

# Philadelphia Integrated Epidemiological Profile, 2009

## Executive Summary

Prepared for the Philadelphia Eligible Metropolitan Area Ryan White Part A Planning Council, Philadelphia HIV Prevention Community Planning Group, Centers for Disease Control (CDC) Atlanta, GA. and the Health Resources and Services Administration (HRSA) Washington, D.C.

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## **Acknowledgements**

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# Philadelphia Integrated Epidemiological Profile

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## *Executive Summary*

The complete epidemiologic profile contains approximately 350 pages, 210 tables and 80 figures with information related to the HIV/AIDS epidemic in the Philadelphia Eligible Metropolitan Area (EMA). This Executive Summary provides a synopsis of the complete profile. The epidemiologic profile describes the general population of the EMA, the HIV/AIDS epidemic, and indicators of risk. Several data sources were evaluated, analyzed, and synthesized to create the document in accordance with the *Integrated Guidelines for Developing Epidemiologic Profiles*. The core questions the profile addresses are:

1. What are the sociodemographic characteristics of the general population of the Philadelphia EMA?
2. What are the indicators of risk for HIV/AIDS infection in the Philadelphia EMA?
3. What is the scope of the HIV/AIDS epidemic in the Philadelphia EMA?
4. What are the HIV/AIDS service utilization patterns within the Philadelphia EMA?
5. What are the number and characteristics of persons who know they are HIV positive but who are not receiving HIV primary medical care?

The profile has been divided into sections, with each section addressing one of the core questions above.

## *Integrated Epidemiologic Profile Background*

The *Integrated Guidelines for Developing Epidemiologic Profiles* is a joint effort of the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). The purpose of that document was to provide a single set of guidelines for the development of an epidemiologic profile. The integrated guidelines have expanded upon previously required components to meet the needs of both care and prevention. Additional data sources have been included to provide a more comprehensive view of the EMA and the HIV/AIDS epidemic. The benefits of an integrated profile are consistency among common data elements, definitions, categories, and time frames, and shared resources for prevention and care.

The audience of the document includes (but is not limited to) prevention and care planning groups, grantees, state and local health departments, applicants for funding, community-based organizations, and consumers of services. The uses are to assist in the prioritization of populations and identification of appropriate interventions, the identification of epidemiologic trends, the development of an HIV prevention plan and Ryan White Part A Comprehensive Care Plan, setting priorities and allocating resources for care, and to serve as a source document in the HRSA and CDC applications. Given the volume of information contained in the profile, it was designed so that the reader could use the table of contents, list of tables, and list of figures as a navigation tool to select the information or data of interest.

### ***Profile Data Sources***

Several different data sources were used to compile the information for the document. Each set of data has various strengths and limitations, and that fact must be considered as the data are interpreted. The data sources used in compiling the information for the profile are described in brief below. More detailed descriptions have been included in Appendix A of the complete profile.

In presenting the empirical data used in this document, it was decided that the reader would be allowed to make the determination as to the implications the information conveyed. Therefore, assumptions were not made regarding the material provided. Key points from each section have been supplied in the summation to assist the reader in assimilating the large amount of numeric data provided in the document.

#### ***General Population Data***

The Census Summary File 3 (SF3) was obtained for both Pennsylvania and New Jersey. SF3 contained a total of 814 general population tables related to demographic characteristics of the population, poverty, educational attainment, housing status, and income. The SF3 data dictionary contained the file names and labels for the associated codes within the dataset used to support the census information. Total population estimates for succeeding years were obtained from the Census Bureau website, <http://eire.census.gov/popest/estimates.php>. Several estimates were also obtained as raw datasets/tables from the Census Bureau's American Community Survey for 2006 and 2007.

The 2007 Census Bureau estimates contained within the ArcView 9.3 2008 data update were also used for the completion of the maps for the Philadelphia EMA and the Philadelphia jurisdiction.

### ***Vital Statistics Data***

Federal and state laws require birth and death certificates to be completed for all births and deaths. Federal law mandates national collection and publication of birth information and other vital statistics data. The National Vital Statistics System is the federal compilation of the data, in cooperation with the National Center for Health Statistics (NCHS) and the states. States use a standard form to collect birth and death data and report this information to NCHS annually. The sources used in this document, unless otherwise noted, were the Pennsylvania Department of Health, Division of Health Statistics and the New Jersey Department of Health and Senior Services, Center for Health Statistics.

Vital statistics records capture all births and deaths that occurred within a geographic area. Reporting is approximately 100% complete. Therefore, inferences can be made concerning the population of live births and deaths in a service area. The procedures are standardized and are used throughout the country to collect data.

Unfortunately, deaths resulting from HIV infection, or for which the underlying cause was HIV, may not be reported on the death certificate. As a result, there may be underreporting of the HIV factors in many deaths.

### ***Behavioral Risk Data***

There were three different sources of behavioral data used, each of which has been described here in brief.

***Behavioral Risk Factor Surveillance System (BRFSS).*** The Behavioral Risk Factor Surveillance System is a collaboration of the Centers for Disease Control and Prevention (CDC) with the states. It has measured risk behaviors in adults since 1984. It is administered by health departments and is conducted via household telephone surveys. The BRFSS survey data are population based; therefore, estimates related to testing attitudes may be generalized to the adult population of a given state or area included in the survey. The behaviors include those

related to chronic diseases, injuries, and infectious diseases that are preventable. One of the limitations of the data is that persons without a household telephone are not included. In addition, the data are self-reported and may be subject to recall bias.

***Youth Risk Behavior Survey.*** The CDC established the Youth Risk Behavior Surveillance System (YRBSS) to monitor the health-risk behaviors that influence youth. The YRBSS measures the prevalence of behavioral risks, monitors when they start, and assesses changes over time. The issues that are addressed in this survey are injuries and violence, tobacco use, alcohol and other drugs, sexual behaviors related to unintended pregnancy, STDs and HIV infection, dietary behaviors, and physical activity. Limitations to this data include the inability to generalize the information to all students. The information is based on self-reported behaviors. The survey is conducted in English, so non-English-speaking students are excluded, as are special education classes, correspondence schools, group-home schools, correctional schools, and youth who have dropped out of school.

***HIV Testing Survey (HITS).*** The HIV Testing Survey project has sites in 23 states/cities, including the City of Philadelphia. HITS is a cross-sectional anonymous interview project with persons at risk for HIV infection. The project's strengths: the project is conducted over a 12-month period, uses a standardized questionnaire, and provides local data on high-risk populations. The limitations of the data are: it has a small sample size, it is self-reported data, and it may not be generalized to at-risk populations.

***Substance Abuse Datasets.*** The datasets that were analyzed have been described below.

***Treatment Episode Data Set (TEDS).*** The Treatment Episode Data Set (TEDS) contains descriptive information on the number of annual admissions to substance abuse treatment programs across the nation. The data, which are collected by the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies, included treatment statistics and demographic information on persons admitted to both public and private (non-profit) substance abuse treatment programs. One limitation to consider with this data is that states may vary in their treatment admission processes. Additionally, these treatment admissions vary by such factors as the availability of public funds. Another key limitation is that this data set represents the number of *admissions*, not the number of *clients*; therefore, it is possible for one client to have multiple admissions.

***Drug Abuse Warning Network (DAWN).*** The Drug Abuse Warning Network (DAWN) monitors emergency department (ED) visits related to the abuse of major drugs, as well as drug-related deaths reviewed by medical examiners and coroners. Along with national surveillance, data are also collected for 21 metropolitan areas, including Philadelphia. Reportable data reflect patients between the ages of 6 and 97 who were treated for conditions associated with drug use, abuse, dependence, or attempt of suicide. This information does not reflect those who had accidental ingestion or inhalation or suffered adverse reactions with appropriate use of any of the drugs. Additional limitations are that DAWN does not include persons admitted to another part of the hospital for treatment (instead of the ED), those treated in a physician's office, or those treated at a drug treatment center.

***National Household Survey of Drug Abuse (NHSDA).*** The National Household Survey of Drug Abuse (NHSDA) is sponsored by the Office of Applied Studies at SAMHSA. The NHSDA is designed to produce drug and alcohol use incidence and prevalence estimates and report the consequences and patterns of use and abuse in the general U.S. civilian population aged 12 and older. Questions include age at first use, as well as lifetime, annual, and past-month usage for the following drug classes: cannabis, cocaine, hallucinogens, heroin, alcohol, tobacco, and non-medical use of prescription drugs, including psychotherapeutics. Persons who are excluded from this sample are homeless people, active military personnel, residents of correctional facilities, nursing homes, mental institutions, hospitals, and drug treatment facilities, where the population at risk for drug use is high.

***Arrestee Drug Abuse Monitoring (ADAM).*** The Arrestee Drug Abuse Monitoring (ADAM) program was established in the late 1990s and is a program of the National Institute of Justice. It measures the amount of drug use among those arrested for various offenses. The information is collected from interviews with the arrestees, as well as through voluntary urinalysis usually conducted within 48 hours of the booking.

A limitation of the ADAM program is that the information is only relevant to recent arrestees and not to the larger incarcerated population or the general population. Also, the data are collected by self-reporting and participation is voluntary, which may lead to false answers or refusal to participate in the study.

***Uniform Crime Report (UCR).*** The Uniform Crime Report (UCR) serves as a national assessment of reported crimes that are not available elsewhere in the criminal justice system. The data are collected for all crimes except traffic violations and include the arrestee's age, sex, and race by the category of crime committed. The information is reported to an agency via the victim, the police, or through a witness report. Participating law enforcement agencies contribute to this report on a monthly basis by supplying data to either the FBI directly or to state reporting programs. The limitations to the UCR include calling into question the amount of crime being reported. Often, the reporting of crime varies from area to area and may be influenced by whether the victim believed the crime to be important enough to report. A considerable volume of crime is not reported because the victims think the likelihood of apprehending the suspect is small. It is also important to consider that arrest figures may include one person who is arrested several times during the reporting period, and that statistics for drug-related arrests may only reflect the levels of law enforcement in a particular community, rather than the actual magnitude of drug-related crimes being committed there.

### ***Sexually Transmitted Disease Surveillance***

Data for the City of Philadelphia are obtained from the Philadelphia Department of Public Health, Division of Disease Control. Data for the four Pennsylvania counties of Bucks, Chester, Delaware, and Montgomery is available on the Pennsylvania Department of Health website, <http://webserver.health.state.pa.us/health/>. The STD data for the New Jersey counties of Burlington, Camden, Gloucester, and Salem are obtained at the New Jersey Department of Health and Senior Services website, <http://www.state.nj.us/health/cd/stats.htm>.

The Philadelphia Department of Public Health, Division of Disease Control (DDC) currently operates three programs for the control of communicable diseases: the Acute Communicable Disease (CD) Control Program, the Sexually Transmitted Disease (STD) Control Program, and the Childhood Immunization Program. DDC performs surveillance for reportable diseases and conditions through these three programs, and it has been responsible for the development and implementation of appropriate disease prevention activities.

The Pennsylvania Department of Health's Sexually Transmitted Disease Program provides clinical services through county/municipal health departments, intervention and prevention, surveillance and partner notification activities, screening, information and education. The Sexually Transmitted Disease Program of the New Jersey Department of Health and Senior

Services, Communicable Disease Service, provides technical support and consultation to local health departments and non-government health care providers and organizations, surveillance, STD education, training, gonorrhea and chlamydia screening services, intervention and prevention activities, outreach services, and STD research.

Surrogate measures have been used to help understand a situation where adequate direct measures were not readily available. For example, it may be difficult to obtain HIV/AIDS surveillance data on teenagers, but incidence rates of sexually transmitted diseases among teenagers can be used as surrogate measures of high-risk sexual behavior, since HIV is a sexually transmitted disease, and individuals can become infected with a sexually transmitted disease when engaging in unprotected sexual activities. Therefore, sexually transmitted disease data are included to provide an understanding of sexual risk behaviors in various populations.

While sexually transmitted diseases are the result of risky sexual behavior, these diseases may not represent a direct correlation for HIV risk. Sexually transmitted diseases are reportable, but reporting requirements may vary from state to state. Trends related to chlamydia infections may be reflective of reporting and screening practice changes rather than actual disease trends.

### *AIDS Surveillance*

AIDS is a reportable condition in all states and territories. According to the CDC guidelines for human immunodeficiency virus case surveillance, the AIDS surveillance system was established to: monitor incidence of AIDS and the demographic breakdown of those who have it, describe the exposure categories among persons diagnosed with AIDS, and assist in the development and implementation of public health intervention and prevention strategies and programs.

There are two basic types of surveillance—active and passive—which have been defined in the *AIDS Surveillance Quarterly Update*, published by the AIDS Activities Coordinating Office of the City of Philadelphia’s Department of Public Health. *Passive surveillance* is a process in which diagnosing physicians voluntarily submit reports to the Department of Health. *Active surveillance* employs strategies intended to identify unreported cases; it depends on secondary information sources for leads. Information from death certificates, direct contact with

physicians, and reviews of medical records initiate the follow-up investigations. The AIDS case count in Philadelphia results from a combination of active and passive surveillance.

Physicians began reporting AIDS cases to the Department of Health in 1983. States and local health departments actively solicit disease reports from health care providers and laboratories. Standardized case report forms are used. These forms collect sociodemographic information, mode of exposure, laboratory and clinical information, vital status, and referrals for treatment or services.

AIDS surveillance is the only source of AIDS information that is available in all areas (states); the data are reflective of the impact of AIDS on a community and trends of the epidemic in a community. According to the CDC, AIDS surveillance has been determined to be >85% complete.

Due to the prolonged and variable period from infection with HIV to the development of AIDS, trends in AIDS surveillance do not represent recent HIV infections. Asymptomatic HIV-infected persons are also not represented by AIDS case data. In addition, incomplete HIV or CD4+ T-cell testing may interfere with the completeness of reporting. Further, the widespread use of HAART complicates the interpretation of AIDS case surveillance data and estimation of the HIV/AIDS epidemic in an area. Newly reported AIDS cases may reflect treatment failures or the failure of the health care system to halt progression of HIV infection to AIDS. AIDS cases represent late-stage HIV infections.

All information about AIDS patients is strictly confidential and is collected strictly for epidemiologic purposes. Confidentiality of AIDS case reports is of critical importance to maintaining effective HIV/AIDS surveillance. Federal, state, and local health departments have implemented procedures and policies to assure the confidentiality and security of AIDS data. The CDC is prohibited from accepting patient names, and before records are transmitted electronically, all information is encrypted by a computer program. In addition, strict guidelines govern the release of reports similar to this one and ensure that AIDS data are not represented in such a way so as to possibly identify any individual with AIDS. Maintenance of confidentiality and security safeguards are criteria for federal funding and are a top priority within the Philadelphia AIDS Surveillance Unit.

### ***HIV/AIDS Dataset***

The AIDS Public Information Data Set (AIDSPIDS) is the CDC's national AIDS surveillance database. These data are provided to the CDC by state or local health departments for surveillance purposes. The most recent data available are AIDS cases through December 2002. With this data set, it is important to keep in mind the possibility of delays between the diagnosis of a patient and the notification of state and local health departments. Surveillance of AIDS data is therefore an ongoing process. Also, because of the long and variable periods between infection and symptom development, trends in AIDS case data do not represent persons recently infected with HIV. However, the use of AIDS case surveillance is important in the assessment of access to care for different populations.

### ***HIV Counseling and Testing Data***

Local counseling and testing data were obtained for the period of 2003 to 2007 from the New Jersey Department of Health, Pennsylvania Departments of Health and the City of Philadelphia AIDS Activities Coordinating Office (AACO). Testing sites included STD clinics, drug treatment facilities, family planning facilities, prisons and jails, and hospitals or primary medical doctors' offices. Tests were either anonymous or confidential.

Data on the median time in months in which patients testing positive for HIV were then diagnosed with AIDS in Philadelphia were provided by AACO. The purpose was to indicate testing delay patterns.

### ***Service Utilization Data***

Local needs assessment information conducted by the Office of HIV Planning on the type of services used by clients was also provided for the 2003-07 time period. Data on the 2007-2008 Implementation Plan and the demographics of 2007 ADAP clients at the state and local level are also included.

### ***Ryan White CARE Act Data***

Providers serving Ryan White CARE Act-funded grantees report on all clients who received services eligible for CARE Act Part A, B, C, or D funding, regardless of the actual funding source used to pay for those services. The provider agency, or service provider, is the agency

that provides direct services to clients and their families and is funded by the Ryan White CARE Act. Services may be funded by one or more parts of the Ryan White CARE Act grants, or through subcontract(s) with official Ryan White CARE Act grantees.

The CARE Act Data Report includes total clients receiving services during the reporting period, new clients, gender, age, ethnicity, race, household income, living/housing arrangements, insurance, HIV/AIDS status, and vital/enrollment status. Also reported are services provided and total number of clients receiving those services.

### ***Epidemiologic Profile Limitations***

When using this document to assist in making planning decisions, the overall strengths and limitations of the document must be taken into account. The profile is a compilation of a number of different data sources and should only be used as an augmentation of an existing process. There may be questions that the profile cannot answer.

The HIV/AIDS surveillance system in the Philadelphia EMA is extensive in that it is inclusive of three different health departments. However, it is based only on those people who have been tested for HIV. As a result, AIDS infections have been underreported and under-detected because only persons who choose to be tested have been counted. While HIV reporting has occurred in New Jersey for a number of years, the legislation in Pennsylvania related to HIV reporting passed in September of 2002.

It is also important to remember the variability of reporting times, since persons are tested at different times following HIV infection, and many individuals are not tested until they have progressed to AIDS. As such, the data in this report do not necessarily represent characteristics of persons who have been recently infected with HIV.

Analyses of several different data sets have been presented in this document to provide as comprehensive a picture as possible of the City of Philadelphia and the Philadelphia EMA. Unfortunately, there are differences in the data sets based on the geographic areas. While most data sets contained information at the county level, some were only available at the state level. In a few instances, such as the TEDS, the data was at EMA level.

The most current analysis available is presented for each source of data; however, the most recent data collected also varied from one source to another. In all cases, the source, date and geographic area represented are cited.



## Sociodemographic Characteristics of the General Population of the Philadelphia EMA

This section provides information related to the general population for both the City of Philadelphia and the Philadelphia EMA. The data have been presented at the county level unless otherwise indicated. The types of information covered within this section are population totals, race and ethnicity, age, gender, unmarried partner households, educational attainment, poverty, income, insurance coverage, teen pregnancy, mortality vital statistics, and tuberculosis.

### Summary

#### *Population*

Between the 2000 and 2008 census counts, the general population of the EMA increased by 107,973 individuals. It is estimated the population increased from 5,100,931 in 2000 to a total of 5,208,904 persons by the year 2008. The city of Philadelphia represented the only percentage drop in total population with an estimated -4.62% or 70,155 individuals. Chester County saw the largest percentage increase of 13.38%. Of the nine counties, Salem County had the smallest population total with 66,141.

#### *Demographic Composition*

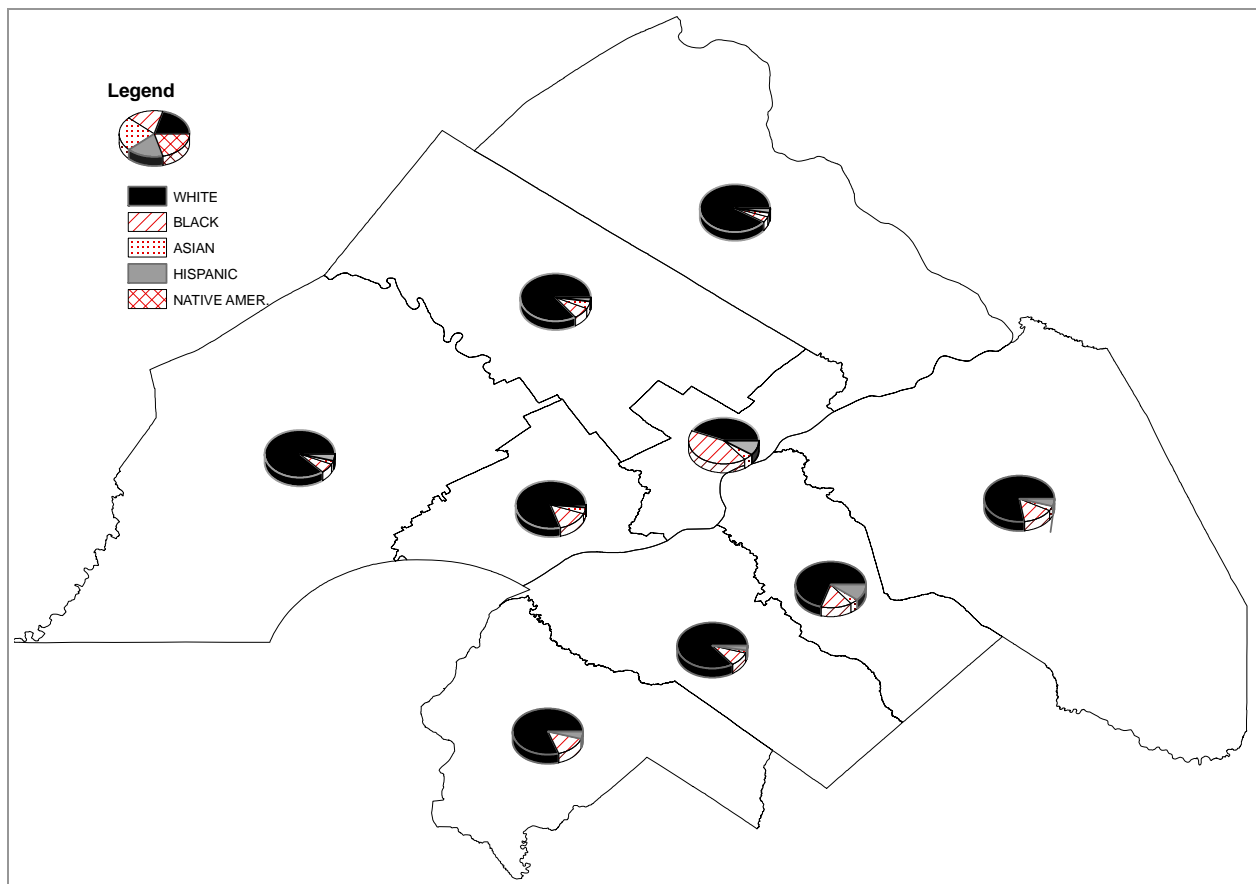
Within the Census categories is another breakdown, the race alone or the race and not-Hispanic. By way of example, the categories would be listed as either White alone or not-Hispanic with White as a sub-category. The census race categories used in the profile were not-Hispanic White, Black, American Indian and Alaskan Native, Asian, Native Hawaiian and Pacific Islander and the ethnicity category is Hispanic.

Based on the census 2007 estimates, 67.54% of the population of the EMA was White, 19.94% was Black, 6.40% Hispanic, 4.40% Asian, .15% American Indian and Alaskan Native, and .01% Native Hawaiian and Pacific Islander.

### *Gender and Age by Race and Ethnicity*

The age categories were 19 and under, 20-24, 25-34, 35-44, 45-54, and 55 and over. White females made up the largest percentage of the total EMA population with 36.01% or 1,872,718, and the largest single age category for this group was those 55 and over with 10.71%. White males represented 34.21% or 1,779,024 individuals. The greatest single age group for males was the 19 and under category at 8.8%, followed closely by the 55 and over group at 8.51%. The categories of Native Hawaiian and Pacific Islander and Native American Alaska native were not included because data were unavailable.

### **Philadelphia EMA Demographic Composition by Race and Ethnicity, 2007**



Source: ArcGIS 9.3 ERSI Data & Maps

### ***Unmarried Partner Households***

Definitions related to the unmarried partner household categories are included in the full epidemiological profile for the purpose of clarity. According to the 2007 American Community Survey conducted by the Census Bureau, there are 1,955,609 households within the nine counties of the Philadelphia EMA. The largest proportion of unmarried partner households are in Salem County with 5.81%, followed by Camden County at 5.76%, Philadelphia County is third with 5.73%, and Chester County is fourth at 5.05%.

### ***Educational Attainment***

Educational attainment was determined for the Philadelphia EMA by gender for persons 25 years of age and older. The categories were: less than 9<sup>th</sup> grade, 9<sup>th</sup> to 12<sup>th</sup> grade with no diploma, high school graduate (includes equivalency), some college with no degree, associate degree, bachelor's degree, and graduate or professional degree. Approximately 3.98% of the estimated 3,441,723 persons 25 and older for whom educational attainment was determined had completed less than nine years of education. An estimated 17.62% of females and 14.79% of males had either a high school or equivalency diploma. Census 2007 estimated data, as the most current available, were used for all counties.

### ***Linguistic Isolation***

Definitions related to linguistic isolation and subsequent categories are included in the full epidemiological profile for the purpose of clarity. According to the 2007 American Community Survey conducted by the Census Bureau, there are 1,930,804 households within the nine counties of the Philadelphia EMA for which linguistic isolation was determined. Of that number, 15.45% speak a language other than English at home and 3.65% are defined as having linguistic isolation.

### ***Poverty***

Poverty status was determined for those individuals who fell below the federally defined poverty level using 2007 inflation adjusted dollars by county total population and gender. Within the EMA, Philadelphia had the highest percentage of individuals living below the poverty level at 23.79%. Of the remaining counties, both Salem and Camden County had percentages greater than 10 percent, with a rate of 10.9% and 10.69% respectively.

Households with Social Security, Supplemental Security, Retirement and Public Assistance income were also determined for 2007. The majority of supplemental security and public assistance recipient households were in Philadelphia. Delaware and Salem had over 30% of social security income recipient households. Burlington, Salem and Delaware had more than 21% of households receiving retirement income.

Philadelphia had the lowest median income of all nine counties with \$26,358. This was followed by Delaware at \$32,141 and Camden with \$32,351.

### *Insurance Coverage*

Insurance status for New Jersey and Pennsylvania were compared to that of the United States. In 2007, 15.6% of persons in New Jersey were uninsured, as were 9.8% in Pennsylvania, as compared to the United States, which had 15.3%. More non-elderly males were without insurance as compared to females in the same locations.

### *Teen Pregnancy*

Live births and pregnancies were reported in the Pennsylvania; only live births were reported in New Jersey. The age brackets used were: under 15, 15 to 17, and 18 to 19 years of age. With some exceptions, live births generally increased across all age brackets in the nine EMA counties during the period 2002 through 2006.

### *Vital Statistics*

Mortality was presented by age for the Pennsylvania counties. The data were based on the top five causes of death by age group. The categories utilized for consistency were: 5 and under, 5 to 24, 25 to 44, 45 to 64, and 65 and over. For persons 5 and under within the Pennsylvania counties, the primary cause of death was perinatal conditions. For persons 5 to 24, accident was the leading cause of death in four of the five counties. For persons 25 to 44, the leading cause was accident in four of the five counties. In all five counties the leading causes of death for those 45 to 64 was cancer and heart disease for persons 65 and older.

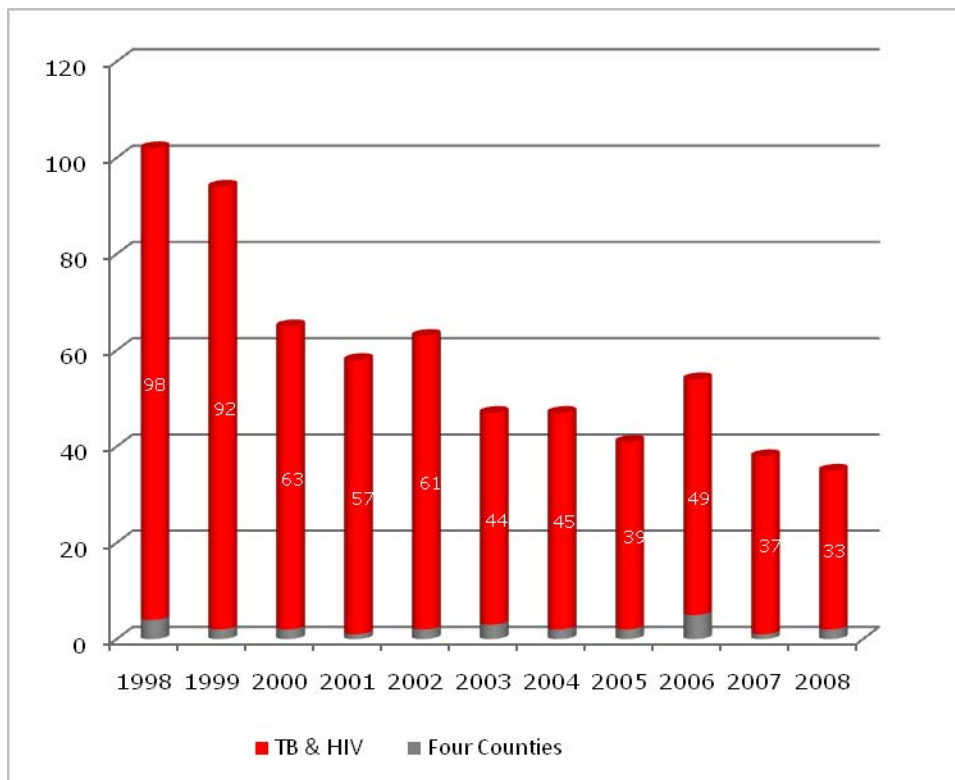
In all four New Jersey counties heart disease appears to be the leading cause of death.

## Tuberculosis

The number of tuberculosis (TB) cases and case rates per 100,000 were provided for selected areas based on the availability of data for the period of 2003 through 2007. Unlike the tables contained throughout this section, the TB information was only available for the MSA as opposed to EMA level data, and therefore includes New Castle County, Delaware and Cecil County, Maryland. New Jersey had a slightly higher case rate as compared to the national rate. Pennsylvania had rates at approximately half the national rate. Philadelphia had the highest case rate at 8.6% and the Philadelphia MSA was 4.0%. Of the eight counties for which information was available, Philadelphia had the highest case rate at 9.2.

The number of persons in the state of New Jersey with HIV and TB co-infection in 2008 was 33.

### Tuberculosis and HIV Co-infections for the State of New Jersey and Four EMA Counties, 1998 to 2008



New Jersey Department of Health and Senior Services for Health Statistics



## Indicators of Risk for HIV/AIDS Infection

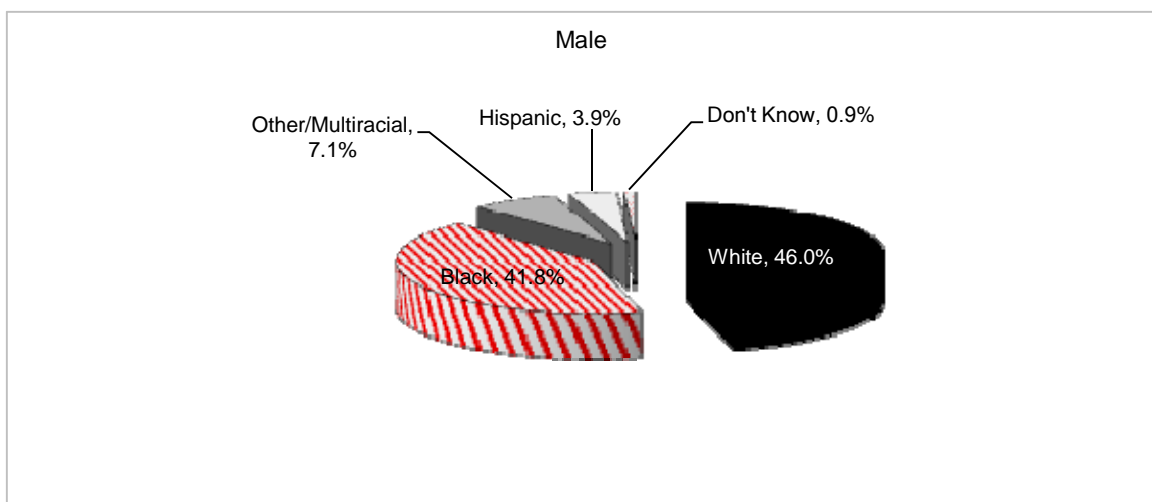
Section II provides information obtained for different behavioral risks, substance abuse, and sexually transmitted diseases. The data were either local, EMA, or state level. All the behavioral-risk data were survey based. The substance abuse data came from reporting provided to the CDC, the National Center for Health Statistics, SAMHSA, and various federal organizations. Sexually transmitted disease information was obtained from either local or state health departments.

### Summary

#### *Behavioral Risk*

After adjusting the Philadelphia MSA sample in the Behavioral Risk Factor Surveillance System (BRFSS) survey of 2007 for non-coverage and non-response, there were a total of 2,880 responses. The BRFSS survey examined HIV testing behavior questions, as well as other risk indicators.

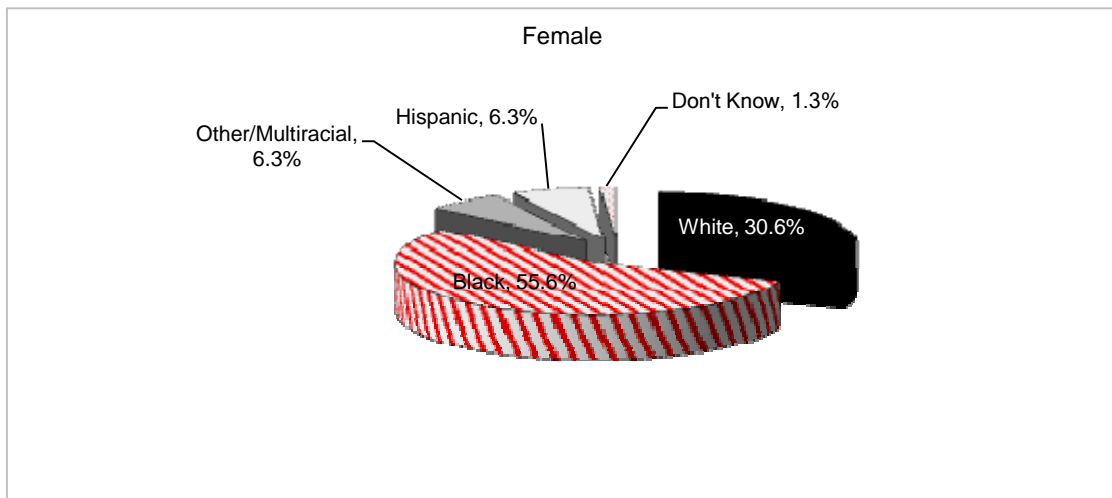
#### Race/Ethnicity Groups of Male Who Have Ever Tested for HIV, 2007 (N=308)



\*Other/Multiracial is combined category of Asian/Pacific Islander/Native Hawaiian/American Indian and Multiracial Non-Hispanic

Source: Behavioral Risk Factor Surveillance System 2007, CDC

## Race/Ethnicity Groups of Females Who Have Ever Tested for HIV, 2007 (N=671)



\*Other/Multiracial is combined category of Asian/Pacific Islander/Native Hawaiian/American Indian and Multiracial Non-Hispanic

Source: Behavioral Risk Factor Surveillance System 2007, CDC

The Youth Risk Behavior Surveillance System (YRBSS) was created to monitor the health-risk behaviors that influence youth. The YRBSS measures the prevalence of behavioral risks, monitors when they start, and assesses changes over time. The information discussed was based on 2005 New Jersey state information and the Philadelphia school district area. Results were also compared to the 2005 national data. Of the 13,917 students who participated in the national sample, 1,495 students were in the New Jersey state sample and 1,408 in the Philadelphia survey. An updated 2007 Philadelphia school district report was included to show trend comparison. There were a total of 2,450 students who participated in the 2007 Philadelphia survey. Of the 2,450 surveyed students in 2007, 60.6% said they have had sexual intercourse compared to 66.8% of the 1,408 surveyed students in 2005. When asked whether students had sexual intercourse with one or more person during the past three months, 43.4% in 2007 indicated they had compared to 48.5% in 2005

The HIV Testing Survey (HITS) is a national project that has 23 sites throughout the country, including Philadelphia. In 2001, the Philadelphia-based survey interviewed 271 HIV-negative high-risk individuals. All 271 participants responded to the question concerning having been tested within the last year; 74.5% were tested and 25.5% were not. The most common reasons

given for not having been tested for HIV were: because it was unlikely they had been exposed to HIV, because they thought they were HIV negative, or because they did not have time.

### *Substance Abuse*

The Treatment Episode Data Set (TEDS) contains descriptive data representing approximately 83% of the TEDS-eligible admissions, 67% of the total known admissions, and 58% of substance abuse treatment providers. The Philadelphia EMA had a total of 23,563 admissions to treatment centers that were included in the data set for services provided in 2007. Alcohol was largely the problem substance for those who were 40 and older; while heroin were largely the problem substances for those aged between 21-29 years old. Marijuana/hashish was largely the problem substance for those who were less than 20 years of age. This was consistent among both male and female groups.

The National Survey on Drug Use and Health (NSDUH) was designed to produce drug-and-alcohol use incidence and prevalence estimates, and to report the patterns of use and abuse within the general U.S. civilian population for persons 12 years of age and older. The information is state level and has been included for both New Jersey and Pennsylvania. There were an estimated 30,000 persons between the ages of 12-17 who had dependence on an illicit drug during 2005-2006 in New Jersey and an estimated 41,000 persons in Pennsylvania.

The Uniform Crime Report (UCR) serves as national assessment of reported crimes. Information is contained within this report that is not available elsewhere in the criminal justice system. Data were collected for all crimes except traffic violations and include the arrestees' age, sex, and race by the category of crime committed. The data provided were based on the Philadelphia EMA for 2008. There was a total of 1,437 arrests for prostitution and commercialized vice. Most arrestees overall identified as male and Black.

The Drug Abuse Warning Network (DAWN) monitors emergency department (ED) visits associated with the abuse of major drugs, as well as drug-related deaths reviewed by medical examiners and coroners. National surveillance data and data for 21 metropolitan areas, including the Philadelphia EMA, were collected. In 2002, there were an estimated 12,437 patients who mentioned cocaine as a major substance of abuse; marijuana mentions totaled

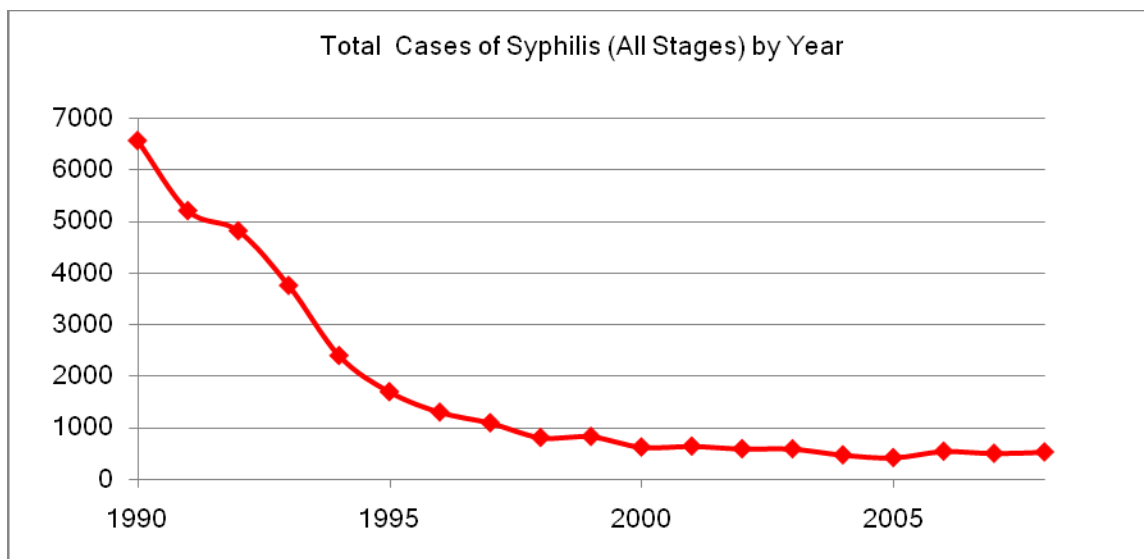
6,787 visits, and heroin had a total of 4,918 mentions. Alcohol in combination with another drug totaled 9,921 mentions.

The Arrestee Drug Abuse Monitoring (ADAM) program, an initiative of the National Institute of Justice, was created to measure the extent of drug use in the population who had been arrested. During 2003, there were a weighted total of 1,919 male participants who took part in the ADAM study in Philadelphia. Sixty-seven percent of the Philadelphia male arrestees tested positive for any of five drugs (cocaine, marijuana, methamphetamine, opiates and PCP).

### *Sexually Transmitted Diseases*

The surveillance information provided on sexually transmitted diseases was acquired from state and local health departments. The diseases presented were chlamydia, gonorrhea, and syphilis. Condom usage among MSM presenting with a new STD was also discussed in this section. The STD information covers the period of 2003 through 2008 depending on the availability of data by county. Philadelphia data show cases and rates as recent as 2008 while the figures for the Pennsylvania and New Jersey counties show data ending in 2007. The data are further stratified by gender, race and ethnicity, and age.

### **Reported Cases of Syphilis: Philadelphia, 1990-2008**



Source: City of Philadelphia, Department of Public Health, Communicable Diseases Office

## Scope of the HIV/AIDS Epidemic in Philadelphia and the EMA

Individuals from all racial and ethnic groups, ages, genders, and socioeconomic backgrounds have been affected by and infected with HIV/AIDS. However, the impact of the epidemic has not been the same for all populations within the nine-county EMA. At the onset of the epidemic, those primarily infected were White men who had sex with men (MSM). Another segment of the population heavily impacted was injection drug users (IDU). Now there are upsurges among high-risk heterosexuals, women, and minorities. Heterosexual contact was the highest exposure category of diagnosed cases in 2003-2008 for the City of Philadelphia. Men who have sex with men and injection drug users continue to be highly affected by the HIV/AIDS epidemic.

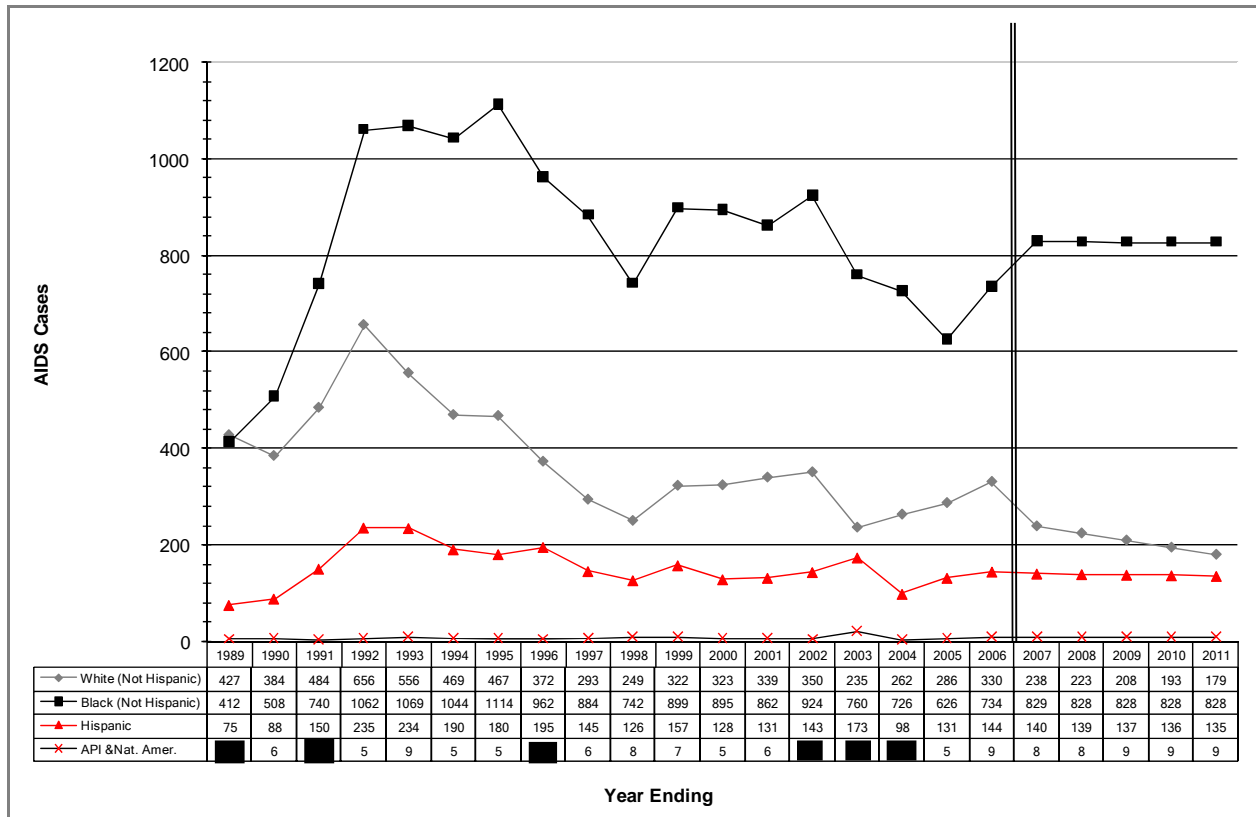
The information in this section of the profile pertains to the AIDS epidemic in the City of Philadelphia and the Philadelphia EMA. The data to complete this section were obtained from the City of Philadelphia, Department of Public Health, AIDS Activities Coordinating Office, Surveillance Unit; the Pennsylvania Department of Health, Bureau of Health Statistics and Research, Bureau of Epidemiology Data Support, HIV/AIDS Surveillance; and the New Jersey Department of Health and Senior Services, Division of AIDS Prevention and Control, HIV/AIDS Surveillance Unit. A data request was submitted to each health department for the following: incidence, prevalence, and cumulative AIDS and HIV cases for the last five years, broken out by gender for the categories of age, race, ethnicity, and exposure through the most recent year end for which the data were available. Data, although requested, was not available broken out by gender for some of the categories. The data were presented based on what was available and provided by the individual surveillance units.

Tables specific to the EMA, the City of Philadelphia, and the Pennsylvania and New Jersey counties have been included. In most cases the information has been presented by gender over a period of at least five years. Unfortunately, this could not be done in all instances by county and/or cities, due to the small cell sizes, or because the information was not available or not provided.

Forecasting for the EMA for the period of 2008 through 2011 was completed and has been provided in this section. The forecasting was done by race and ethnicity, gender, and exposure category. It is important to bear in mind that a forecast is a calculated prediction, or best guess,

and should never be taken to represent an absolute value. It is also important to note that due to incomplete data for 2008, forecasting concluded with known year end data for 2007. Data for 2008 are forecasted data and are not indicative of year end totals.

### Forecasted AIDS Cases for 2007 through 2011 by Race/Ethnicity



### Summary

#### Philadelphia Eligible Metropolitan Area (EMA)

Philadelphia represents the majority of AIDS cases within the nine-county area. During the period of 2003 through 2008, Philadelphia went from having 78.15% of the new AIDS cases in the EMA in 2003 to 73.21% of the EMA totals in 2007 and 78.14% of the EMA totals in 2008 (please keep in mind that 2008 data is only through June 31, 2008.) In 2007, Philadelphia accounted for 73.80% of the cumulative AIDS cases and 76.52% of the living AIDS cases in the EMA. Of the four suburban Pennsylvania counties, Delaware experienced the majority of AIDS cases by incidence, prevalence, and cumulative counts, whereas Camden County represented the largest proportion of the epidemic for the four New Jersey counties.

AIDS Incidence for the Philadelphia EMA by Counties, 2002 - 2008\*

<u>County</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008*</u>
Bucks	18	18	29	35	21	<5*
Chester	20	21	14	20	24	<5*
Delaware	49	59	43	101	74	12*
Montgomery	31	41	33	59	34	<5*
Philadelphia	866	804	684	729	675	211
Burlington	21	22	26	28	24	9*
Camden	77	69	74	65	54	22*
Gloucester	21	12	16	15	10	5*
Salem	5	10	<5*	12	6	<5*
<b>Total</b>	<b>1108</b>	<b>1056</b>	<b>919</b>	<b>1064</b>	<b>922</b>	

\*Cases reported through June 30, 2008 for PA and December 31, 2008 for NJ

Increase for PA counties in 2006 may partly reflect improvement attributable to Electronic Laboratory Reporting in PA-NEDSS

Includes adult cases which are assigned pediatric modes of transmission since infection is believed to have occurred before age 13.

City of Philadelphia, Department of Public Health, AIDS Activities Coordinating Office, Surveillance Unit Quarterly Update

HIV/AIDS Surveillance - Bureau of Epidemiology

Data Support - Bureau of Health Statistics and Research, Pennsylvania Department of Health

New Jersey Division of AIDS Prevention and Control

Values and indicators for cells with cases less than five have been removed for confidentiality reasons.

**City of Philadelphia.** AIDS incidence in Philadelphia was 866 in 2003, 675 in 2007, and 211 in 2008 (data reported through June 31, 2008.) With respect to cumulative cases, as of June 2008, Philadelphia represented 73.84% or 19,835 of the total AIDS cases in the EMA. For 2007, the number of individuals living with AIDS in Philadelphia was 10,061 or 76.52% of the EMA total (living AIDS cases were not available for 2008.) At the time this document was written, the majority of diagnosed cases in 2008 were among Black, male heterosexuals. Additional data from the Pennsylvania Department of Health, Bureau of Health Statistics and Research, Bureau of Epidemiology Data Support, HIV/AIDS Surveillance are included in a section to illustrate HIV (non-AIDS) cases. Cases for Philadelphia in this section were reported by year of HIV diagnosis. Data was not available broken out by gender across all years.

Cumulative AIDS Cases for for the Philadelphia EMA by Counties, 2003 - 2008\*

County	2003	2004	2005	2006	2007	2008*
Bucks	631	649	678	713	734	738
Chester	476	497	511	531	555	557
Delaware	1,225	1,284	1,327	1,428	1,502	1,514
Montgomery	812	853	886	945	979	983
Philadelphia	16,732	17,536	18,220	18,949	19,624	19,835
Burlington	630	652	678	706	730	739
Camden	1,615	1,684	1,758	1,823	1,877	1,899
Gloucester	337	349	365	380	390	395
Salem	167	177	180	192	198	200
Total	22,625	23,681	24,603	25,667	26,589	26,860

\*Cases reported through June 30, 2008 for PA and December 31, 2008 for NJ

Increase for PA counties in 2006 may partly reflect improvement attributable to Electronic Laboratory Reporting in PA-NEDSS

Includes adult cases which are assigned pediatric modes of transmission since infection is believed to have occurred before age 13.

City of Philadelphia, Department of Public Health, AIDS Activities Coordinating Office, Surveillance Unit Quarterly Update  
HIV/AIDS Surveillance - Bureau of Epidemiology

Data Support - Bureau of Health Statistics and Research, Pennsylvania Department of Health

New Jersey Division of AIDS Prevention and Control

Values and indicators for cells with cases less than five have been removed for confidentiality reasons.

**Pennsylvania Counties.** Of the four Pennsylvania counties, Delaware County had the most AIDS cases. By June 2008, the cumulative number of cases in Delaware County was 1,514, followed by Montgomery County with 983, Bucks with 738, and last, Chester County with 557. The racial group with the highest percentage of cases in Bucks and Montgomery counties was White. For Chester and Delaware counties the largest percentage of cases by racial group was among Blacks. In Bucks and Montgomery counties, the leading exposure category was MSM; for Chester and Delaware counties it was IDU. HIV incidence rates have been shown by year through June 2008. However, only year 2007 data was available broken out by gender.

**New Jersey Counties.** The information presented for the New Jersey counties differs from that of Pennsylvania in that more complete HIV case data has been included, covering the period 2003 through 2008 as available. Comparison for the Philadelphia EMA was done separately for New Jersey counties and Pennsylvania counties because of this difference. Camden County accounted for the highest total for cumulative HIV/AIDS cases among the four New Jersey counties, with a total of 2,867 as of June 30, 2008. This was followed by Burlington with 1104, Gloucester at 593 and Salem County with a total of 300 cases. In all four counties the

majority of HIV and AIDS cases were reported for individuals 35-44 years of age. In all counties the majority of AIDS and HIV cases by gender were male. The majority for the racial breakdown was Black in three out of four counties, with Gloucester being the exception, where White constituted the largest racial group affected. The MSM exposure category accounts for more cases than any other exposure category except in Salem and Camden County where the Heterosexual exposure category accounted for more cases than MSM category.

***HIV/AIDS Dataset.*** The AIDS Public Information Data Set (AIDSPIDS) is the CDC's national, publicly available AIDS surveillance database. Data are provided to the CDC by state or local health departments for surveillance purposes as part of the HIV/AIDS Reporting System (HARS). The most recent data available were for AIDS cases through December 2002. With this data set, it is important to consider the possibility of delays between the diagnosis of a patient and the notification of or report to state and local health departments. Surveillance of AIDS data is therefore an ongoing process. Additionally, because of the long and variable periods between infection and symptom development, trends in AIDS case data do not represent persons recently infected with HIV. However, the use of AIDS case surveillance is an important component in the assessment of access to care for different populations.



## HIV/AIDS Service Utilization Patterns in Philadelphia and the EMA

This section in the profile addresses the patterns of service utilization of HIV-infected persons in the Philadelphia EMA. The data may vary geographically and include state or local sources, as well as needs assessments performed by the Office of HIV Planning. The information in this section includes counseling and testing numbers from a local survey in addition to data provided by the NJ Department of Health, the PA Department of Health, and the Philadelphia AIDS Activities Coordinating Office. Along with HIV testing-delay information, this section will also discuss results of local focus groups that were conducted as a part of the needs assessment activities of the Office of HIV Planning. Only information relevant to service utilization patterns of the focus-group participants has been included here. Additional information in this section includes data from the Philadelphia Department of Public Health's Implementation Plan. These data show service utilization numbers by type of service category being used. Demographics related to those clients utilizing the AIDS Drug Assistance Program (ADAP) are also included here. Additional demographic information on CARE Act recipients was provided by the Philadelphia Health Department and is included as supplemental data to consider with service utilization patterns in the EMA. Demographic comparisons of AIDS prevalence and service utilization can also be found in this section.

### *Summary*

#### *HIV Counseling and Testing Information*

The Philadelphia Health Management Corporation (PHMC) Southeastern Pennsylvania Household Health Survey is a comprehensive survey on the region's health. Included in this survey was a question on whether subjects had ever had an HIV test. Among male respondents, the majority of Blacks (63.0%), Latinos (64.6%) and those who identified as Biracial (66.7%) stated they had ever been tested for HIV. Among females, the majority of Black (61.6%), Latino (63.2%), and Biracial (69.3%) respondents stated they had ever been tested for HIV. Counseling and testing information was also available by local and state sources. When examining the total number of HIV tests and the number of positive tests in the four New Jersey counties from 2004 to 2008, the numbers appear fairly consistent. The number of tests given in Camden County over the five-year period averaged a little over 4,785 per year. This was followed by Burlington County, with an average of about 1,637 tests a year. There was an average of about 1,220 tests given in Gloucester County between 2004 and 2008, and Salem County's average number of tests was 155. Camden County consistently had the largest numbers of both tests given and positive results in the five-year period. Most clients testing in Burlington, Salem and Camden in 2008 were Black, while most testers in Gloucester County identified as White. For all counties, testers were mainly between 20-29 years old. In the

Pennsylvania counties, the average numbers of HIV counseling and testing visits during the five-year period were: Bucks 1,889, Chester 1,376, Delaware 2,412, Montgomery 1,961, and Philadelphia over 36,000. In Philadelphia, of a total of 719 positive results during 2007, 527 were male. The largest race to test positive was Black with 483 people. By age, the largest group to test positive in Philadelphia during 2007 was between 25 to 44 years old. Heterosexual (228) was the risk category most likely to test positive while MSM (198) was the second most likely.

Total Number HIV Tests and Number of Positive Tests in Four NJ Counties, 2004-2008

County	2004		2005		2006		2007		2008	
	Tested	Positive	Tested	Positive	Tested	Positive	Tested	Positive	Tested	Positive
Camden	4,109	69	3,934	57	5,417	35	4,943	21	5,523	24
Burlington	1,268	10	1,610	8	1,536	9	1,262	11	2,510	18
Gloucester	1,075	0	1,119	<5	1,278	<5	1,123	<5	1,508	5
Salem	58	0	194	<5	116	<5	130	0	275	<5
Total	6,510	79	6,857	68	8,347	47	7,458	33	9,816	48

Note: Data entered through June 27, 2009

Source: NJ Dept. of Health & Senior Services, Research & Evaluation/Division of AIDS, 2009

Total Number of HIV Counseling & Testing Visits in 5 Pennsylvania Counties 2003-2007\*

County	Number of Visits** By Clients County of Residence in Pennsylvania					TOTAL
	2003	2004	2005	2006	2007	
Bucks	1,660	1,854	1,493	1,868	2,570	9,445
Chester	965	1,726	1,230	1,587	1,370	6,878
Delaware	3,272	3,164	1,560	1,646	2,419	12,061
Montgomery	2,041	2,309	1,641	1,955	1,859	9,805
Philadelphia	39,294	40,481	25,172	32,288	45,604	182,839
Total	47,232	49,534	31,096	39,344	53,822	221,028

\* Records scanned to date of report

\*\* A visit consists of a client meeting face to face with a counselor for counseling only, or counseling and testing.

In 2005 approximately 74% of clients counseled consented to testing.

Source: Data Provided by the Division of HIV/AIDS Prevention, PA Department of Health. 2008

### *HIV-Testing Delays*

HIV-testing delays can help determine the median time between patients' testing positive for HIV and diagnosis with AIDS. This information helps to determine who is late in both their testing and admittance into care. The average time for a diagnosis to move from HIV to AIDS in months was anywhere from 24 to 38 over the course of the 10 years shown. From 2001 to 2006, the median time for men was in the 0-2 month range, indicating that males were testing late in their disease progression. From 2001-2006, Blacks had a median time of 0-2 while Asian/Pacific Islanders had a median time of 0-1 also indicating late testing. For exposure category, male heterosexuals from 1997 to 2006 had the shortest median time in months to progress from an HIV diagnosis to an AIDS diagnosis. On average, the time span was 0.2 months.

In 2007, AACO reviewed HIV-reporting data to determine how many people had developed AIDS over a 12-month period. Based on the analysis, concurrent HIV/AIDS is positively associated with age at HIV diagnosis. That is, the older a person is when they are diagnosed with HIV, the more likely it is that they will be classified as concurrent HIV/AIDS. Cases with concurrent infection are also more likely to be Black males and heterosexuals. Outreach efforts

for finding individuals who are late testers and increased HIV testing should occur among these at-risk populations.

### *Office of HIV Planning Needs Assessment Activities*

The Office of HIV Planning and two committees of the Ryan White Planning Council conducted needs assessment activities that asked various questions related to care and prevention. One of the questions asked about service utilization patterns in the past year. Among the 122 participants, the top three prevention services used were condoms or safe sex kits, receiving safe sex information, and information on disclosure. The top three care services used by consumers were medical case management services, medical care, and dental care. In 2007, the Office of HIV Planning conducted a survey on the HIV services being used by clients in the local region. Of the 540 respondents analyzed, the top three core services used were case management (385), medications (312) and dental care (254). The top three support services used were food bank/home-delivered meals (187), transportation (185) and housing assistance (179).

### *Implementation Plans*

Additional service utilization information was obtained from the 2005 to 2007 Implementation Plans. This information showed the number of people who were served by service categories. Excluding information and referral, the largest number of people served was in ambulatory/outpatient medical care from 2005 (8,365), 2006 (9,515) and 2007 (9,850). This was followed by case management with 6,564 clients served in 2005, 7,693 in 2006 and 7,494 in 2007. When comparing AIDS prevalence and service utilization in 2008, AACO served a proportion of racial/ethnic minorities and a proportion of women that exceeded the local AIDS prevalence data.

Ryan White Part A Clients by Currently Funded Service 2002 through 2008 with Forecasted Clients 2009 through 2011

SERVICE	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
AMBULATORY/OUTPATIENT MEDICAL CARE	6,337	6,139	6,703	8,365	9,515	9,850	9,186	10,697	11,367	12,038
MEDICAL CASE MANAGEMENT SERVICES	4,925	5,621	5,361	6,564	7,693	7,494	10,634	10,214	11,043	11,871
ORAL HEALTH CARE	1,359	1,877	2,123	2,093	2,180	2,358	2,384	2,638	2,785	2,931
FOOD BANK / HOME DELIVERED MEALS	4,832	4,149	2,509	3,534	2,101	2,225	3,335	1,991	1,679	1,366
OUTREACH SERVICES	1,691	1,001	1,726	1,013	1,671	1,754	1,377	1,535	1,553	1,571
LEGAL SERVICES				1,051	1,695	1,264	1,136	1,243	1,225	1,207
MEDICAL TRANSPORTATION SERVICES	4,370	2,529	3,565	4,129	2,613	1,256	1,330	1,025	574	124
SUBSTANCE ABUSE SERVICES:										
OUTPATIENT HOUSING	196	358	403	322	578	689	331	588	633	677
MENTAL HEALTH SERVICE	630	622	398	563	424	451	500	412	387	361
EARLY INTERVENTION SERVICES				2,707	243	114	234	188	184	179
EMERGENCY FINANCIAL ASSISTANCE				130	51	39	45	39	36	33
DRUG REIMBURSEMENT PROGRAM	1,061	1,655	1,424	1,045	886	728	1,675	1,132	1,112	1,093

Source: AIDS Activities Coordinating Office & the Office of HIV Planning, 2009

### *AIDS Drug Assistance Program (ADAP)*

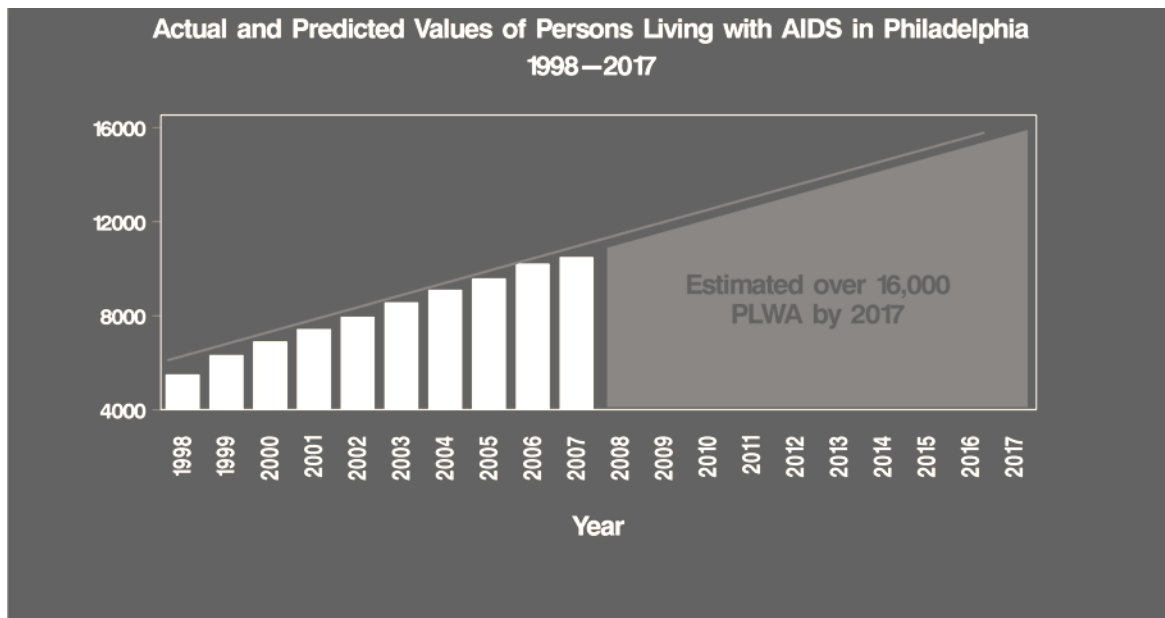
Information was also available for the AIDS Drug Assistance Program (ADAP), which provides HIV-related drugs to people who are uninsured, underinsured, or with low income. Data for the total number of ADAP clients served in the local Pennsylvania and New Jersey areas were presented by demographic group to give the reader an idea of who was utilizing these services. The total number of clients served in the five Pennsylvania counties of Bucks, Chester, Delaware, Montgomery and Philadelphia in 2006 was 2,507. In the four New Jersey counties of Burlington, Camden, Gloucester and Salem, the total number of clients served in 2007 was 695. In both the local New Jersey and Pennsylvania counties most clients were male. In Burlington, Camden, Delaware, and Philadelphia most clients were Black, whereas in Gloucester, Salem, Bucks, and Montgomery counties most clients were White. Chester County had an even amount of clients that identified as either Black or White. Most clients in both the Pennsylvania and New Jersey counties were between 40 and 49 years old. According to the National ADAP Monitoring Project, in 2006 and 2007 neither New Jersey nor Pennsylvania reported having a waiting list for clients to access ADAP.

### *Demographic Comparisons of CARE Act Client Data with Estimated Persons Living with HIV/AIDS*

Demographic comparisons between Part A CARE Act clients who received care services during 2006 and the estimated persons living with HIV/AIDS (PLWHA) in the Philadelphia metropolitan area were also provided. Overall, males, White Non-Hispanics, Hispanics, and those between 13 to 44 years old represented a smaller proportion of clients receiving CARE Act services than those estimated to be PLWHA in those demographic groups. Conversely, females, Black Non-Hispanics, Asian/Pacific Islanders, and those over 44 represented a larger proportion of clients receiving CARE Act services than those estimated to be PLWHA.

Additional information presented on the characteristics of CARE Act clients from 2003 to 2008 show supplementary demographics such as household income, type of housing, and type of insurance. The majority of recipients in 2008 were less than or equal to the federal poverty line, were permanently housed or had an unknown housing status, and had Medicaid as their insurance.

### **Ryan White Part A Clients by Currently Funded Service 2002 through 2008 with Forecasted Clients 2009 through 2011**



Source: AIDS Activities Coordinating Office, 2009

### *Expenditures for Women, Infants, Children, and Youth*

According to the health department, the Philadelphia EMA Part A program has expended funds exceeding the requirement in all years for which WICY reporting has been required.

### *Other Health Statistics*

There were a total of 199 drug and alcohol treatment facilities during the period of July 2005 to June 2006 in all five counties. Most of these facilities were in Philadelphia (111). There were a total of 74 hospitals listed during that same time period with 34 located in Philadelphia County. There were 190 nursing homes listed with most (60) located in Montgomery County and 50 located in Philadelphia. There were 345 home health agencies that served the five southeastern counties of Pennsylvania, 89 of them were located in Montgomery County and 83 were in Philadelphia.

### *Forecasted Cost Service Estimates*

Forecasted cost service estimates based on the unit cost data from 2002 to 2008 show that the basic unit cost for medical care services for the Philadelphia metropolitan area in 2011 will be \$100.53. The estimated unit cost for providing medications in 2011 will be \$797.00. Case management's unit cost will be \$16.04, substance abuse unit costs are estimated to be \$85.92, mental health single unit costs are estimated at \$123.42, oral health care unit costs in 2011 were projected at \$53.45, care outreach was \$10.98, food was \$2.81, emergency financial assistance was projected at \$1,852.99, housing was \$517.97, transportation was \$196.71, and legal services/client advocacy was estimated at \$7.12 in 2011. Since all of these estimates are based on unit cost and service units from 2002 to 2008, the estimates do not take an influx of new clients into consideration. Caution should therefore be considered in interpreting this data.

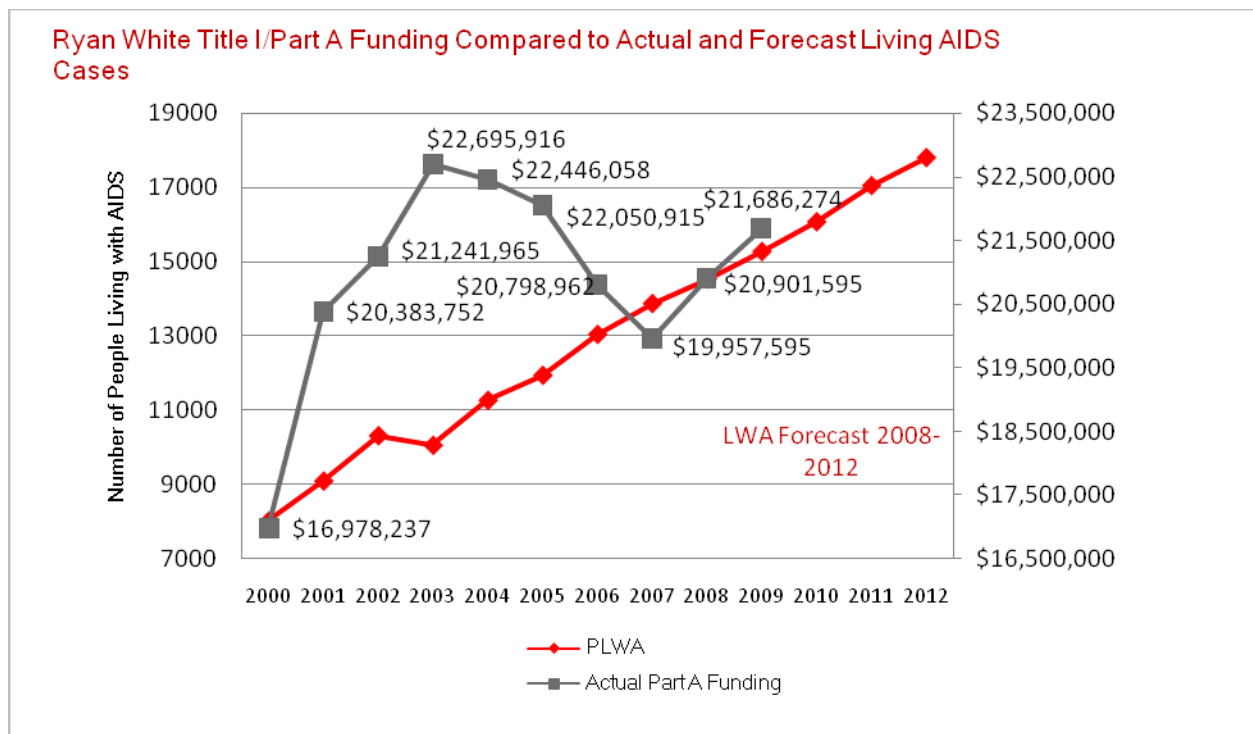
Overall, funding under Part A has not kept pace with the increases in the epidemic. This is demonstrated through a review of actual funding as compared to living AIDS cases.



## Measuring Unmet Need in the Philadelphia EMA

### Summary

Measuring unmet need (the number of people who know they are HIV positive but are not in care) is difficult. At best, the estimates of unmet need are what have been utilized for this purpose. The City of Philadelphia estimates the number of HIV-positive individuals with unmet need to be 5,317 (22%). Data collected by the Office of HIV Planning also attempts to document unmet need in the EMA. Consumer needs assessment activities completed by this office show that stigma, denial and addictions contribute to unmet need, as do lack of funding for the services. This number is slightly higher for those who sought medical care only after they became sick. In an effort to understand, in part, why unmet need might exist, the Office of HIV Planning collected data as to why respondents were not in care (even when needed). The data show that, among other reasons, denial, stigma, competing needs, and active addictions play a role in preventing individuals from accessing medical care. Philadelphia Health Management Corporation's 2008 Household Health Survey asked individuals about their insurance status, reasons for being uninsured and whether care was put off due to cost. Cost was a top reason for being uninsured and putting off care. Forecasting shows that funding should continue to rise to meet the needs of the number of people living with AIDS and that the annualized medical cost increase is higher than the actual Part A funding in the region.



Framework for Estimated Unmet Need in the Philadelphia EMA

Population Sizes		Value	Data Source(s)	
<b>Row A.</b>	Number of persons living with AIDS (PLWA), for the period of 12/31/2007	13,872	Local HARS data	
<b>Row B.</b>	Number of persons living with HIV (PLWH)/non-AIDS/aware, for the period of 12/31/2007	9,861	Midpoint of CDC estimate	
<b>Row C.</b>	Total number of HIV+/aware for the period of 12/31/2007	23,733	Local HARS data and CDC estimate	
Care Patterns		Value	Data Source(s)	
<b>Row D.</b>	Number of PLWA who received the specified HIV primary medical care during the 12-month period of 2007	11,570	HIV/AIDS surveillance data, local representative sample (CAREWare) of persons in private care, Medicaid, VA and Part A CareWare unduplicated client data	
<b>Row E.</b>	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period of 2007	6,846	HIV/AIDS surveillance data, local representative sample (CAREWare) of persons in private care, Medicaid, VA and Part A CareWare unduplicated client data	
<b>Row F.</b>	Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period of 2007	18,416		
Calculated Results		Value	Percent	Calculation
<b>Row G.</b>	Number of PLWA who did not receive the specified HIV primary medical care	2,302	17%	A - D
<b>Row H.</b>	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	3,015	31%	B - E
<b>Row I.</b>	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	5,317	22%	G + H

**NOTE:** The data in "Percent" cells of Column 4 Rows D, E, G, H and I is calculated with a formula. Once grantee fills "Value" data in Column 3 Rows A, B, C, D, E and F, the "error" will correct itself.

