really didn't know they were sick. With diabetes the complications are obvious for the physician, but patients don't see it as being obvious." An emergency department nurse echoed these concerns. "People come in for things that are not emergencies. On the other hand we get people coming in with golf ball-sized abscessed teeth."

A need was expressed for the separation of expertise - let the medical professionals handle medical decisions and managed care companies deal with business. As one

physician says "We shouldn't continue to pretend that we are business people. It can be cost effective for the system to clean up that piece. Doctors should continue to make clinical decisions and business people should make the business decisions. Our concern is where the balance is."

There needs to be more collaboration among the hospitals in taking in patients of various managed care systems. "We will have to have a partnership that doesn't exist now at either Chestnut Hill or Germantown," says a physician. Another says, "This can no longer be Chestnut Hill community hospital. It doesn't belong to Chestnut Hill any more, but the people who run the hospital still believe it belongs to Chestnut Hill. The borders have been extended."

Duplication of services, long an issue in hospital management, will become even more critical. A physician said, "There is a perception in our service area of an awful lot of duplication. There are maternity departments within the three hospitals that are doing a few hundred deliveries a year."

Primary care physicians need to be able to

be reimbursed for the maintenance and support efforts they do. "If we stop providing more in-depth care and counseling, if we are being pushed to this ultra-efficient direction and I have six minutes per patient, then someone else has to put time into managing these more in-depth social problems. We are also delivering a lot of primary care over the phone and through nurses and assistants that we cannot bill for."

Other suggestions included a step down from more expensive emergency room care - a satellite open during off-hours for the non acutely sick people.

PRIORITY 7: Advocate that the managed care programs coordinate with community health needs and existing programs, and provide education and choice for participants in the program.

Problem: Managed care is reshaping the provision of services to all segments of this community and particularly services for the poor. Medical Assistance will undergo a major transition to an all-managed care system in the near future. Many consumers

and providers are concerned that this care may take away control from the group of consumers most vulnerable and least able to assert themselves in the health care system. Low income adults were more than twice as likely to report poorer health status and were more likely to live in households having a chronically ill family member. Yet they were three times more likely than the non-low income households to lack health insurance. They also were less likely to seek care because of the cost and were three times more likely to report that an illness caused a major financial problem.

Many consumers are frustrated with the complexities of health insurance and how it takes away choices. One card holder complained, "They give you these medical cards and then they tell you, 'No, you cannot go to this doctor because we have to save money here'...I just have been having real problems with the system "

"With my plan," says a foster mother "we are not allowed to take our kids to other doctors - we have a nurse. If the child is sick, I have to take them to her, and if she says the child is sick, she will give me the

OK to go to the doctor. If I go to another doctor, they say I am going against my contract." A physician says, "Many times they are forced to go to a group with 15 or 20 physicians; they see a different doctor every time. They can't get care with continuity."

Needs: The new plans must contribute to outreach programs that reach citizens in the most accessible ways. Mental health treatment options need to be included for middle and low income families.

The program format must be sensitive to the cultural diversity of the neighborhoods. As one physician says, "You will have to be able to say that I want to care for the people in the Germantown area, and I don't think they feel that. The consumers are not going to feel comfortable here unless you change the way they are seen."

"If they end up hiring more black physicians and putting more black members on the board because they need to change their image, even if it is driven by economic reasons, the new result is that we are serving the community better," says another physician.

Of great importance, considering the competition between programs, is that non-commercial education needs to be available to help participants make decisions about providers and to use the managed care coverage most effectively.

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APPENDIX

Partners for a Healthy Community Advisory Group

•**Judy Lechner Brody, Ed.D.** Regional Superintendent of Schools for the Northwest Region of Philadelphia. During the previous four years, she was Principal of the Huey School in Southwest Philadelphia. Responding to the needs of parents and children, various services were provided at the school site including a health center sponsored by Misericordia Hospital and Mercy Health Corporation, a mental health program, a Parent Center, a "pilot program" with a DHS caseworker relocated at the school, and a latch key program. Committed to the community school concept, she seeks to bring health and other needed services for children and families into schools in the Northwest Region.

•**Allen Chandler, M.D.**, Senior Public Health Physician in Philadelphia Health Department. Served previously as Medical Director of Pediatric and Adolescent Programs. Summa Cum Laude graduate of Morgan State and graduate with honors from Jefferson Medical School, he served a Pediatric residency at Jefferson before going into private Pediatric practice in Philadelphia in 1962. A Mt. Airy resident, he continues this practice and also has risen in the Army National Guard to Deputy Surgeon General of the United States Army at the rank of Major General.

•**Captain Jeanette Dooley**, 14th District Police Department (includes Germantown and Chestnut Hill) has been with the Philadelphia Police Department for 20 years. Served in organized crime, narcotics, internal affairs and drug screening units. She has researched drug problems and their social impact. An advocate of community policing.

•**Rev. Richard Fernandez**, Director of Northwest Interfaith Movement. Northwest Interfaith serves as the cooperative social service program of the churches and synagogues in the area. It has been involved in a broad range of projects and issues related to older adults in nursing homes, children's day care centers, victims of crimes, meals on wheels, runaways, training in child development, grants for day care programs, food programs, housing development for elderly disabled. He has

served as the director of these programs for over ten years.

•**William Leary, Ph.D.**, Superintendent of Schools, Springfield Township. He has been in Springfield since 1990. Before coming to Springfield he served as Superintendent of Schools in the Waynesboro Area School District for ten years and in the East Penn School District for nine years. He has been an English teacher, guidance counselor, college admissions officer and high school principal. He received his doctorate in educational administration from the University of Pittsburgh.

•**Cary F. Leptuck**, President and Chief Executive Officer of Chestnut Hill Hospital HealthCare since 1979. A graduate of Fairleigh Dickenson and Columbia Universities, he is an active member of numerous professional, civic and community organizations. He serves on the board of directors of Voluntary Hospitals of America (VHA) East and the Philadelphia Health Academy. He is a past chairman of the Hospital Association of Pennsylvania and the Delaware Valley Hospital Council, and the 1993 recipient of the Senior Level Regent Award of the American College of Healthcare Executives.

•**Robert Patterson, M.D.**, Chief of Metabolic Nutrition, Germantown Hospital and Director of the Northwest Medical Practice. Major concerns include attracting primary care physicians to the area, improved health education and transportation resources for the population, improved health services for the mentally retarded in community living situations. He is a 1972 graduate of Temple University School of Medicine and board certified in internal medicine.

•**David A. Ricci**, Executive Vice President of The Germantown Hospital and Medical Center since 1988. He developed the hospital's first community wellness center for low income families. He was selected in 1993 as a Fellow by the Healthcare Forum in the Creating Healthier Communities Fellowship Program and received the American College of Healthcare Executives Regents Award for Southeastern Pennsylvania in 1992.

•**Hon. David Richardson, Jr.**, Pennsylvania House of Representatives. Life long Germantown resident and graduate of Germantown High School, he has served as a Member of the Pennsylvania House of Representatives since 1973. Majority chairman of the Health and Welfare Committee. Executive Director of the Greater Germantown Youth Corporation and Member of the Black Peoples' Unity Movement.

•**Andrew Ross, Esquire**, President, Chestnut Hill Community Association. He is a litigation attorney and former member of Chestnut Hill Hospital's Long Range Planning Committee. The Association operates a weekly newspaper, supports local social, cultural and recreational activities through a community fund drive, and reviews land use matters for zoning and aesthetic concerns. His health service priorities include access to good primary care, health information and support programs in the community and quality specialty care in a smaller, less bureaucratic setting.

•**Hon. Allyson Schwartz**, State Senator 4th District. Interest in women's health and health care reform issues, which has included participation in: The Mayor's Public/Private Task Force on Homelessness, PA Citizens Crime Commission Task Force on Health Care Cost Containment; Mayor's Commission on Health Care in the Eighties and Philadelphia Health Management Corporation board membership. She has a M.S.S. from Bryn Mawr and has received awards for her outstanding contribution to social work. Publications include "Towards a Better Future for Philadelphia's Children: Report of the Philadelphia Task Force on Children at Risk," Dept of Human Services, Philadelphia, Feb. 1990. Elected to the Pennsylvania Senate in 1990.

•**Althris Shirdan, Ph.D.**, Director, West Oak Lane Community Corp. Association and adjunct professor of Sociology at La Salle University. Previously served as a researcher for Temple University's Department of Psychiatry on a series of community mental health demonstration projects in Philadelphia public schools. The Association develops low cost housing and housing for mentally and physically challenged adults. It is also involved in neighborhood development and job readiness programs.

•**Cornelia Swinson**, Director, Child Health Watch and the Wister Neighborhood Council. The Wister Neighborhood Association was established in 1949. Child Health Watch is a program to eliminate barriers in connecting children with appropriate health services funded by the Pew Charitable Trust. It emphasizes the need for more door to door outreach to address health needs of children; convenes a Germantown "neighborhood leadership council" (health serving institutions, residents, school personnel, community based agencies, county assistance representatives and pharmacy representatives) of the Germantown Child Health Watch each month.

•**Marian B. Tasco**, Councilwoman, 9th District (Northwest Philadelphia), Philadelphia City Council, Chairlady of the Committee on Public Health, Human Services and Recreation of Council. She held hearings in May of this year on the AIDS-STDS-TB-Drug-Homelessness and Lead Poisoning problems in Philadelphia. She is co-chair of "Kinship Care: Across Generations-Across Systems: A National Forum for Legislators, Policy makers and Human Service Providers".

•**Judith Thomas**, Chairperson, Chestnut Hill Hospital Healthcare Ambulatory Services Board; Officer, Chestnut Hill Hospital HealthCare. Longtime resident of Chestnut Hill. Actively involved at the Hospital as a volunteer since 1959. Former officer of the Chestnut Hill Community Association. Has served on the Advisory Board of the Philadelphia County Assistance Office, Pennsylvania Department of Public Welfare since John White, Sr. was chairman. Represented the Advisory Board on the HealthPass Committee involved in the establishment of that program.

•**T. Ramsey Thorp, M.D.**, President of the Chestnut Hill Hospital Medical Staff, who also teaches on the University of Pennsylvania Medical School faculty. A 1962 graduate of the University of Pennsylvania Medical School, he is board certified in ophthalmology. He went to high school at Germantown Friends and has been a life long resident of the area.

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CHILDREN THRIVING

PHILADELPHIA FAMILY CENTERS: Status Report as of 9/26/94

OVERVIEW

Proposals for the support of four Family Centers have been prepared and submitted through a process marked by community participation, interagency collaboration, and commitment to Philadelphia's children and families. Three of those Centers have been funded and are opening throughout October and November; we will hear about funding of the fourth in October. Five other Family Centers are in various stages of development, a total of nine. There is an effort underway to secure federal support for the Family Centers initiative.

Three strategies guide the development of Family Centers:

- 1) resource development;
- 2) program development and
- 3) community development.

Resource development refers to the raw materials of services, supports, funding and technical assistance as they may currently be embodied in agencies, individuals and opportunities. Program-development refers to new configurations that weave these services and people together, across current institutional and organizational boundaries, to respond more effectively and systematically to emerging definitions of need and interest in the community. Community development refers to building sustained capacity within and among the community's individuals, families and organizations for ongoing needs determination and effective program development, and to improving concretely the community's economic, physical and social infrastructure.

Each Family Center grows out of a community process which begins with calling together parents, community leaders, community-based organizations, local service providers and governmental entities to determine what services and supports are needed and wanted for children and families of that community. Within this framework, Family Centers will generally offer a core of integrated services onsite including: family support, parenting education and child development; physical and mental health services; Early Intervention case management; and social work. Many communities have requested early morning drop-off, afterschool care, more recreation and library programs, child care/Head Start, tutoring, mentoring, GED classes, adult and youth jobs, cultural events, community policing, community organizing and peer/family mediation. The Family Center schools will be among the 10 schools receiving National School Community Corps – an Americorps project – this year. Each school will have 6 full-time and 10 part-time Corps members. This should enable us to provide many of the above services.

GUIDING PRINCIPLES

Our vision starts with a sense of how Family Centers are different. The operation and ongoing development of each Family Center is guided by the following principles. Family Centers:

- > **Build on strengths and capacities** in order to address needs and opportunities. Just as schools ground themselves in the premise that all children can learn, the Family Center assumes that all individuals, families and communities can solve problems and take advantage of opportunities by working together.

- >**Serve as a place of celebration, expression and communications** as well as information and service provision. Community arts and culture, ethnic heritage, local history and neighborhood traditions are given prominence.
- >**Represent a community's deployment of resources it needs in order to improve the lives of its members.** It is not the locally-based 'outpost' of external agencies, but an internally generated structure that the community organizes to nurture its children.
- >**Aim for a state of affairs in which it would be unusual for any member of a given community not to be actively involved.** The Family Center assumes that seeking help is a sign of self-determination rather than neediness; that it is normative rather than dysfunctional. It assumes that those who seek help also have something to offer the community.
- >**Achieve an atmosphere of hospitality.** The Family Center invites, involves and informs. Participation and involvement will not be means-tested, nor will traditional registration or intake be required for access to services. Anyone in the community is welcome to become a Family Center member.
- >**Dispense with the waiting list mentality, both in operations and in philosophy.** If and when service capacity is deemed insufficient, needed resources are found, created, leveraged or purchased.
- >**Work to build, blend and extend the resources of individuals, families, organizations and the community as a whole.** Existing resources are coordinated, integrated and, where appropriate, redirected. The Family Center is not simply a means for arraying and accessing resources; it is a process for identifying and developing them.

NEW FAMILY CENTERS

Central Germantown Family Center

Location: Wayne and Cheltenham Avenues

School Link: Pickett Middle School and feeder elementary schools (Fulton, Kelly, Lingelbach, Wister)

Management Model: Sub-contracted to Germantown Settlement

Funding Source: State Family Centers RFP and City match

Status: Community Meeting scheduled September 27, 1994. Grand Opening scheduled October 11, 1994.

Major Initiatives for Coordination and Collaboration: Family to Family, Rebuilding Communities, Enterprise Community, Community School, HUD Family Investment Center Application, National School and Community Corps and Philadelphia Plan

Site Director and Parent Educators: Interviews underway

Physical Health Services: New hybrid model of school-linked and school-based services in which local providers collaborate.

Mental Health Services: In development

Social Work Services: Interviews underway

Haddington West Family Center

Location: 59th and Race

School Link: Barry Elementary School

Management Model: Principal directs

Funding Source: State Family Centers RFP and City match

Status: Community Meeting scheduled October 6, 1994. Grand Opening scheduled first week of November, date to be determined.

Major Initiatives for Coordination and Collaboration: Healthy Start, National School and Community Corps, HRSA Healthy Schools/Healthy Communities School-based Health Clinic Application

Site Director and Parent Educators: Principal will direct, parent educators already on staff

Physical Health Services: Application submitted for school-based health clinic.

Mental Health Services: In development

Social Work Services: Interviews underway

Norris Square Family Center

Location: 4th and Diamond

School Link: McKinley Elementary School

Management Model: Directed by Office of Family Centers

Funding Source: State Family Centers RFP and City match

Status: Community Meeting scheduled October 5, 1994. Grand Opening scheduled third week of October, date to be determined.

Major Initiatives for Coordination and Collaboration: Empowerment Zone, National School and Community Corps, Philadelphia Plan

Site Director and Parent Educators: Seeking applicants for Site Director, parent educators on staff.

Physical Health Services: In development

Mental Health Services: In development

Social Work Services: Interviews underway

The Family Centers under consideration are: McMichael Elementary School in Mantua, Birney Elementary School in Logan, Vaux Middle School in North Central West of Broad, Dick Elementary School in Strawberry Mansion and District Health Center 5 in North Central West of Broad. The outstanding proposal is for a Family Center in South Philadelphia, site to be determined.

For further information, contact the Office of Family Centers at 215/686-7847.

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