

CUMBERLAND COUNTY

COMMUNITY DIAGNOSIS DOCUMENT

A GUIDE TO HEALTHY COMMUNITIES

1997-1999

Compiled by

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Table of Contents

<i>Introduction</i>	3
Mission Statement	3
Community Diagnosis	3
History	4
Summary	5
<i>County Description</i>	7
Geographic	7
Land Area	7
Economic Base	7
Demographics	8
Medical Community	8
<i>Community Needs Assessment</i>	9
Primary Data	9
Secondary Data	15
<i>Health Issues and Priorities</i>	20
Community Process	20
Cumberland County Priorities	23
<i>Future Planning</i>	25
<i>Appendices</i>	27

Introduction

Mission Statement

The overall mission of the council is to assist the Department of Health by advising the Department regarding the health problems of Cumberland County and thus assist the Department in its responsibility to undertake “Community Diagnosis”. The role of the Department of Health is to support the Council by providing the resources needed by the Council to undertake the work, and by facilitating the “Community Diagnosis” process. The following is a proposed objective statement. The mission of the Council is to assist the Department of Health by:

- Developing a community health assessment that includes health problems and needs identification.
- Developing goals, objectives, and plans of action to meet these needs along with identifying and securing resources to address these needs.
- Establishing priorities for all major identified health problems and develop/implement strategies for appropriate interventions.
- Drafting and presenting to the Department of Health the community health assessment.
- Promoting and supporting the importance of reducing the health problems to the Department and the community.
- Maintaining good communications with the Department via periodic reports from the Council through the Regional Health Council Representative and Community Development Staff.

Community Diagnosis

A simple definition (used by the North Carolina Center for Health and Environmental Statistics) of a community diagnosis is “ a means of examining aggregate health and social statistics, liberally spiced with knowledge of the local situation, in order to determine the health needs of the community.” By using this definition, we acknowledge that significant input from residents of the local area is essential to performing a community diagnosis effectively. Although a great deal of qualified health data can be obtained from the State, the process will only be successful if local citizens are fully involved and are comfortable with the eventual findings. This is why the formation and effective utilization of county health councils are vital in achieving accurate results.

The final outcome of community diagnosis and its products should:

- Provide justification for budget improvement requests submitted to the State Legislature;
- Provide to state-level programs and their regional office personnel information that fosters better planning, promotion, and coordination of prevention and intervention strategies at the local level;
- Serve health planning and advocacy needs at the community level. Here, the community leaders and local health departments provide the leadership to ensure that documented community health problems are addressed.

The end result of the process will be a set of prioritized health goals and proposed interventions to address the needs of the community. The Tennessee Department of Health is committed to assisting communities throughout our state in finding the answers to these questions via the community diagnosis process. This document will explain the community diagnosis process and outcomes for Cumberland County. We will also provide a historical perspective with details of the council and its formation.

History

“Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy.”

The Future of Public Health
Institute of Medicine, 1988

This manual is designed to assist local communities, local and regional health departments, and the state department of health in fulfilling the mission of public health, as defined above. If we, as a society, are to improve the conditions that affect the health of all of us, we must begin in local communities, dealing with local conditions. Health care is a very localized phenomenon. The needs and problems of one community may be very different from other communities, even those in close geographical proximity. Community leaders together with local health departments have a responsibility to play key roles in this effort. They should lead their communities in an examination of local health problems and in the development of plans to overcome those problems.

This mission can be accomplished by implementing the three core functions of public health at all levels of government. They are:

Assessment: The assessment function involves the monitoring and surveillance of local problems, the assessment of needs, and the identification of resources for dealing with them.

Policy Development: Policy development goes hand in hand with leadership, which fosters local involvement and a sense of ownership of these policies. It should emphasize local needs and should advocate an equitable distribution of public resources and complementary private activities commensurate with community needs.

Assurance: Assurance means that high quality services, including personal health services, which are needed for the protection of the community are available and accessible to all persons. Each community should receive proper consideration in the allocation of federal, state, and local funds for health. Each community should be informed about how to obtain public health services and/or comply with health requirements.

In summary, community-based health planning is a process, which assists local citizens in their respective communities to do the following:

- **Identifying the community's health care needs.**
- **Examine the social, economic, and political realities affecting the local delivery of health care.**
- **Determine what the community can realistically achieve in a health care system to meet their needs.**
- **Develop and mobilize an action plan based on analysis for the community.**

The end result of the process should answer three questions for the community:

Where is the community now?

Where does the community want to be?

How will it get there?

The Tennessee Department of Health is committed to assisting communities throughout our state in finding the answers to these questions via the community diagnosis process. The following is the Cumberland County Community Diagnosis Document, which details the process the Cumberland County community utilized to assess its strength, weaknesses, and gaps in resources. A very thorough analysis of health statistical data, community surveys, resources, and key leaders perceptions of Cumberland County's health care status facing the community is presented in document form to be utilized as a baseline document for public relations, grant applications, and as a foundation of the work plan for the future.

Summary

The Cumberland County Health Council was established in May 1997 by the Tennessee Department of Health Community Development Staff with an initial group of twenty-one concerned community leaders. Mr. Brock Hill, County Executive was elected as the first chairperson for the Cumberland County Health Council. This council consists of various community leaders such as the county executive, school superintendent, industry

representation, health care providers, local law enforcement, various community agencies, and other concerned community leaders as determined appropriate by the council members(appendix 1). The council has grown to over fifty-seven actively involved members. The Department of Health Community Development Staff facilitates the Community Diagnosis Process that seeks to identify community health care problems by analyzing health statistical data, community surveys, and council perceptions. The Community Diagnosis Process seeks to identify community health care problems by analyzing health statistical data, community surveys, and council perceptions. The initial step in the process is to select a county health council. The basic steps of the Community Diagnosis Process are as follows:

- **Assemble the initiating group**
- **Select the County Health Council**
- **Present data to the council**
- **Discuss and define health problems**
- **Analyze the Behavioral Risk Factor Survey**
- **Distribute the Community Assessment Survey**
- **Score /Rank health problems**
- **Design interventions**
- **Develop funding strategies**
- **Assess development and effectiveness of interventions**

During the course of the Community Diagnosis Process, the Cumberland County Health Council established by laws (appendix 2) that reflect the mission and goals of the council illustrating their commitment to their community. The council typically meets on the 4th Wednesday of each month from 12:00 to 1:00 p.m. where meetings are open to the public.

County Description

Geographic

- Cumberland County is located on the Cumberland Plateau in middle Tennessee.
- White, Putnam, Bledsoe, Rhea, Roane, Morgan, and Fentress counties in Tennessee surround this county.
- Cumberland County is located 75 miles from Knoxville and 120 miles from Nashville.
- Crossville, the county seat of Cumberland County is located 2 miles from Interstate-40 and accessible to several U.S. and State Highways.
- The average monthly high for July is 82 degrees and the average monthly low for January is 39 degrees with precipitation average being 52 inches per year.

Land Area

- Cumberland County is known for its parks and recreational areas.
- The county consists of 679 square miles with population density being 51 people per square mile.
- The major agricultural products grown in Cumberland County are beans, corn, tobacco, pimento, and peppers.
- The elevation height for this county is 1,980 feet above sea level.

Economic Base

- The county's median family personal income is \$23,498.
- The county's median household personal income is \$20,474.
- Cumberland County's per capita personal income is \$9,782.
- The average weekly income of 1998 wages was \$401.
- The individual poverty rate for Cumberland County is 18.1%.
- The family poverty rate for Cumberland County is 14.2%.
- The 1998 average labor-force total was 20,500, of those, 19,330 are employed and 1,170 are unemployed giving Cumberland County an unemployment rate of 5.7%.
- The major industrial employers in Cumberland County include Aristokraft, Avery Dennison, Crossville Rubber, and Flowers Snacks of Tennessee.

Demographics

- Cumberland County's education system consists of 8 elementary schools, 1 high school, 2 private &/or parochial schools, 1 technology center, and 2 college satellite sites.
- The number of TennCare enrollees in Cumberland County for 1999 is 6,282.
- The 1998 population estimate for Cumberland County is 44,291.
- The median age for a Cumberland County resident is 37.5 years.

Medical Community

- There is one hospital facility operating in Cumberland County that has a total of 186 licensed beds.
- The local county hospital is the most used by Cumberland County residents, second Davidson County and third is Knox County hospitals.
- There are four nursing homes located in Cumberland County that has a total of 383 licensed beds.
- Cumberland County has sixty-five medical doctors and fourteen dentists practicing in the county.

References: Tennessee Department of Health, Upper Cumberland Development District

Community Needs Assessment

Primary Data

Cumberland County Community Health Assessment Survey

The Community Health Assessment Survey provides a profile of perceived health care needs and problems facing the community. Its purpose is to obtain subjective data from a cross section of the health care services, problems and needs in the county. The survey includes questions about the health and social problems affecting the community as well as the availability, adequacy, accessibility and level of satisfaction of health care service in the community. The community survey is not a scientific random sample of the community, however it does represent a cross section of the community, i. e. young families, single parents, the elderly, farmers, business leaders, rural residents, etc. The community development staff distributed the Community Health Assessment Survey to the health council members, who then circulated the surveys throughout the community. Results of the survey were tabulated and analyzed using the “Epi Info” computer software. The community development staff presented the final results and analysis of the survey to the county health council. The following list identifies the perceived problems facing the Cumberland County community based on the survey results.

		Top Ten Issues Highlighted
Smoking	61%	
Adult Alcohol Abuse	55%	
High Blood Pressure	54%	
Teen Pregnancy	51%	
Arthritis	50%	
Stress	50%	
Teen Alcohol /Drug Abuse	50%	
Smokeless Tobacco	49%	
Heart Conditions	47%	
Adult Drug Abuse	46%	
Domestic Violence	44%	
School Dropout	44%	
Motor Vehicle Deaths	44%	
Depression	40%	
Diabetes	39%	
Obesity	39%	
Lung Cancer	35%	
Child Abuse/Neglect	35%	
Crime	35%	
Poverty	35%	
Other Cancer	32%	
Breast Cancer	31%	
Lack of Sex Education	31%	
Poor Nutrition for the Elderly	29%	

Asthma	28%
Eating Disorders	28%
Poor Nutrition for Children	28%
Unemployment	28%
Sexually Transmitted Diseases	25%
Prostrate	24%
Youth Violence	24%
HIV/AIDS	22%
Colon Cancer	21%
Influenza	20%
Pneumonia	19%
School Safety	19%
Other Accidental Deaths	17%
Water Pollution	15%
Homelessness	13%
Air Pollution	13%
Adult Suicide	12%
Teen Suicide	11%
Lack of Childhood Vaccinations	11%
Homicide	10%
Toxic Waste	10%
Gangs	9%
On the Job Safety	9%
Hepatitis	8%
Tuberculosis	8%

Cumberland County Availability of Services

“Adequate” (50% or greater)		“Not Adequate” (25% or greater)	
1) Pharmacy Services	85%	1) Recreational Activities	33%
2) Eye Care	79%	1) Health Insurance	33%
3) Dental Care	78%	2) Specialized Doctors	32%
3) Ambulance/Emergency Services	78%	3) Child Abuse/Neglect Services	30%
4) Hospital Care	74%	4) Alcohol/Drug Treatment	28%
5) Local Family Doctors	71%	5) Mental Health Services	26%
6) Emergency Room Care	65%	5) Women’s Health Services	26%
7) Home Health Care	64%		
8) County Health Dep. Services	53%		
9) Nursing Home Care	53%		
10) Transportation for Medical Care	51%		
10) Child Care	51%		
11) Specialized Doctors	50%		
11) Medical Equipment Suppliers	50%		

Personal Information

- The majority of the people completing the survey were from Crossville and 65% have lived in the county for more than ten years.
- The average age for the community participants was between 18-39 years of age with 37% being single and 46% married.
- The participant response noted that 91% had health insurance, 13% were TennCare enrollees, and 5% receive either SSI or AFDC.

The Community Development Staff distributed 500 copies of the Community Health Assessment Surveys to members of the Cumberland County Health Council. The council members disbursed the surveys to the community with 323 individuals responding from Cumberland County. The council discussed the top ten issues resulting from the survey and additionally reviewed information about the individuals completing the survey. The council members discussed further the availability of service data. Several members indicated that Cumberland County seems to have sufficient resources but not enough individuals to deliver the services needed.

Behavioral Risk Factor Survey

The Behavioral Risk Factor Survey (BRFS) is a random telephone survey, coordinated through the Centers for Disease Control, which collects information from adults on health behaviors and knowledge related to leading causes of death in each of the states. The Behavioral Risk Factor Survey takes approximately 20 minutes to complete with at least 200 respondents from individuals residing in Cumberland County. About half of all deaths occurring annually are now attributed to modifiable behavioral risks. In addition to determining what types of health risks are most prevalent in the population, the BRFS data will be very useful in determining what types of interventions are most needed for other health problems such as excess deaths from a particular chronic disease. A modified version of the standard BRFS was developed specifically for the “Community Diagnosis” process. In addition to the questions on the standard BRFS survey, a series of health issues are listed. The respondent is asked if the issue is a “Definite Problem”, “Somewhat of a Problem”, “Not a Problem”, or “Not Sure”. The list of the health issues with frequency of response as a “Definite Problem” is as follows:

Tobacco Use	46%	
High Blood Pressure	37%	Top Ten Issues Highlighted
Arthritis	34%	
Heart Conditions	31%	
Obesity	29%	
Cancer	29%	
Alcohol Abuse	29%	
Teen Pregnancy	27%	
Drug Abuse	27%	
Health Problems of the Lungs	21%	
Environmental Issues	14%	
Animal Control	14%	
Diabetes	12%	
Violence in the Home	11%	
STD'S	7%	
Mental Health Problems	7%	
Suicide	5%	
Other Violence	4%	

Percent Saying Definite Problem Cumberland County's Access to Care Issues

Access to Assisted Living Services	7%
Access to Dental Care	6%
Transportation to Health Care	5%
Access to Physicians or Doctors	4%

Access to Hospitals	4%
Access to Prenatal Care	3%
Access to Nursing Home Care	3%
Access to Pharmacies, Medicines	2%
Access to Birth Control Methods	1%

Other Issues to Consider

Tobacco Use

Percent of respondents reporting smoking at least 100 cigarettes in their life:

Yes: 55%

No: 46%

Percent of respondents that report current cigarette use:

Daily Use: 45%

Some Use: 6%

Not At All: 49%

Questions Regarding Mammograms

Percent of women reporting having a mammogram:

Yes: 64%

No: 36%

Reasons reported for not having a mammogram:

Doctor not recommended: 10%

Not needed: 17%

Cost too much: 7%

Too young: 37%

No reason: 23%

Not sure/other: 6%

When was last mammogram performed:

In last year: 75%

1-2 years : 11%

> Than 2 years: 16%

The findings of the survey revealed that the community respondents perceive tobacco use, high blood pressure, heart conditions, obesity, cancer, alcohol use, teen pregnancy, and drug abuse as top health problems facing their county. A local physician noted that he sees an increasing number of younger patients that are being admitted to the hospital for drug and alcohol related treatment. Additionally, the physician noted that approximately 50% of all the patients that he sees are the victims of automobile accidents, which involved alcohol usage.

The council discussed the top three access to care issues viewed as a definite problem by respondents to the survey living in Cumberland County. The access to care issues include access to assisted living services, access to dental care and transportation to health services. The council's perception was that the access to assisted living services may be perceived as a "definite problem" as a result of the increasing retirement population relocating to Cumberland County. In reference to the dental care issue a council member noted that a dentist works three days a week at the Health Department in Cumberland County. The dentist sees patients from this county, but also sees a number of people from surrounding counties. There are future plans of expanding the existing dental services within the local health department. Transportation to existing services is available through TennCare and the Upper Cumberland Human Resource Agency. Both are viable means of transportation in Cumberland County. Additionally, several physicians have relocated to the area which could have a direct result on the shortage designation status.

Secondary Data

Summary of Data Use

Cumberland Health Indicator Trends Using 3-Year Moving Averages

Pregnancy and Birth Data

Data is based on information from the Office of Vital Records, Tennessee Department of Health. All health indicator trends are formatted into three-year moving averages to reflect a trend over the past ten years.

HEALTH INDICATOR	COUNTY TREND	COUNTY COMPARED TO REGION	COUNTY COMPARED TO STATE
1. Number births/1,000 females	Unstable	Below	Below
2. Percent births to unwed women	Increasing	Above	Below
3. Number teenage pregnancies	Decreasing	Above	Below
4. Number pregnancies/1,000 females	Stable	Below	Below
5. Number of pregnancies/1000 females ages 10-14	Unstable	Below	Below
6. Number of pregnancies/1000 females ages 15-17	Stable	Above	Below
7. Number of pregnancies/1000 females ages 18-19	Stable	Above	Below
8. Percent pregnancies to unwed women	Stable	Above	Below
9. Percent of live births classified as low birthweight	Increasing	Above	Above
10. Percent of live births classified as very low birthweight	Unstable	Equal	Below
11. Percent births w/1 or more high risk characteristics	Stable	Above	Above

12. Infant deaths/1,000 births	Stable	Below	Below
13. Neonatal deaths/1,000 births	Stable	Below	Below

In analyzing the pregnancy and birth trends, the council focused on the following trends that showed an increasing indicator:

- Percent of births to unwed women
- Percent of live births classified as low birth weight

Mortality Data

Using information reported by physicians on death certificates, underlying cause of death is coded by staff in Vital Records. The staff uses National Center for Health Statistics rules for assigning codes for underlying cause of death.

14. White male age-adjusted mortality rate/100,000 population	Stable	Below	Below
15. Other races male age-adjusted mortality rate/100,000 population	Unstable	Below	Below
16. White female age-adjusted mortality rate/100,000 population	Increasing	Below	Below
17. Other races female age adjusted mortality rate/100,000 population	Unstable	Below	Below
18. Female breast cancer mortality rate 100,000 women age 40 or more	Decreasing	Below	Below
19. Nonmotor vehicle accidental mortality rate	Decreasing	Below	Below
20. Motor vehicle accidental mortality rate	Increasing	Above	Above
21. Violent death rates/100,000 population	Unstable	Above	Above

The above mortality data shows an increasing trend for:

- White female age adjusted mortality rate/100,000 population.
- Motor vehicle accidental mortality rate.

Morbidity Data

Based on the number of incidence (new cases) which occur for a given disease in a specified time frame and the number of prevalence (existing cases) for a disease in a specified time period.

22. Vaccine preventable disease rate/100,000 population	Unstable	Below	Below
23. Tuberculosis disease rate/100,000 population	Increasing	Below	Below
24. Chlamydia rate/100,000 population	Increasing	Below	Below
25. Syphilis rate/100,000 population	Stable	Below	Below
26. Gonorrhea rate/100,000 Population	Stable	Below	Below

The above morbidity table shows increasing trends for the following:

- Tuberculosis disease rate/100,000 population
- Chlamydia rate/100,000 population

Healthy People 2000 Objectives

In 1991, the Public Health Service of the U.S. Department of Health and Human Services published Healthy People 2000: National Health Promotion and Disease Prevention Objectives. That report was intended to assist both health providers and consumers in addressing measurable targets to be achieved by the year 2000. The data contained in this report addresses health status indicators for births, deaths, selected diseases, and external influences. The following is a comparison of the objectives to Cumberland County. The data used for Cumberland County is based on 1994-96 three year moving averages.

Healthy People 2000 Compared to Cumberland County

Health Status Indicators	Cumberland County Rate	Tennessee Rate	Nation's Rate
Death from all causes	463.9	563.1	No Objective
Coronary Heart Disease	116.3	134.8	100
Deaths from Stroke	27.0	34	20
Deaths of Females from Breast Cancer	16.7	22.4	20.6
Deaths from Lung Cancer	46.7	47.5	42
Deaths from Motor Vehicle Accidents	41.0	23.6	16.8
Deaths from Homicide	3.3	12.1	7.2
Deaths from Suicide	18.2	12.6	10.5
Infant Deaths	5.8	9.6	7.0
Percent of Births to Adolescent Mothers	6.2	6.6	None
Low Birthweight	8.7	8.7	5.0
Late Prenatal Care	18.3	19.9	10.0
Incidence of AIDS	4.1	14.1	-----
Incidence of Tuberculosis	8.2	11.6	3.5

* Three-year cumulative total cases are less than 5.

The indicators that are in bold are Cumberland County's rate's that are above the state's objectives according to Tennessee's Healthy People 2000.

List of Data Sources

TN Department of Health Office of Vital Records
 TN Department of Health Picture of the present, 1997
 TN Department of Health, Health Access
 TN Department of Economic and Community Development
 Upper Cumberland Development District
 Healthy People 2000

Health Issues and Priorities

Community Process

In summary, the Health Indicator Trends that have shown an increasing trend over the past 10 years include:

- **Percent births to unwed women**
- **Percent of live births classified as low birth weight**
- **White female age-adjusted mortality rate/100,000 population**
- **Motor vehicle accidental mortality rate**
- **Tuberculosis disease rate/100,000 population**
- **Chlamydia rate/100,000 population**

In analyzing these trends, the council's awareness of these problems increased dramatically. The findings of the data reveal that in Cumberland County there is a decreasing trend for percent of pregnancies to unwed women and teen-age pregnancies.

After a thorough analysis of all data sets, Behavioral Risk Factor Survey, and Community Health Assessment Survey, the council established priorities among a multitude of problems. The following health priorities and their related recommendations are listed below. In order to ensure that all health problems are addressed in the same way, the council utilized a process that is objective, reasonable, and easy to use. The method that was used sets priorities based on the size and seriousness of the problem in conjunction with the knowledge about the effectiveness of potentially available interventions. All issues were identified through the council's discussion, review of the data, and other related "Data Analysis" in the previous section.

CUMBERLAND COUNTY
Prioritization Table

Top Issues	BRFS	Comm. Quest.	Health Indicator Trends (Secondary Data)
Tobacco Use/Smoking Smokeless Tobacco	1	1 6	In ages 45-64, deaths from malignant neoplasm's have shown a stable trend from 1990 – 1996 with rates equal to the region and above the state. In ages 65+, deaths from malignant neoplasm's show an increasing trend for the same time frame with rates equal the region and below the state. Lung cancer incidence rates for 1995 were 41.2 with the state's rate at 64.2. The numbers of cases reported were 28.
Adult Alcohol Abuse	7	2	In ages 45-64, deaths from chronic liver disease and cirrhosis show a declining trend over from 1988 to 1996 with rates below the region and the state.
High Blood Pressure	2	3 Stress ranked 5th	In ages 45-64, deaths from cerebrovascular disease have shown a decline from 1991 to 1996 with rates below the region and the state. In ages 65+. The rate shows a steady increase over the past 10 years with rates below the region and the state.
Teen Pregnancy	8	4	For 1994-96, the average number of pregnancies ages 10-17 was 34 with the rate at 17.2 ranking Cumberland # 7 in the region with the rate below the state. For 1993-95, the average number of pregnancies ages 10-17 was 35 with the rate at 18.9 ranking Cumberland # 5 in the region with the rate below the state.
Teen Alcohol Abuse/Drug Abuse	7/9 (Addressed total Pop.)	5	In ages 15-24 years, the suicide rate shows a drastic increase over the past 10 years with the 1994-96 rates above the region and the states. In ages 10-19, number of suicides was 2 with the rate at 38.5 and the state's rate at 5.9.
Heart Conditions	4 Obesity 5	7	In ages 25-44, deaths from heart disease show a drastic increase from 1990 to 1996 with rates above the region and the

			state. In ages 45-64, the rates have remained stable and are above the state and the region.
Adult Drug Abuse	9 (Addressed total pop.)	8	
Domestic violence	14	9	
School Dropout	not addressed	9	For 1994-96, the average numbers of dropouts were 74 with the rate below the state, ranking Cumberland #6 in the region. For 1993-95, the average numbers of dropouts were 109 with the rate above the state ranking Cumberland #2 in the region.
Motor Vehicle Deaths	not addressed	9	The Motor Vehicular Death rate has shown a steady increase from 1988-1996 with rates above the state and the region. The number of deaths for 1994-96 averages 14 for each year.

Cumberland County Priorities

To ensure the accuracy of the council's ranking, the prioritization table provided a means of comparison of all top issues addressed. After reviewing and analyzing all primary and secondary data and open discussion among the health council members, the members scored and ranked the top issues.

Score and Rank Process

Consider the following:

Size: This reflects the percentage of the local population affected by the problem.

The largest percentage will be ranked 1.
The smallest percentage will be ranked 10.

Seriousness: The most serious problem will be ranked 1.
The least serious problem will be ranked 10.

What is the emergent nature of the health problem? Is there an urgency to intervene? Is there public concern? Is the problem a health problem?

What is the severity of the problem? Does the problem have a high death rate? Does the problem cause premature morbidity or mortality?

Is there actual or potential economic loss associated with the health problems? Does the health problem cause long term illness? Will the community have to bear the economic burden?

What is the potential or actual impact on others in the community?

STEP 1: Assign a rank for size.

1 being the highest rank (the largest percentage)
10 being the lowest rank (the smallest percentage)

Assign a rank for seriousness.

1 being the most serious
10 being the least serious

STEP 2: Add size and seriousness

STEP 3: The final rank will be determined by assessing the totals. The lowest total will have a final rank of 1 and the highest total will have a final rank of 10.

The council then scored and ranked the top issues.

TOP ISSUES

- 1) Teen Alcohol Abuse/Drug Abuse
- 2) Tobacco /Smoking/Smokeless Tobacco
- 3) Adult Alcohol Abuse
- 4) High Blood Pressure
- 5) Domestic Violence
- 6) Heart Condition
- 7) Teen Pregnancy
- 8) School Dropout
- 9) Adult Drug Abuse
- 10) Motor Vehicle Deaths

There was much discussion regarding the number one issue of Teen Alcohol/Drug Abuse. The motion was made, seconded and passed to address Teen Alcohol/Drug Abuse as the council's number one priority.

Future Planning

Through the Community Diagnosis Process, it was determined that the top issue of concern was Teen Alcohol/Drug Abuse for Cumberland County. The future plans of the Cumberland County Health Council are to go through the action steps.

Taking Action Outline

The *Taking Action* cycle is a systematic approach to problem solving. There are five phases of the cycle:

A	Phase 1	<u>A</u> ssess the Situation
C	Phase 2	Determine <u>C</u> auses
T	Phase 3	<u>T</u> arget Solutions
I	Phase 4	Design <u>I</u> mplementation
ON	Phase 5	Make it <u>O</u> ngoing

Phase 1 Assess the Situation

- Identifying priority health issue.
- Answering the question, “How does the priority health issue affect your community?”
- Writing mission statement based on answers to questions.
- Making decision to pursue health-related concern or to select another ingredient to work on.
- Listing community resources that could be applied to the priority health issue.
- Developing answers to the following questions:
 - Who** are the people/group being targeted?
 - What** do they need?
 - Where** do they need it?
 - When** is it needed?
- Identifying additional data and ways to gather information.

Phase 2 Determine Causes

- Reviewing who, what, where, and when for current health concerns and introduction to the “why”.
- Discussing possible causes and the difference between a cause and a symptom.
- Listing causes of the problem, grouping them, and identifying the ones that are creating the problem issue.
- Identifying additional data that may be needed from the target group.

Phase 3 **T**arget Solutions and Ideas

- Targeting a solution.
- Identifying potential solutions that offer the greatest benefit for the causes.
- Listing possible barriers to the solution and actions to correct them.
- Developing criteria for a good solution.
- Revising the health-related concern into a problem statement which includes the health-related concern, the target population, the cause(s), and the solution or plan of action.

Phase 4 Design **I**mplementation, the Action Plan

- Setting goals and objectives.
- Forming work groups for the following categories: community partners, equipment needs, time lines, marketing plan, and staff needs/training.
- Presenting group/committee reports.
- Finalizing content of the categories.
- Restating goals and objectives.
- Forming budget group.

Budget revisions and final approval of *Action Plan*.

Phase 5 Make it **O**ngoing.

- Forming committees for:
Evaluation
Development/Sustainability
Strategies for short and long term funding options.

Appendices

Appendix 1

Council Makeup

Cumberland County Health Council

Kimberly Freeland
Regional Health Office
200 West 10th Street
Cookeville, TN 38501
Ron Blaylock: Family Resource
756 Stanley Street
Crossville, TN 38555

Bobby Edwards: Youth Services Officer
2 North Main Street, Suite 103
Crossville, TN 38555
Louise Gorenflo: Rural Cumberland
Resources
185 Hood Drive
Crossville, TN 38555
Pat Ball, RN: School Nurse
396 Meadow Creek
Crossville, TN 38555

Carolyn Isbell
The Stephens Center
403 University Street
Livingston, TN 38570
Linda Faye Guy: Family Support Network,
Developmental Disability
6434 Lantana Road
Crossville, TN 38555
Andy Langford, County Health Department
Director
Cumberland County
J.C. Dunn: Volunteer Juvenile Court
248 Bradrock Street
Crossville, TN 38555
Carissa Lockhart
The Stephens Center
403 University Street
Livingston TN 38570

Andrea Simmons
Cumberland County High School
660 Stanley Street
Crossville, TN 38555
Dianna Daugherty, RN, CEN
Cumberland Medical Center
811 South Main Street
Crossville, TN 38555
Butch Burgess: Dare Officer
9964 Vandever Road
Crossville, TN 38555
Jody Hughes: Battered Women
P.O. Box 3063
Crossville, TN 38555

Loretta Stults: Community Volunteer
First United Methodist Church
26 Church Street
Crossville, TN 38555
Barbara Galliher
Cumberland Good Samaritan
P.O. Box 89
Crossville, TN 38555
Jo Thurman
Cumberland County Health Department

Sue Cox, UT Ag. Extension
P.O. Box 483
Crossville, TN 38555
Sherry Crum: Cumberland County Health
Department

Sandy Allen
Quality Home Health
P.O. Box 697
Jamestown, TN 38556

Jeff Wallace
Crossville Elementary
368 4th Street
Crossville, TN 38555
Brock Hill: Chairperson
Regional Health Council Rep.
County Executive
2 North Main Suite 203
Crossville, TN 38555
Ed Anderson: Administrator
Cumberland Medical Center
421 South Main Street
Crossville, TN 38555
Barry Wagner M.D. Physician
Cumberland Medical Center
421 South Main Street
Crossville, TN 38555
John Buck: Director
Uplands Retirement Village
P.O. Box 168
Pleasant Hill, TN 38578
Rena Davis: Prevention Coordinator
Plateau Mental Health Center
P.O. Box 3165
Cookeville, TN 38501
Dan Richardson: Physician's Office
Dr. Larry Patterson
220 Lantana Road
Crossville, TN 38555
Charlene Hall: Coordinator GPI
FAST Program
584 Hwy 70 East
Crossville, TN 38555
Rev. David Allen: Ministerial Association
105 Meadow Drive
Crossville, TN 38555
Alice Gunderson: Retirement Community
28 Brixton Lane
P.O. Box 2085
Fairfield Glade, TN 38557
Billie Hammond : Retired Community
224 Ridgewood Drive
Crossville, TN 38555

Scott Hull: FAST
584 Hwy 70 East
Crossville, TN 38555

John Hall: Fire Chief
Route 13 Box 510
Crossville, TN 38557

Howard Stubbs: Minority (Schools)
3836 Highway 127 South
Crossville, TN 38555

Jan Boston Sellers: Teens Against Drugs
125 Peace Pipe
Crossville, TN 38555

Charlotte Putts: Headstart
Crossville Headstart
2113 West Creston Road
Crossville, TN 38555

Trudy Brown: Community Volunteer
P.O. Box 371
Pleasant Hill, TN 38578

Tracy Hyder: Crossville Housing
Route 12 Box 226
Crossville, TN 38555

Delano Thompson: County Commissioner
Route 7 Box 172-D
Crossville, TN 38555

Jeff Reeves: First Baptist Church
19 Chief Daybreak
Crossville, TN 38555

Karen Randall: Community Volunteer
P.O. Box 3775
Crossville, TN 38555

Don Hassler: Truancy Officer
Route 6 Box 86
Crossville, TN 38555

Margaret Hoyt
Crossville Housing Authority
67 Irwin Avenue
Crossville, TN 38555
Linda Rubino
UT Extension
P.O. Box 483
Crossville, TN 38555
Becky Hawks: Tennessee Dept. of Health
Cordell Hull Building 4th Floor
425 5th Avenue North
Nashville, TN 37247
Hazel Hulebard
Cumberland County Sheriff's Department
90 Justice Center Drive
Crossville, TN 38555

Ray Mays: Office Manager, Doctor's
Office
125 Brown Avenue
Crossville, TN 38555
Cheryl Gibbs
VORP
15 Division Drive
Crossville TN 38555

Angie Beaty
American Cancer Society
508 State Street
Cookeville, TN 38501
Wendy Dunn
Care More Associates, Inc.
129 Frazier Road
Crossville, TN 38555
Kellie Roberson Moore
TNCEP
P.O. Box 483
Crossville, TN 38555
David Massengil
VORP
15 Division Drive
Crossville, TN 38555

Lisa Phillips
Family Resource Center
756 Stanley Street
Crossville, TN 38555
Joann Fraser: Dietician
Hill Toppers
14 Oakburn
Crossville, TN 38555

Appendix 2

BY LAWS FOR CUMBERLAND COUNTY HEALTH COUNCIL

ARTICLE I. NAME

The name of this organization shall be CUMBERLAND COUNTY HEALTH COUNCIL (hereafter referred to as “COUNCIL”) and will exist within the geographic boundaries of Cumberland County, Tennessee. The council shall exist as a non-incorporated, not-for-profit, voluntary membership community service organization.

ARTICLE II. MISSION

The Cumberland County Health Council is to act as an independent advisory organization whose purpose is to facilitate the availability, accessibility and affordability of quality health care within the Upper Cumberland Tennessee Public Health Region.

ARTICLE III. GOALS

The goals of the Council are to assess the present and future health care needs of the Cumberland County community and to examine the available health care, economic, political and social resources therein which may be coordinated and developed to address unmet health care needs, improve existing services, and solve specific health care problems within the community. From its analysis, the Council will: (1) formally define health care problems and needs within the community, (2) develop goals, objectives and plans of action to address these needs, and (3) formally identify all resources which are available to affect solutions.

ARTICLE IV. OFFICERS

Section 1: Officers

The officers of the council shall consist of the Chairman and Vice-Chairman.

Section 2: Chairman

The Chairman will be elected by majority vote of the Council from nominees among its members. The Chairman will preside over all meetings of the Council and will set the agenda for each meeting.

Section 3: Vice-Chairman

The Vice-Chairman will be selected by majority vote of the Council from nominees among its members. The Vice-Chairman will preside in the absence of the Chairman and assume duties by the Chairman.

Section 5: Term of Office

Officers shall be elected at the meeting in or following July of each year for a term of one year. Officers may be re-elected to serve additional terms.

ARTICLE V. MEMBERS

The Council shall consist of no less than ___ nor more than ___ members. Membership in the Council shall be voluntary and selected by the Board Directors. The Board of Directors will be composed of the current elected officers of the Council. The Council shall consist of an adequate number of voting members as to be effectively representative of all segments of the community. When a member misses three (3) unexcused consecutive meetings or six (6) meetings in a calendar year, the member will receive a notice from the chairperson regarding removal from council. Leaders in the areas of health care, finance, business, industry, civic organizations, social welfare organizations, advocacy groups, and government may be invited to serve. The Council shall also invite the membership of health care consumer representatives from diverse socioeconomic backgrounds.

ARTICLE VI. MEETINGS

Section I: Regular Meetings

The Council will conduct regularly scheduled meetings, at intervals of no less than once every two (2) months, to be held at a time and place specified by the Council Chairman.

Section 2: Special Meetings

The Council Chairman may call a special meeting, as desired appropriate, upon five days written notice to the membership.

Section 3: Quorum

A quorum shall consist of a majority of voting members present at the Council meeting.

ARTICLE VII. COMMITTEES

The Council may establish such standing or special committees as deemed appropriate for the conduct of its business. Committee membership will be assigned by the Chairman

and may consist of both Council members and other concerned individuals who are not members of the Council.

ARTICLE VIII: APPROVAL AND AMENDMENTS

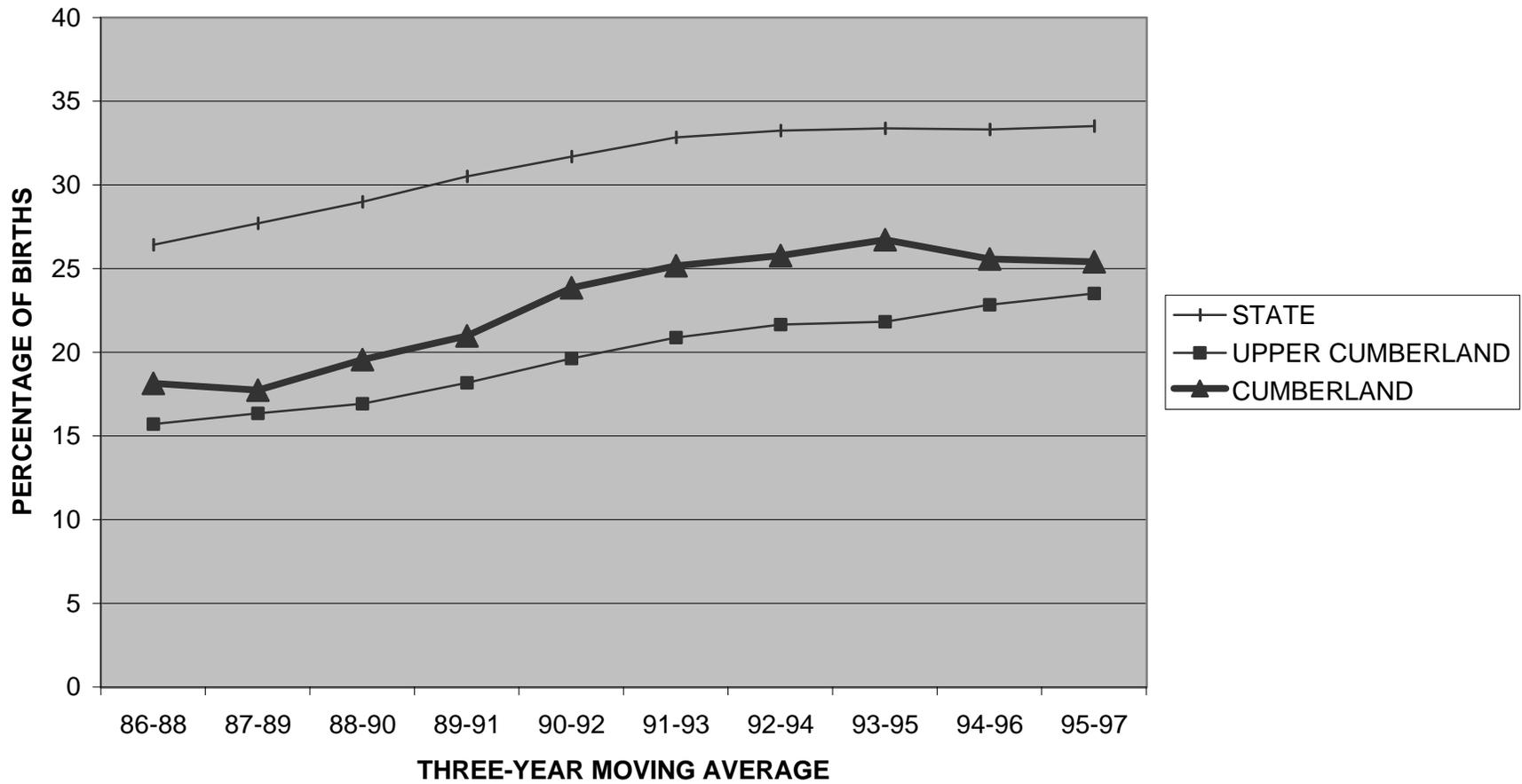
These Bylaws will become effective upon approval by a majority vote of the membership of the Council. Thereafter, these Bylaws may be amended or repealed at any regular or special meeting called for the purpose by a majority vote of the voting members present, provided that the proposed additions, deletions or changes have been submitted in writing to all Council members not less than thirty (30) days prior to the meeting at which formal action on such amendments are sought.

Appendix 3

Pregnancy and Birth Data

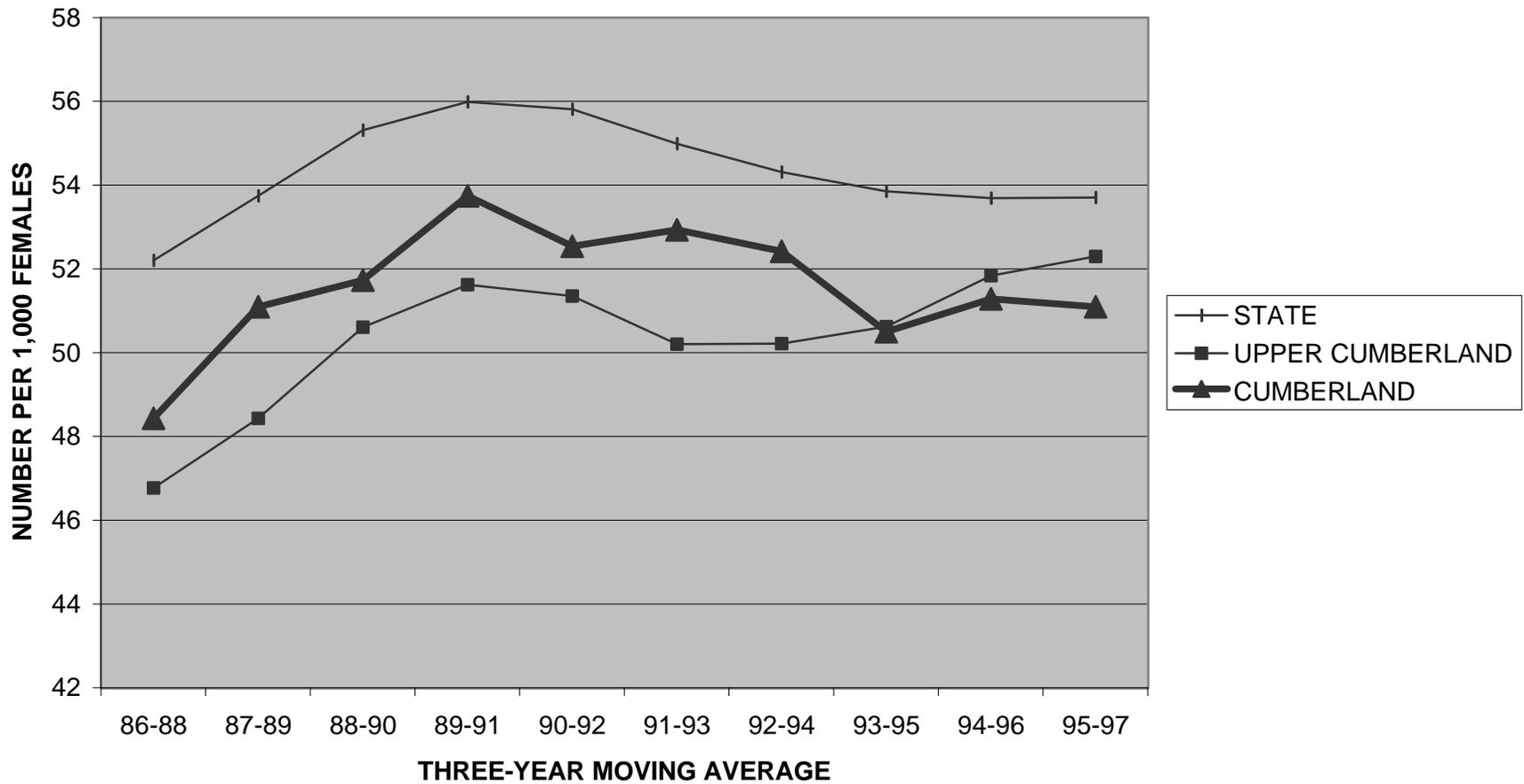
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	26.4	27.7	29.0	30.5	31.7	32.8	33.2	33.4	33.3	33.5
UPPER CUMBERLAND	15.7	16.4	16.9	18.2	19.6	20.9	21.7	21.8	22.9	23.5
CUMBERLAND	18.1	17.7	19.6	21.0	23.8	25.2	25.8	26.7	25.6	25.4

PERCENTAGE OF LIVE BIRTHS TO UNWED MOTHERS AGES 10-44



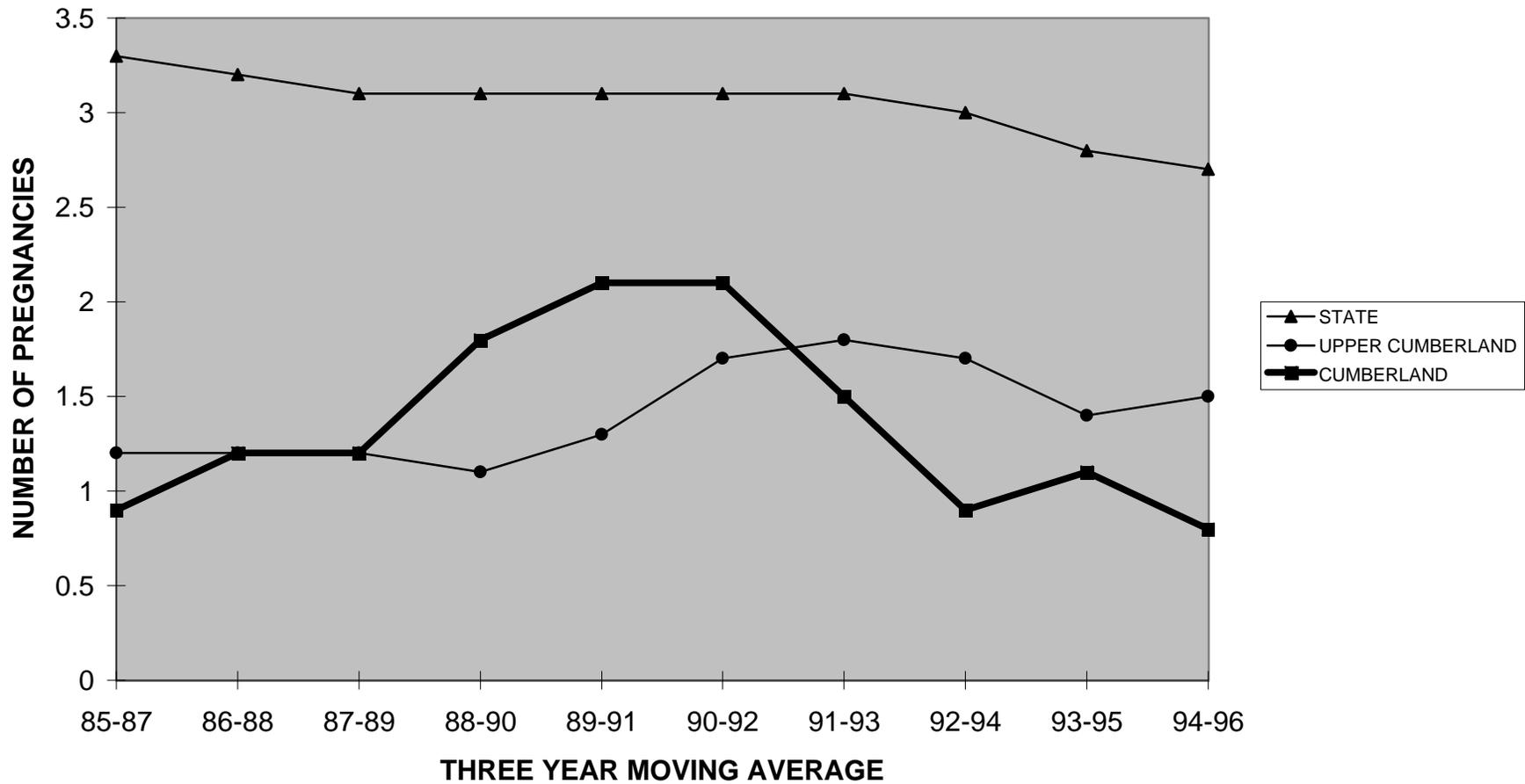
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	52.2	53.7	55.3	56.0	55.8	55.0	54.3	53.9	53.7	53.7
UPPER CUMBERLAND	46.8	48.4	50.6	51.6	51.4	50.2	50.2	50.6	51.8	52.3
CUMBERLAND	48.4	51.1	51.7	53.7	52.5	52.9	52.4	50.5	51.3	51.1

NUMBER OF LIVE BIRTHS PER 1,000 FEMALES AGES 10-44



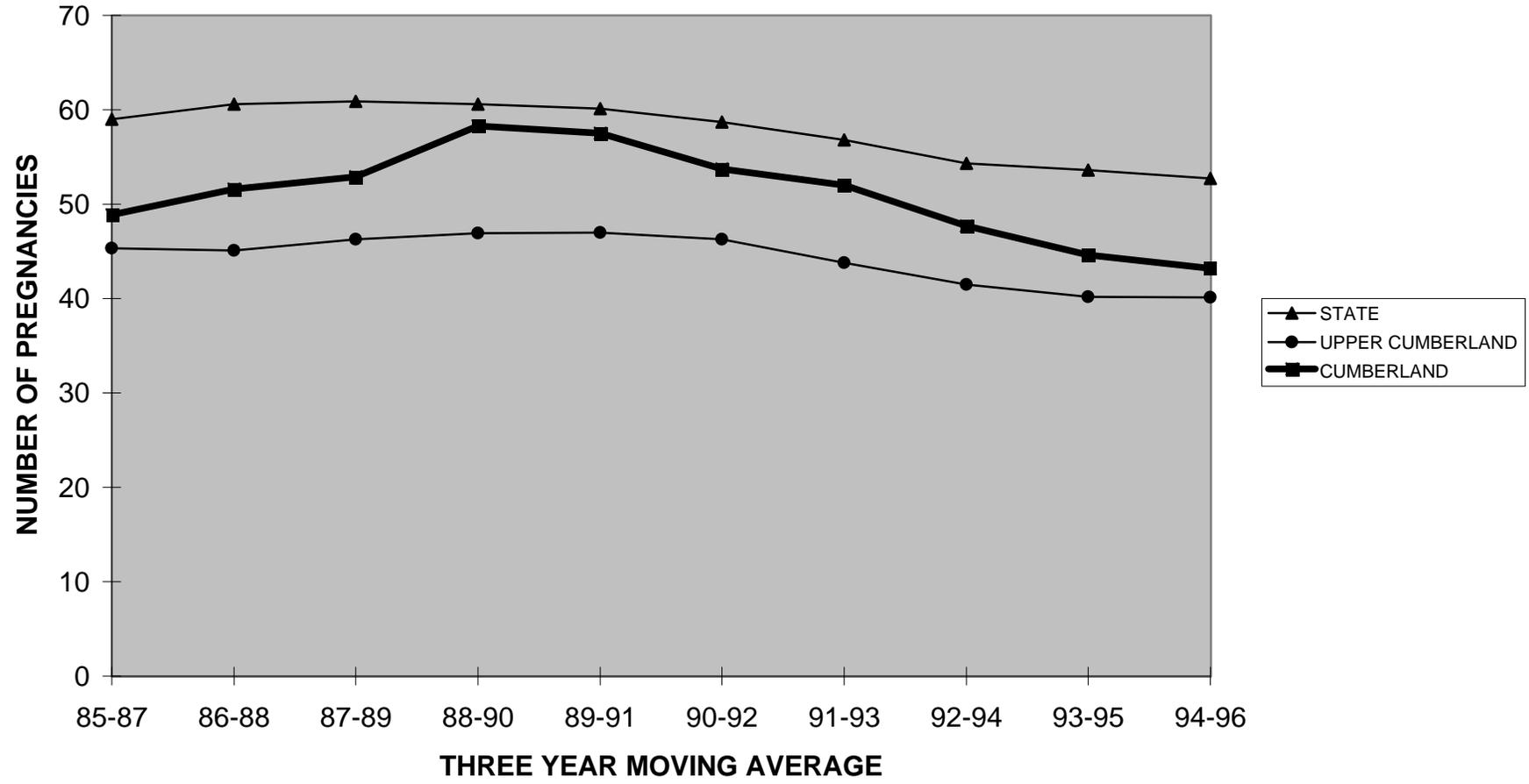
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	3.3	3.2	3.1	3.1	3.1	3.1	3.1	3	2.8	2.7	
UPPER CUMBERLAND	1.2	1.2	1.2	1.1	1.3	1.7	1.8	1.7	1.4	1.5	
CUMBERLAND	0.9	1.2	1.2	1.8	2.1	2.1	1.5	0.9	1.1	0.8	

NUMBER OF PREGNANCIES PER 1,000 FEMALES AGES 10-14



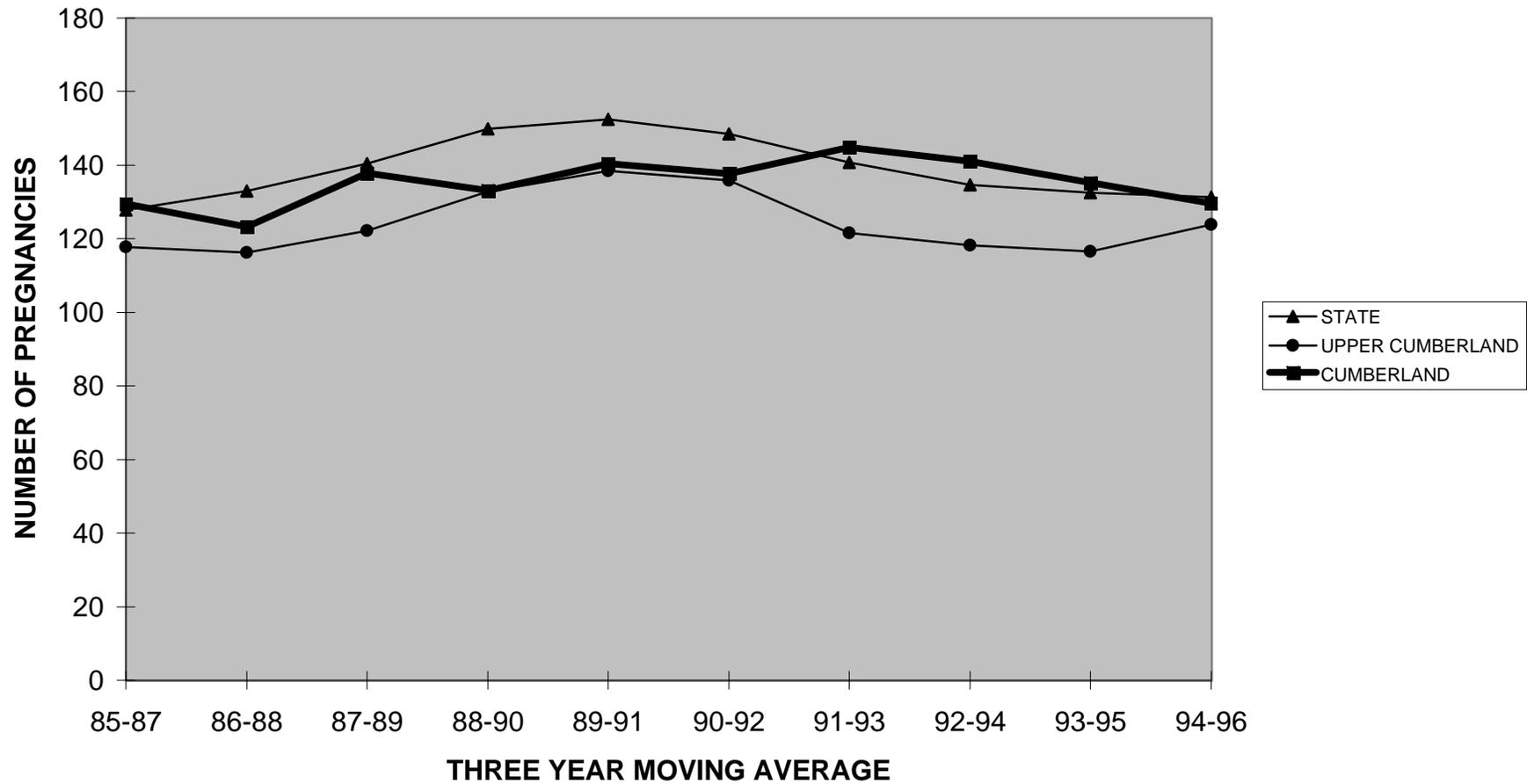
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	59	60.6	60.9	60.6	60.1	58.7	56.8	54.3	53.6	52.7	
UPPER CUMBERLAND	45.3	45.1	46.3	46.9	47	46.3	43.8	41.5	40.2	40.1	
CUMBERLAND	48.9	51.6	52.9	58.3	57.5	53.7	52	47.7	44.6	43.2	

NUMBER OF PREGNANCIES PER 1,000 FEMALES AGES 15-17



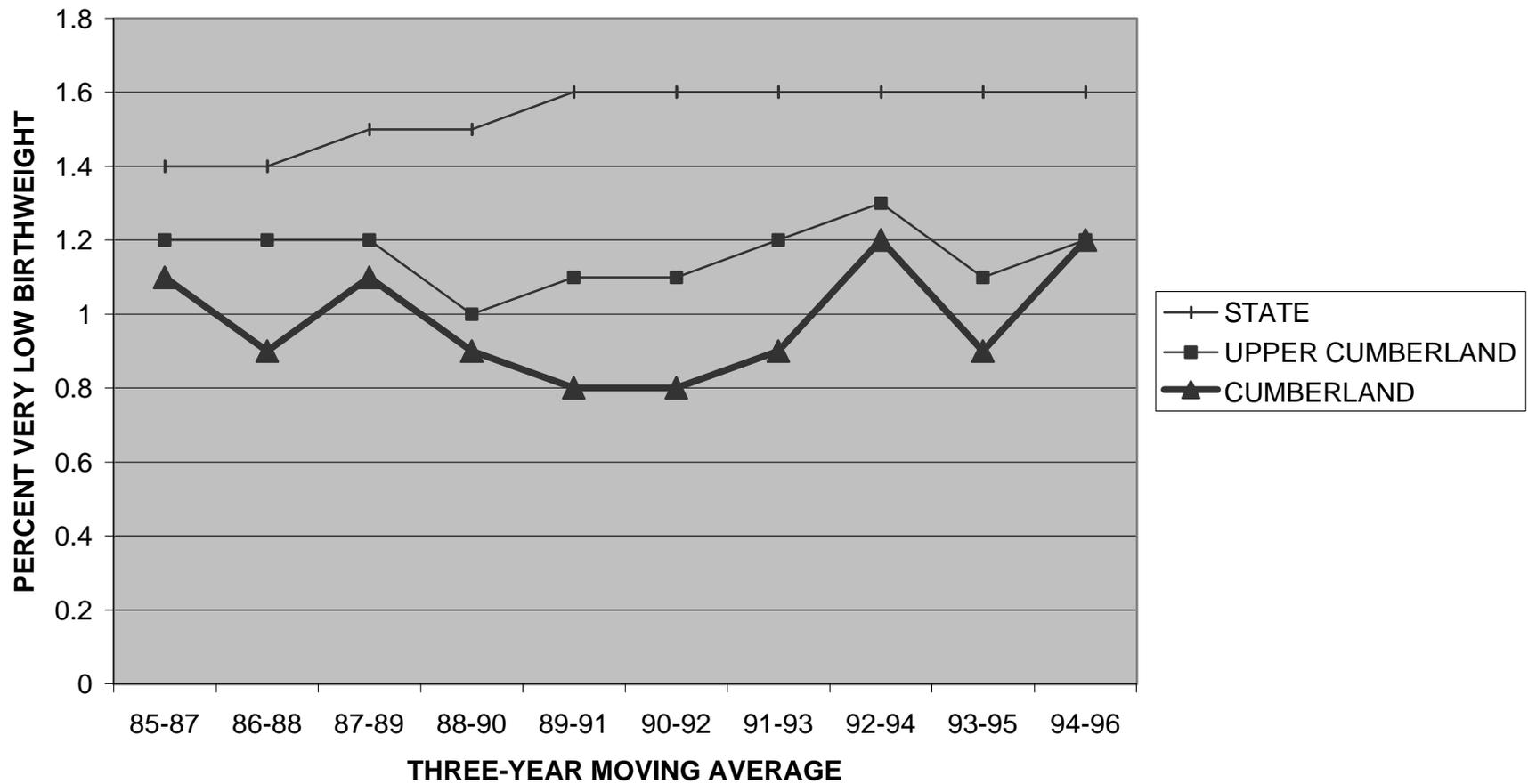
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	127.8	133	140.4	149.8	152.5	148.5	140.7	134.7	132.6	131.3	
UPPER CUMBERLAND	117.8	116.2	122.2	132.8	138.4	135.8	121.5	118.2	116.5	123.8	
CUMBERLAND	129.5	123.3	137.8	133.1	140.5	137.7	144.9	141.1	135.3	129.6	

NUMBER OF PREGNANCIES PER 1,000 FEMALES AGES 18-19



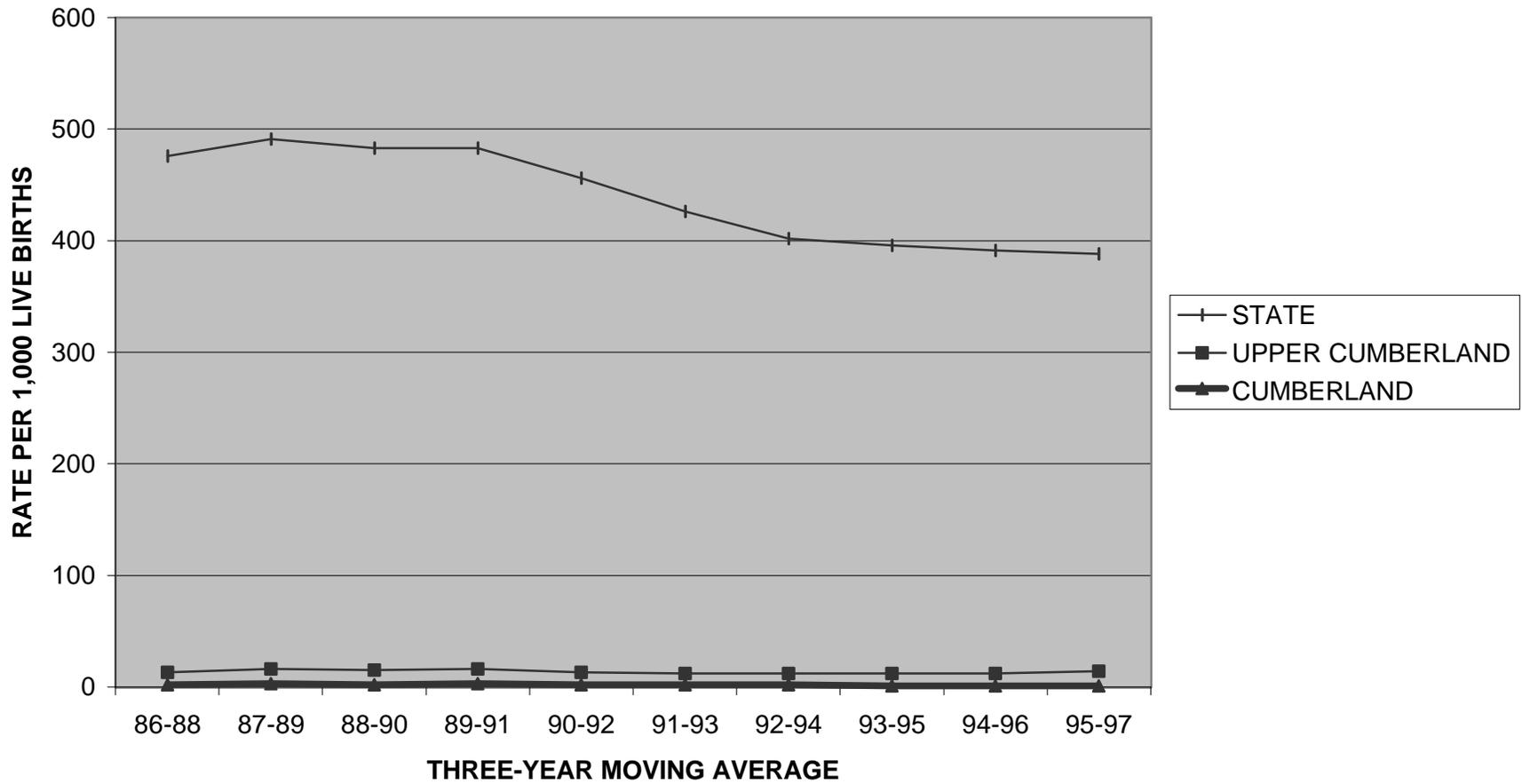
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96
STATE	1.4	1.4	1.5	1.5	1.6	1.6	1.6	1.6	1.6	1.6
UPPER CUMBERLAND	1.2	1.2	1.2	1	1.1	1.1	1.2	1.3	1.1	1.2
CUMBERLAND	1.1	0.9	1.1	0.9	0.8	0.8	0.9	1.2	0.9	1.2

PERCENT OF LIVE BIRTHS CLASSIFIED AS VERY LOW BIRTHWEIGHT, AGES 10-44



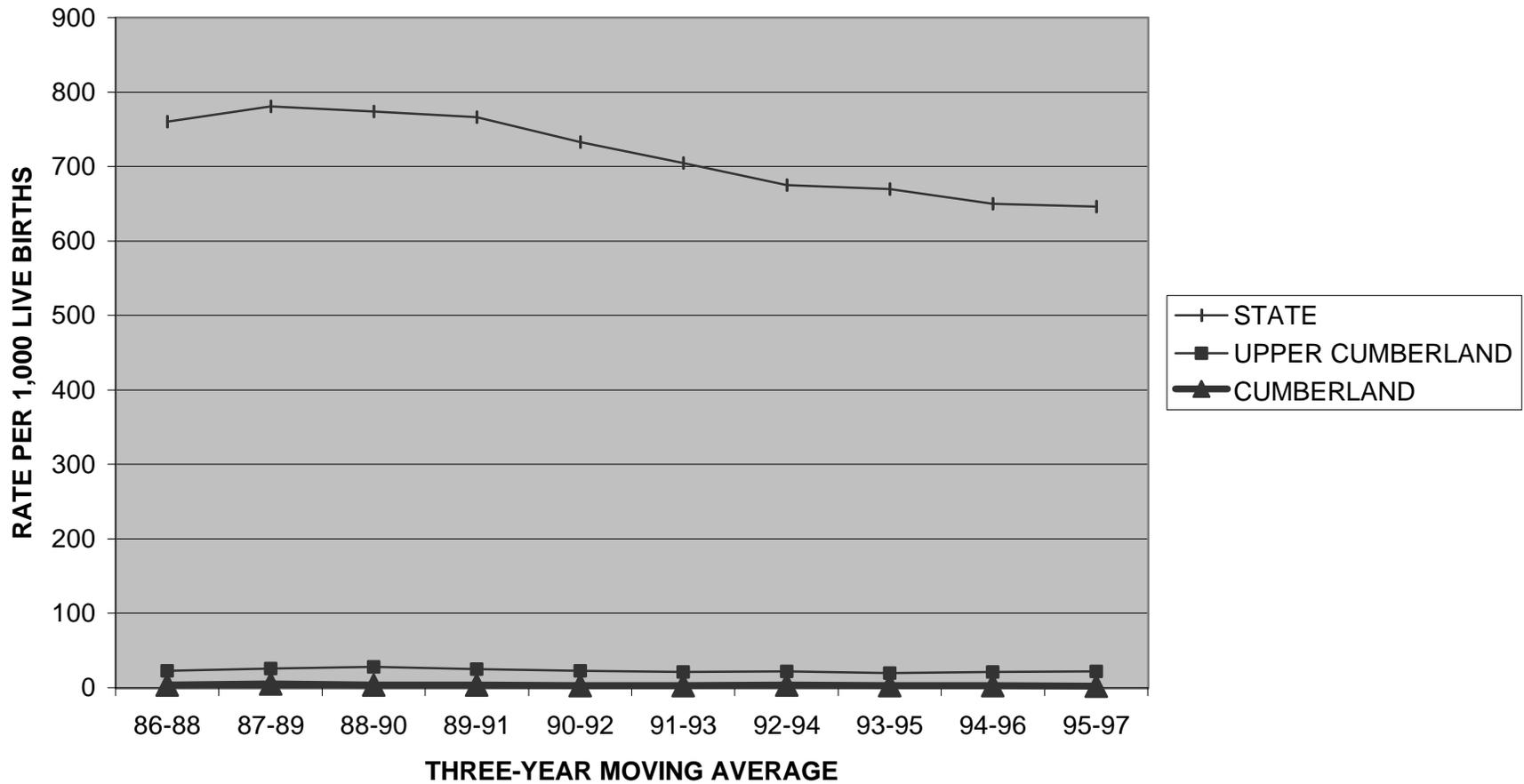
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	476	491	483	483	456	426	402	396	391	388	
UPPER CUMBERLAND	13	16	15	16	13	12	12	12	12	14	
CUMBERLAND	2	3	2	3	2	2	2	1	1	1	

NEONATAL DEATHS PER 1,000 LIVE BIRTHS



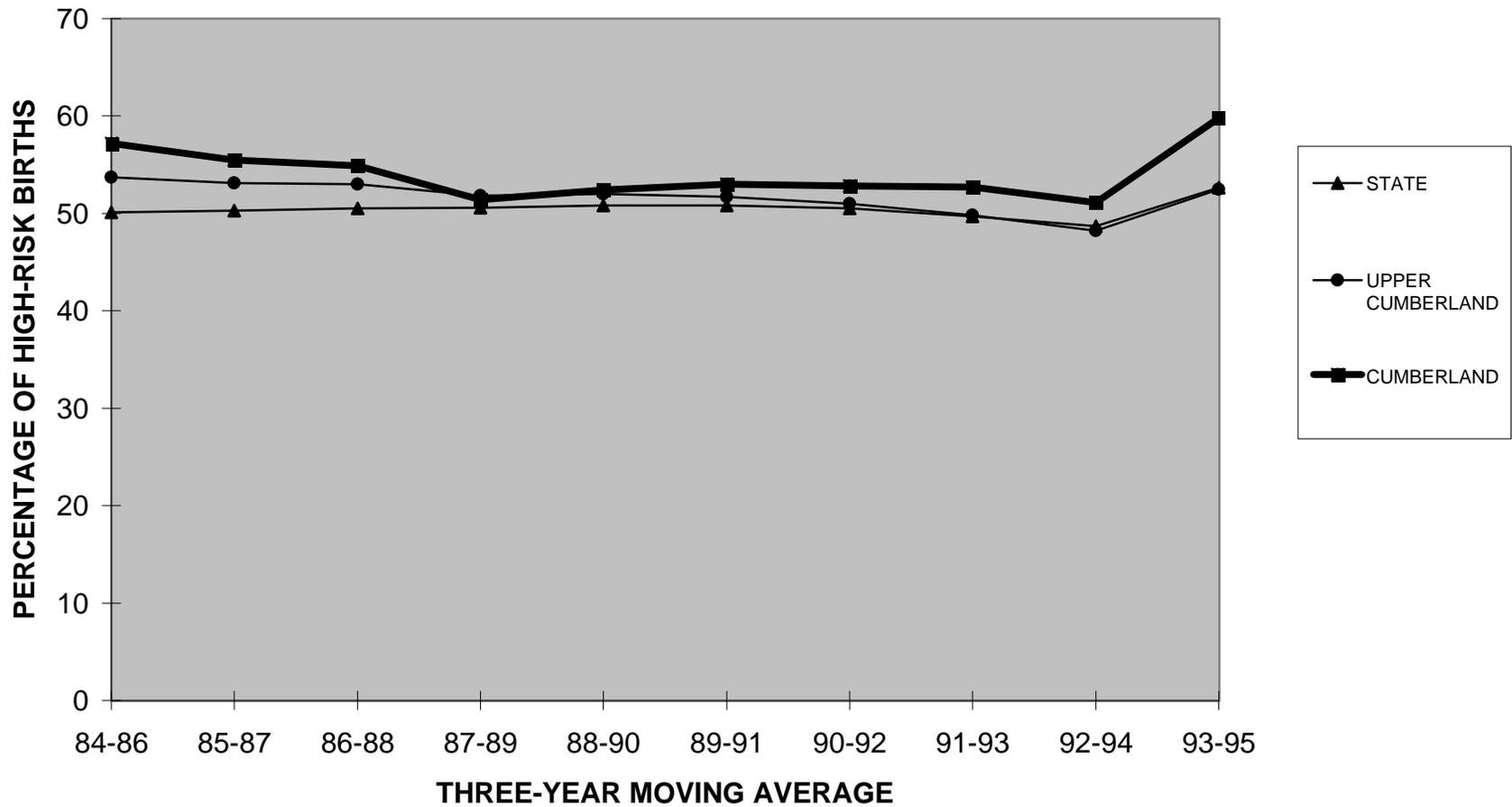
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	760	781	774	766	733	705	675	670	650	646	
UPPER CUMBERLAND	23	26	28	25	23	21	22	20	21	22	
CUMBERLAND	4	5	4	4	3	3	4	3	3	2	

INFANT DEATHS PER 1,000 LIVE BIRTHS



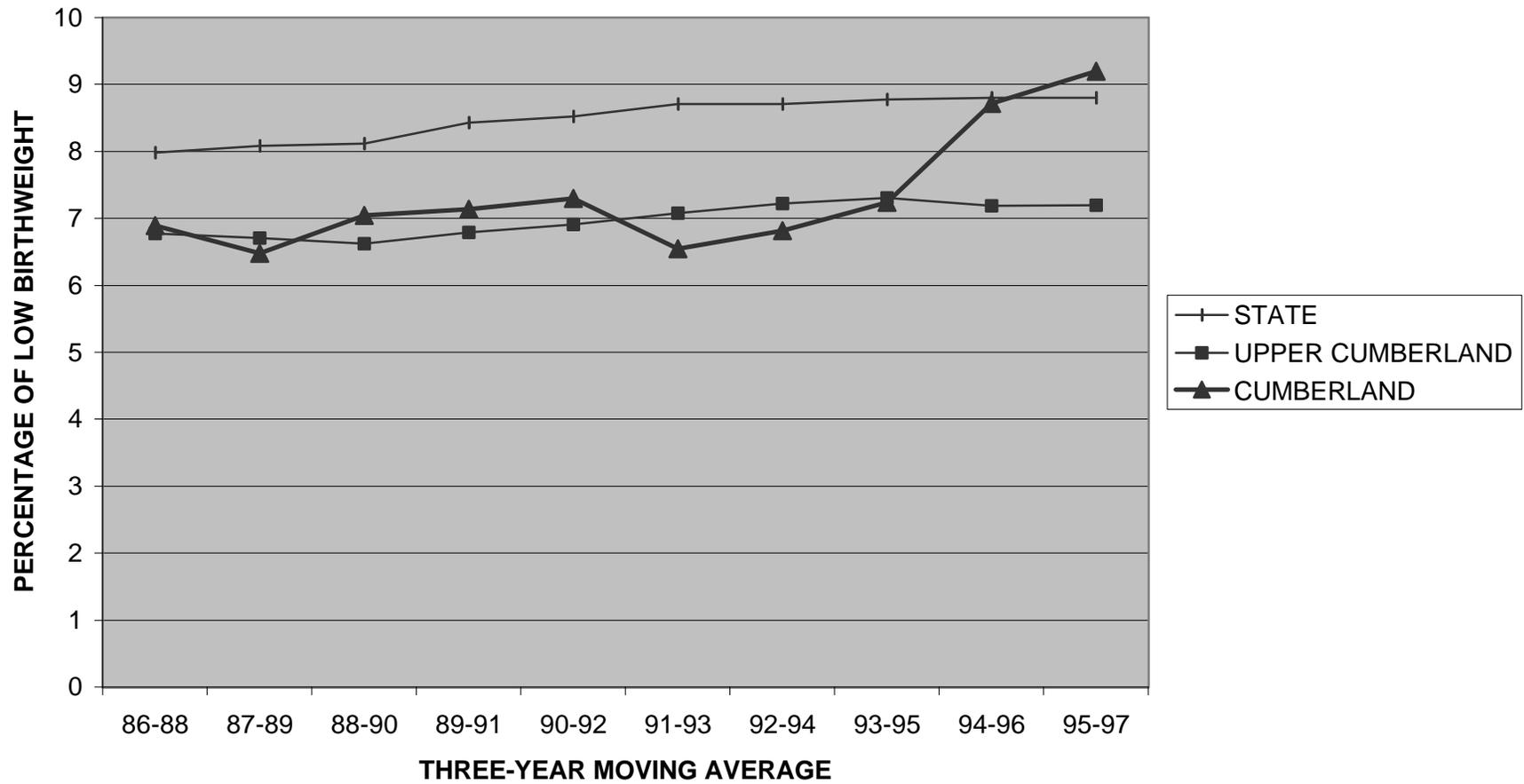
	84-86	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	
STATE	50.1	50.3	50.5	50.6	50.8	50.8	50.5	49.7	48.7	52.6	
UPPER CUMBERLAND	53.7	53.1	53	51.8	52	51.7	51	49.8	48.2	52.5	
CUMBERLAND	57.2	55.5	54.9	51.4	52.4	53	52.8	52.7	51.1	59.8	

PERCENTAGE OF BIRTHS WITH ONE OR MORE HIGH-RISK CHARACTERISTICS*



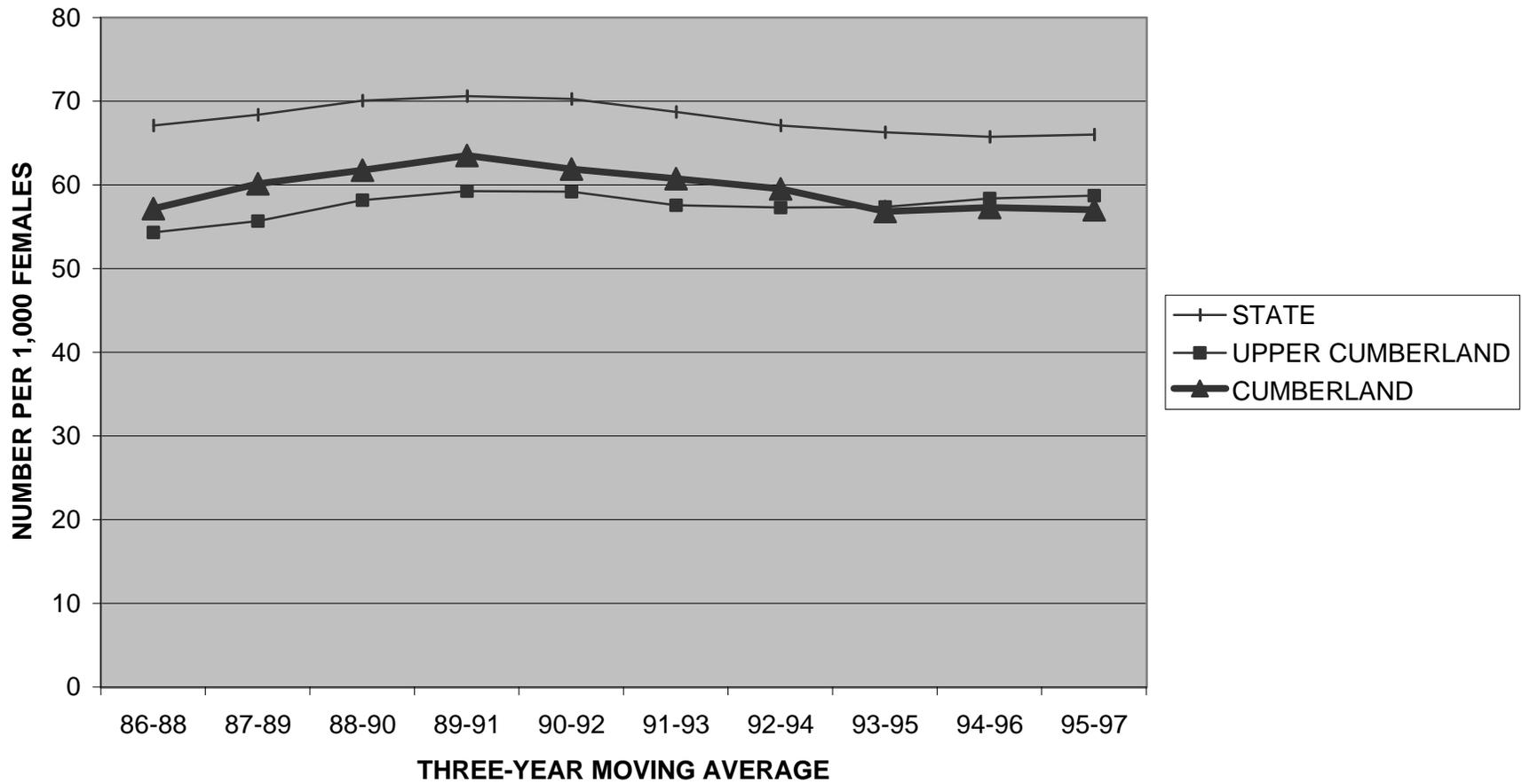
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	8.0	8.1	8.1	8.4	8.5	8.7	8.7	8.8	8.8	8.8	
UPPER CUMBERLAND	6.8	6.7	6.6	6.8	6.9	7.1	7.2	7.3	7.2	7.2	
CUMBERLAND	6.9	6.5	7.0	7.1	7.3	6.5	6.8	7.2	8.7	9.2	

PERCENTAGE OF BIRTHS WHICH WERE LOW BIRTHWEIGHT



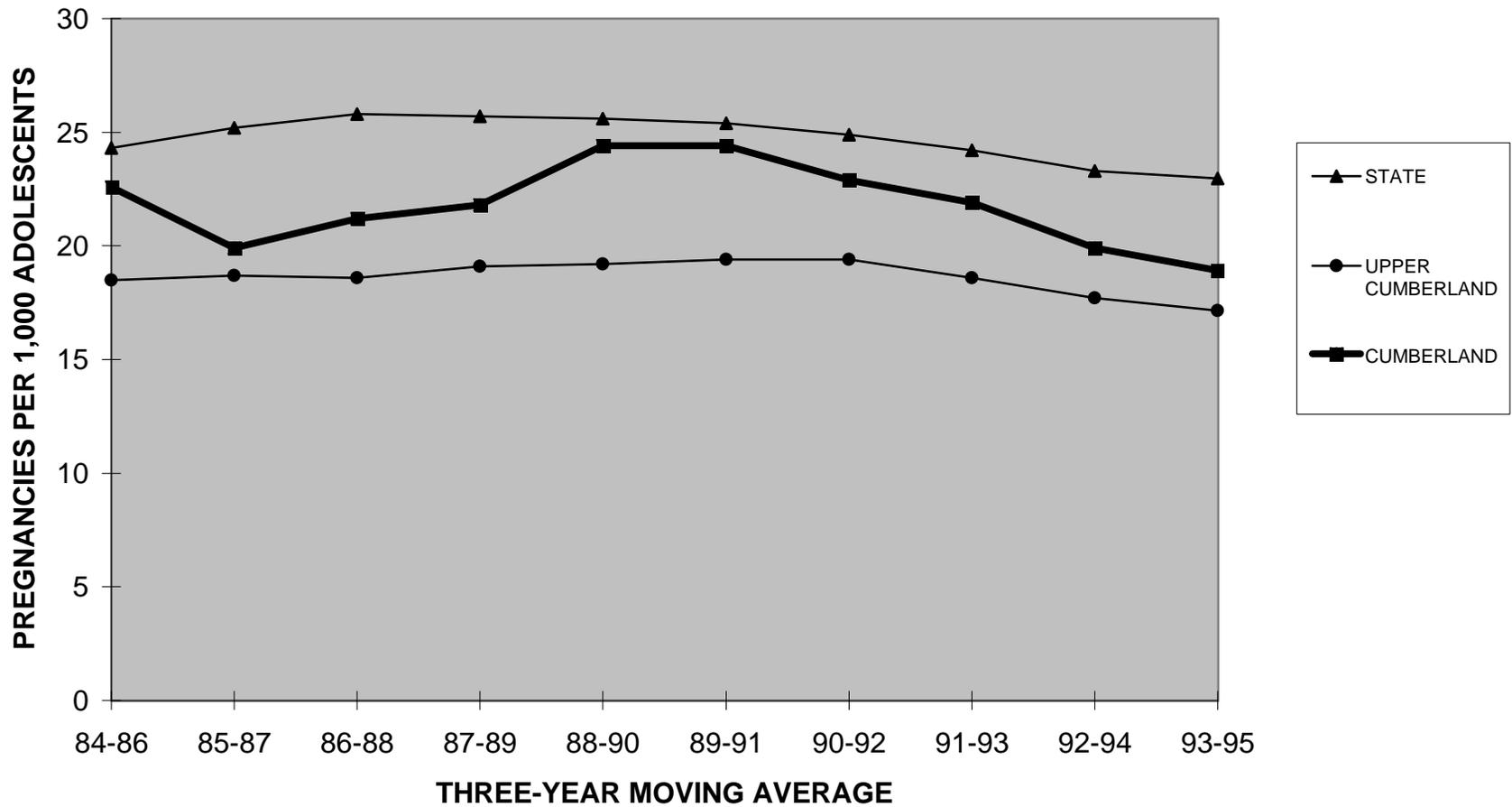
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	67.1	68.4	70.1	70.6	70.3	68.7	67.1	66.3	65.8	66.0	
UPPER CUMBERLAND	54.3	55.6	58.2	59.2	59.2	57.6	57.3	57.4	58.4	58.7	
CUMBERLAND	57.1	60.2	61.8	63.5	61.9	60.7	59.5	56.8	57.3	57.0	

NUMBER OF PREGNANCIES PER 1,000 FEMALES AGES 10-44



	84-86	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	
STATE	24.3	25.2	25.8	25.7	25.6	25.4	24.9	24.2	23.3	23.0	
UPPER CUMBERLAND	18.5	18.7	18.6	19.1	19.2	19.4	19.4	18.6	17.7	17.2	
CUMBERLAND	22.6	19.9	21.2	21.8	24.4	24.4	22.9	21.9	19.9	18.9	

TOTAL NUMBER OF TEENAGE PREGNANCIES PER 1,000 FEMALES AGES 10-17

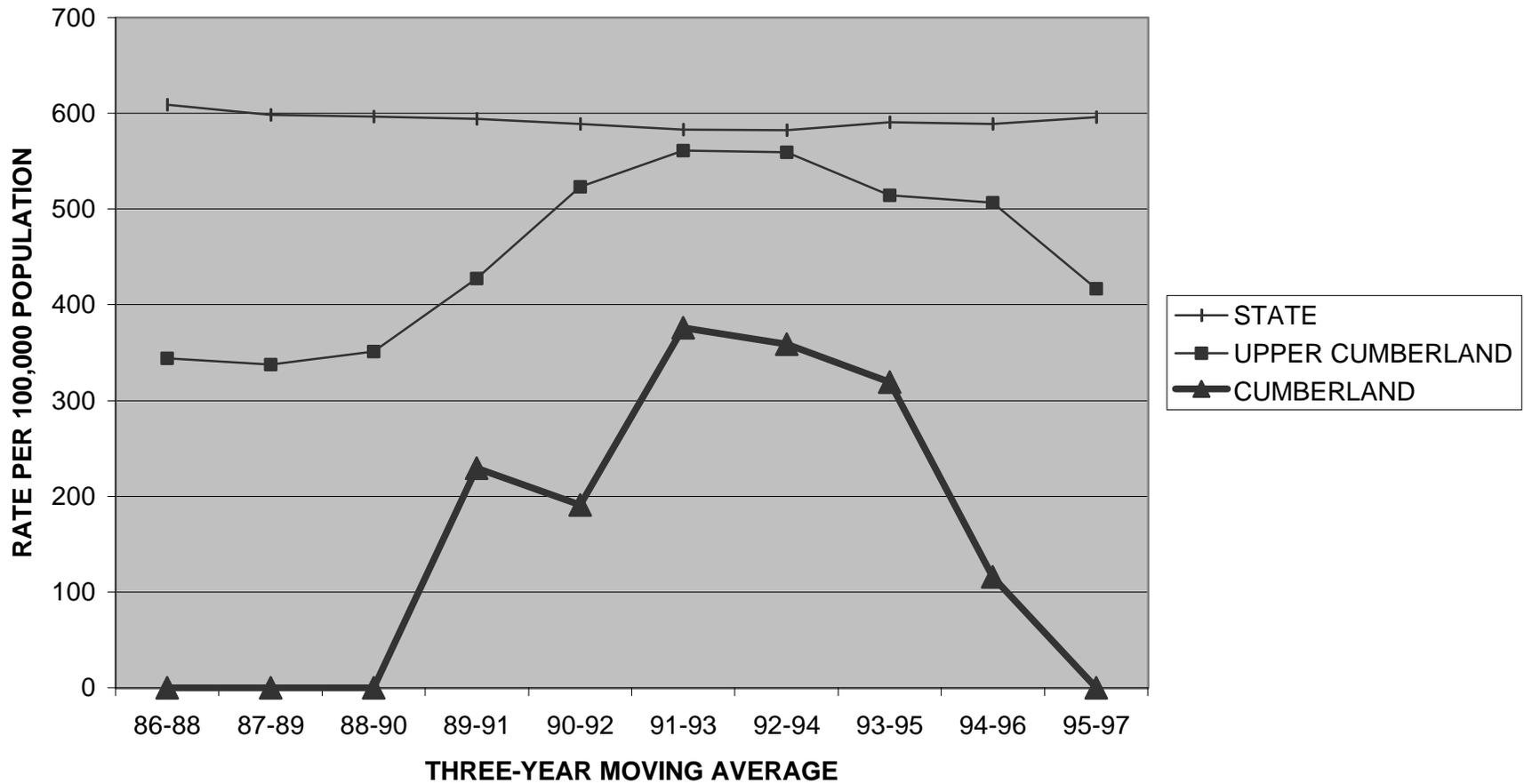


Appendix 4

Mortality Data

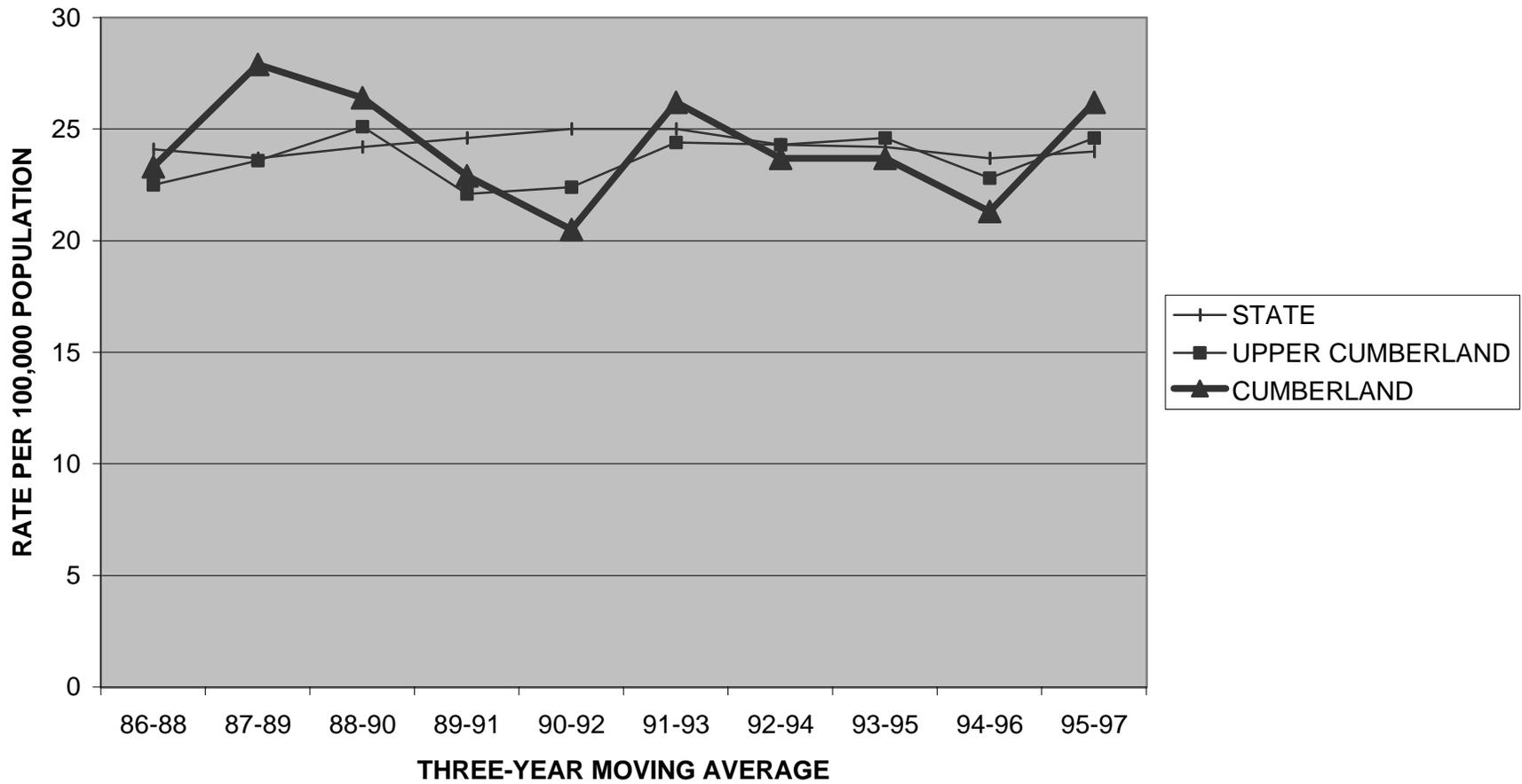
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	608.9	598.3	596.8	594.4	588.8	582.7	582.2	590.6	588.7	595.7	
UPPER CUMBERLAND	344.0	337.6	351.2	427.2	523.4	560.8	559.5	514.1	506.7	416.7	
CUMBERLAND	0.0	0.0	0.0	229.4	191.2	375.9	358.7	319.4	116.0	0.0	

OTHER RACES FEMALE AGE-ADJUSTED MORTALITY RATE PER 100,000 POPULATION



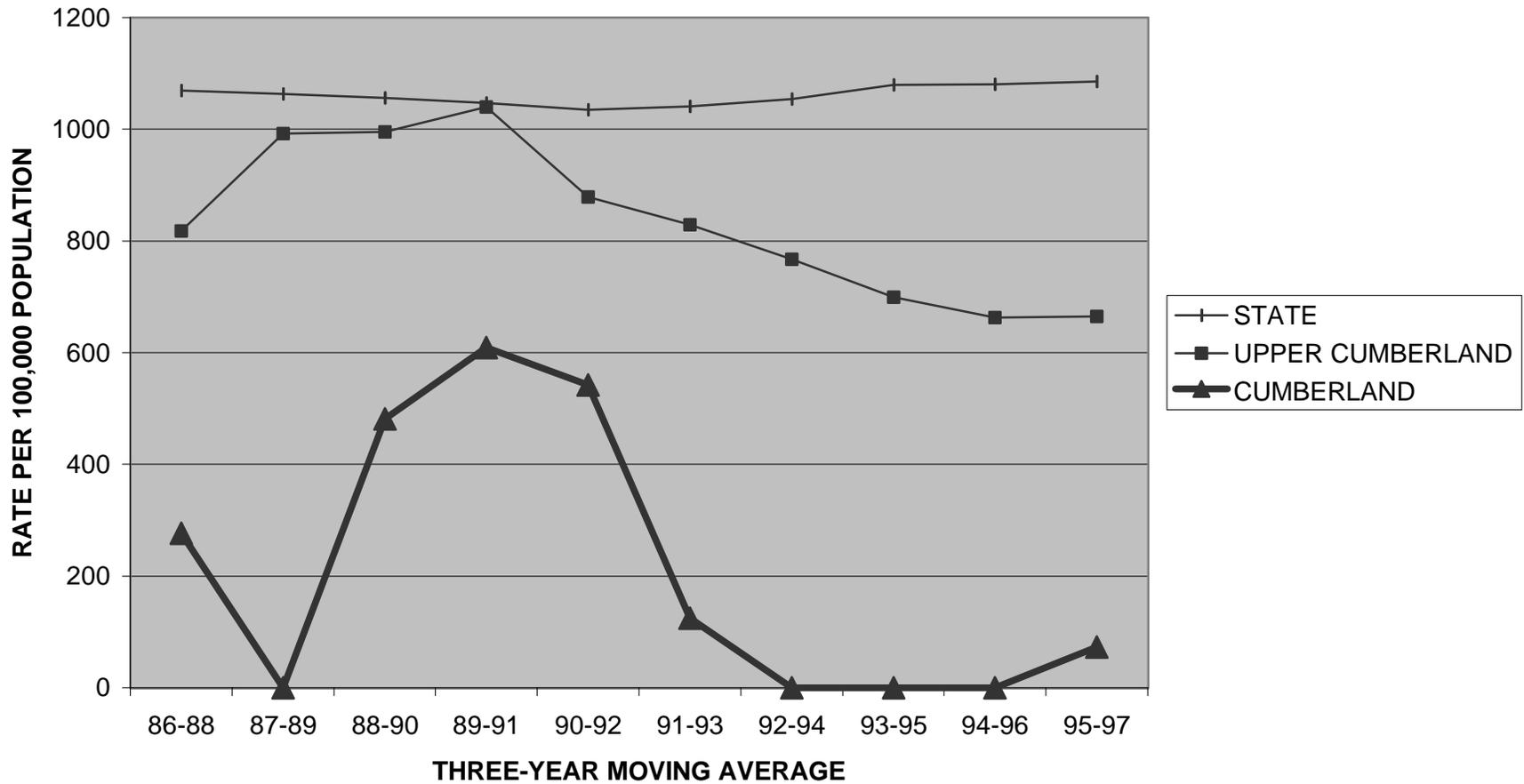
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	24.1	23.7	24.2	24.6	25.0	25.0	24.3	24.2	23.7	24.0	
UPPER CUMBERLAND	22.5	23.6	25.1	22.1	22.4	24.4	24.3	24.6	22.8	24.6	
CUMBERLAND	23.3	27.9	26.4	22.9	20.5	26.2	23.7	23.7	21.3	26.2	

VIOLENT DEATH RATE PER 100,000 POPULATION



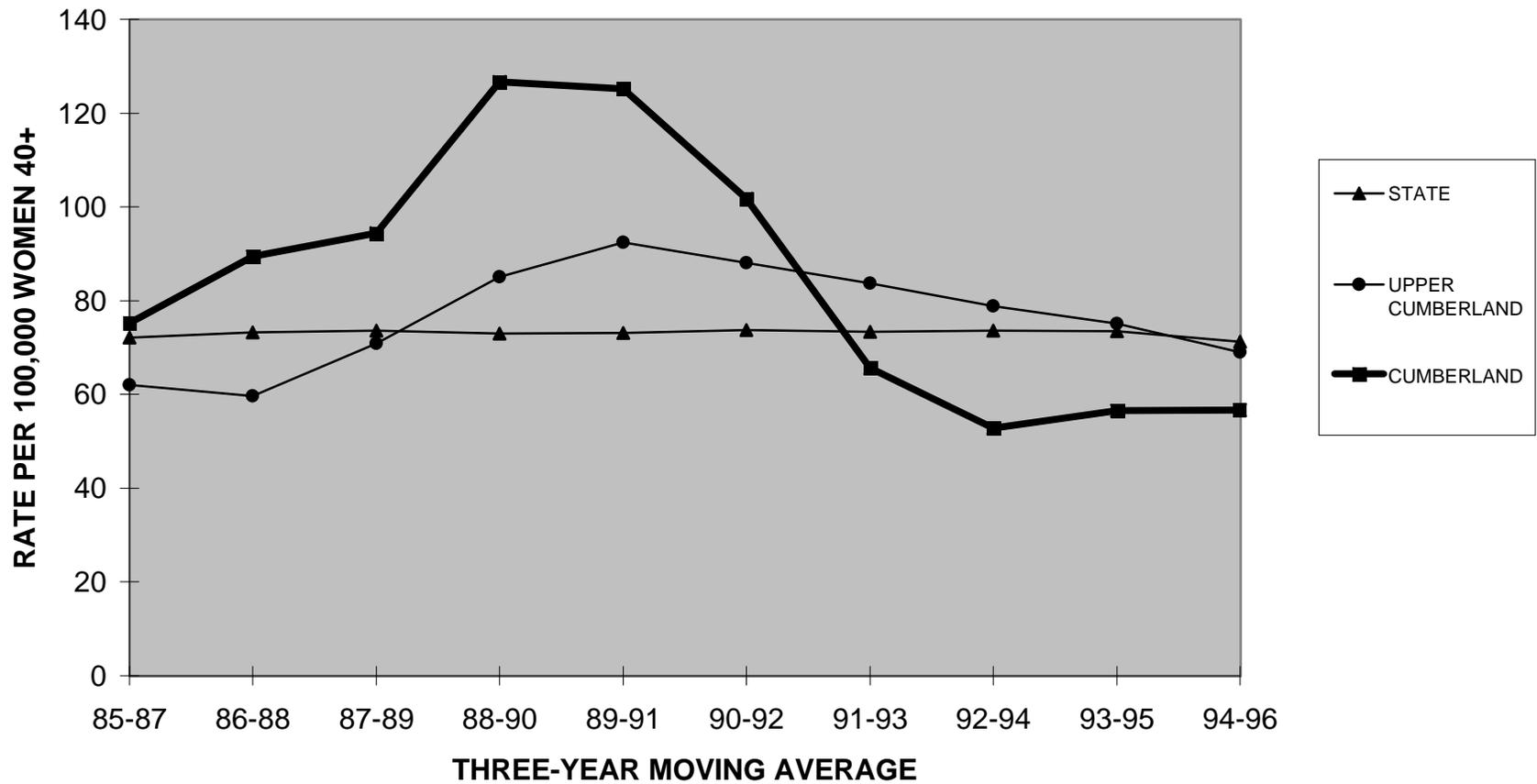
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	1,068.8	1,063.0	1,056.2	1,046.5	1,034.4	1,040.8	1,054.3	1,079.7	1,080.0	1,085.8
UPPER CUMBERLAND	817.8	992.0	995.6	1,039.8	878.9	829.4	766.8	699.8	663.0	665.1
CUMBERLAND	276.9	0.0	481.3	609.2	542.4	124.2	0.0	0.0	0.0	73.4

OTHER RACES MALE AGE-ADJUSTED MORTALITY RATE PER 100,000 POPULATION



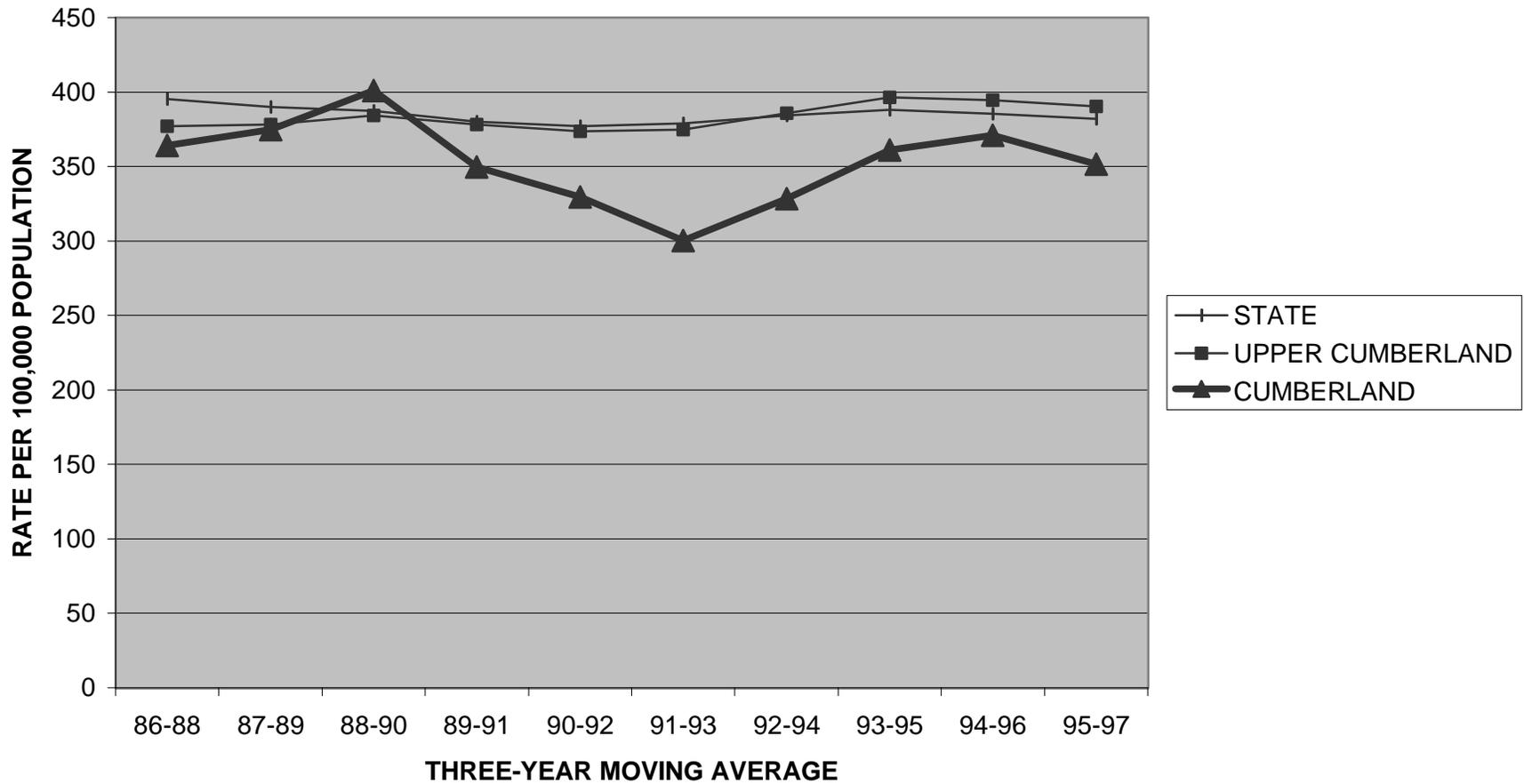
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	72.1	73.3	73.6	73	73.1	73.7	73.4	73.6	73.5	71.2	
UPPER CUMBERLAND	62	59.6	70.9	85.1	92.4	88.1	83.7	78.9	75.1	69	
CUMBERLAND	75.2	89.4	94.4	126.7	125.2	101.7	65.7	52.8	56.5	56.7	

**FEMALE BREAST CANCER MORTALITY RATE PER 100,000 WOMEN
AGES 40 YEARS AND OLDER**



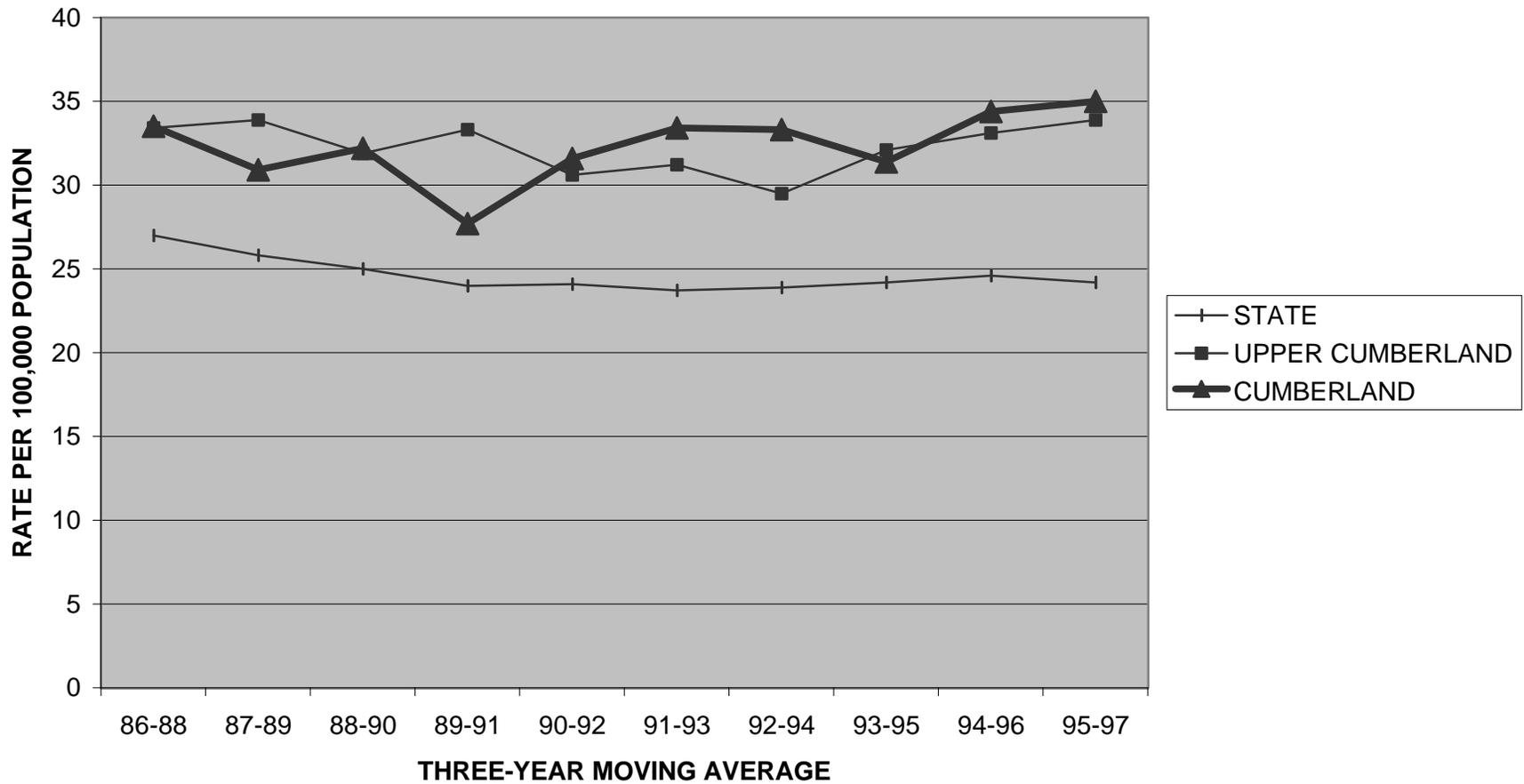
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	395.1	390.0	387.1	380.2	377.2	379.0	384.3	388.0	385.3	381.9	
UPPER CUMBERLAND	377.1	378.1	384.2	378.2	373.6	374.7	385.7	396.6	394.7	390.5	
CUMBERLAND	364.0	374.6	401.1	349.5	329.6	300.2	328.3	361.0	371.0	351.4	

WHITE FEMALE AGE-ADJUSTED MORTALITY RATE PER 100,000 POPULATION



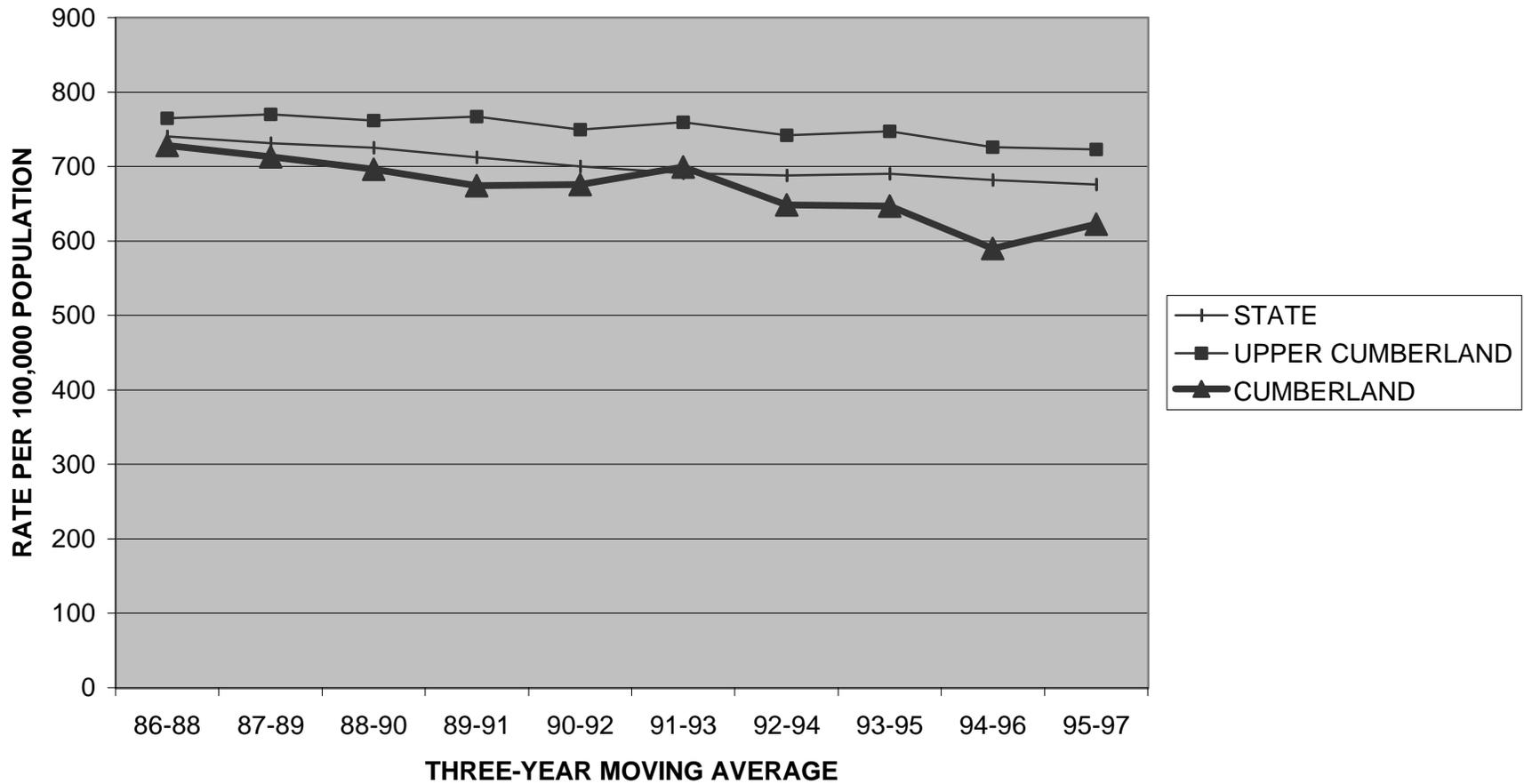
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	27.0	25.8	25.0	24.0	24.1	23.7	23.9	24.2	24.6	24.2	
UPPER CUMBERLAND	33.4	33.9	31.9	33.3	30.6	31.2	29.5	32.1	33.1	33.9	
CUMBERLAND	33.5	30.9	32.2	27.7	31.6	33.4	33.3	31.4	34.4	35.0	

MOTOR VEHICLE ACCIDENTAL MORTALITY RATE PER 100,000 POPULATION



	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	740.2	731.5	725.3	712.3	699.9	691.0	687.8	690.1	682.1	675.8
UPPER CUMBERLAND	764.7	769.7	761.9	766.6	749.6	759.0	742.0	747.1	726.0	723.2
CUMBERLAND	727.9	713.2	696.6	674.6	675.6	699.1	648.2	647.1	590.2	622.6

WHITE MALE AGE-ADJUSTED MORTALITY RATE PER 100,000 POPULATION

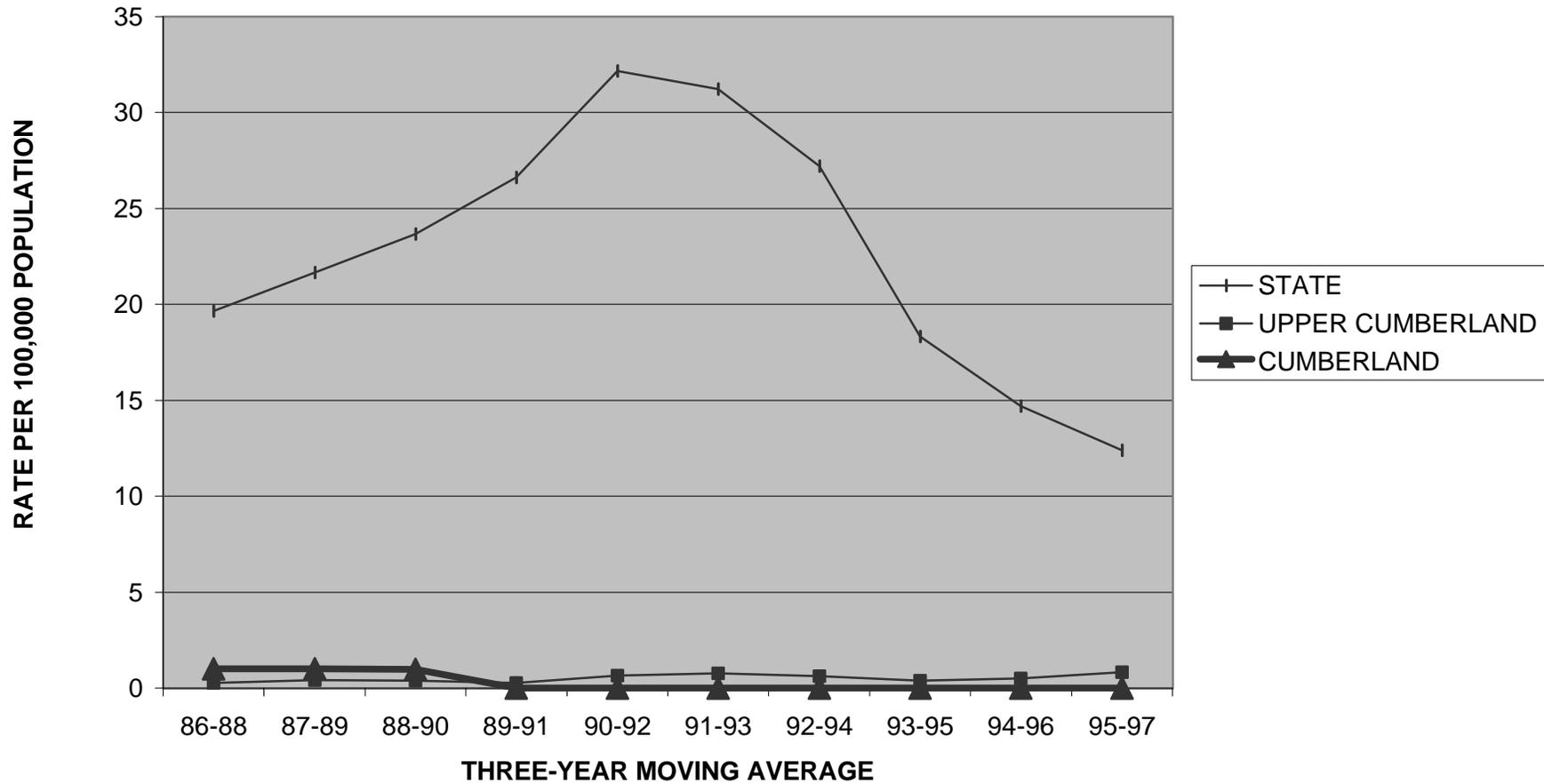


Appendix 5

Morbidity Data

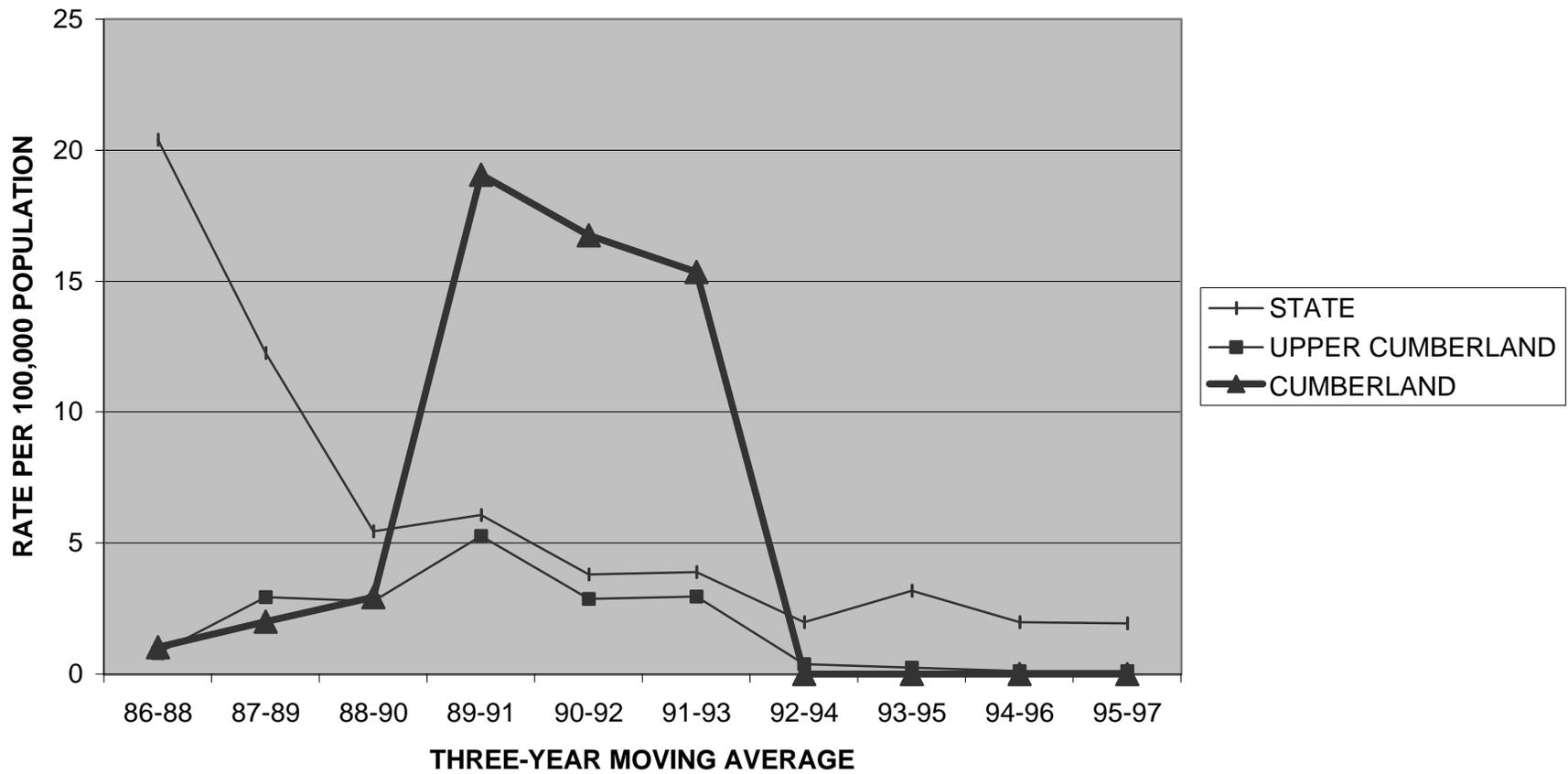
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	19.6	21.7	23.7	26.6	32.2	31.2	27.2	18.3	14.7	12.4	
UPPER CUMBERLAND	0.3	0.4	0.4	0.3	0.7	0.8	0.6	0.4	0.5	0.8	
CUMBERLAND	1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

SYPHILIS RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)



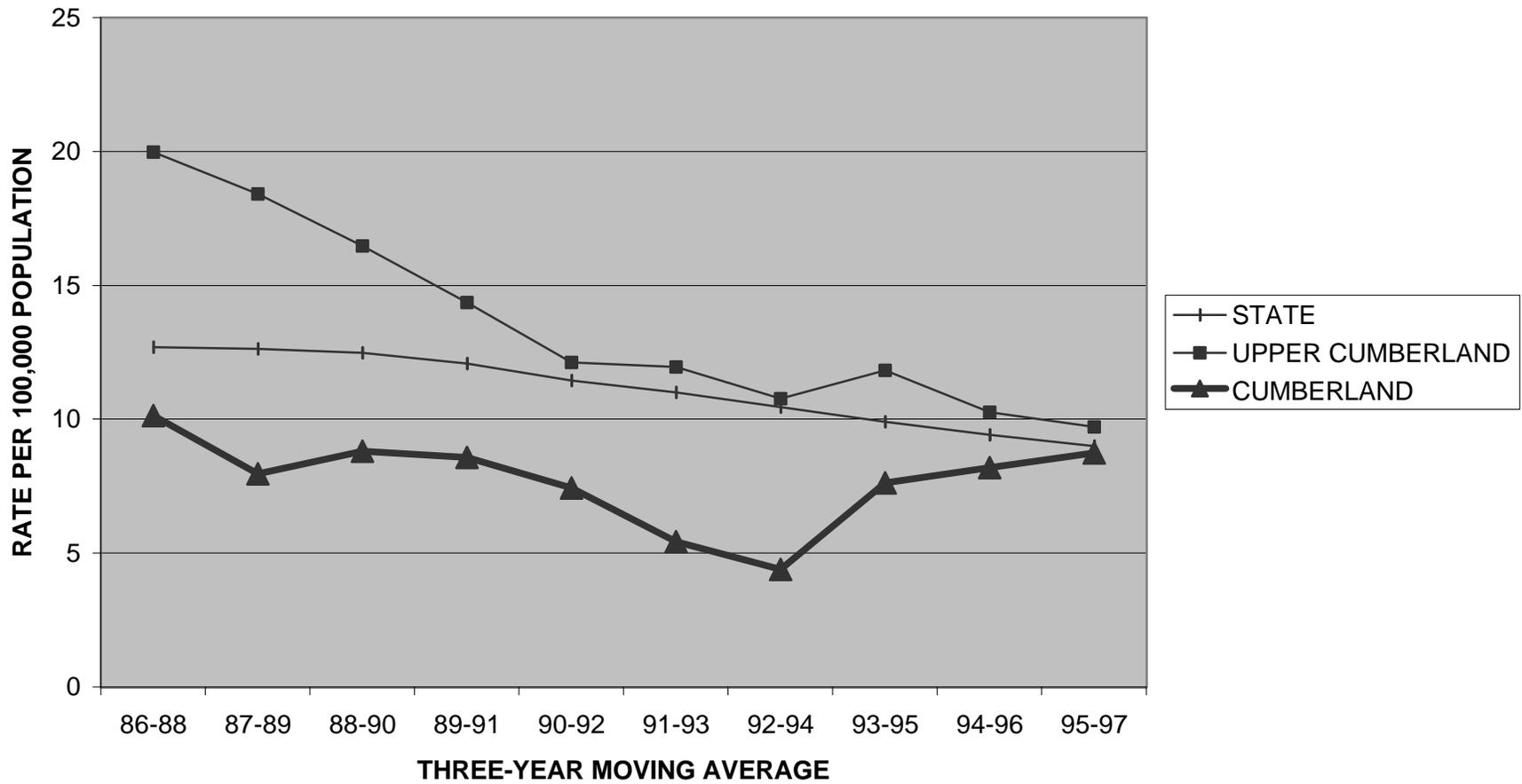
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	20.4	12.3	5.5	6.1	3.8	3.9	2.0	3.2	2.0	1.9
UPPER CUMBERLAND	0.8	2.9	2.8	5.3	2.9	3.0	0.4	0.2	0.1	0.1
CUMBERLAND	1.0	2.0	2.9	19.1	16.7	15.4	0.0	0.0	0.0	0.0

VACCINE-PREVENTABLE DISEASE RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)



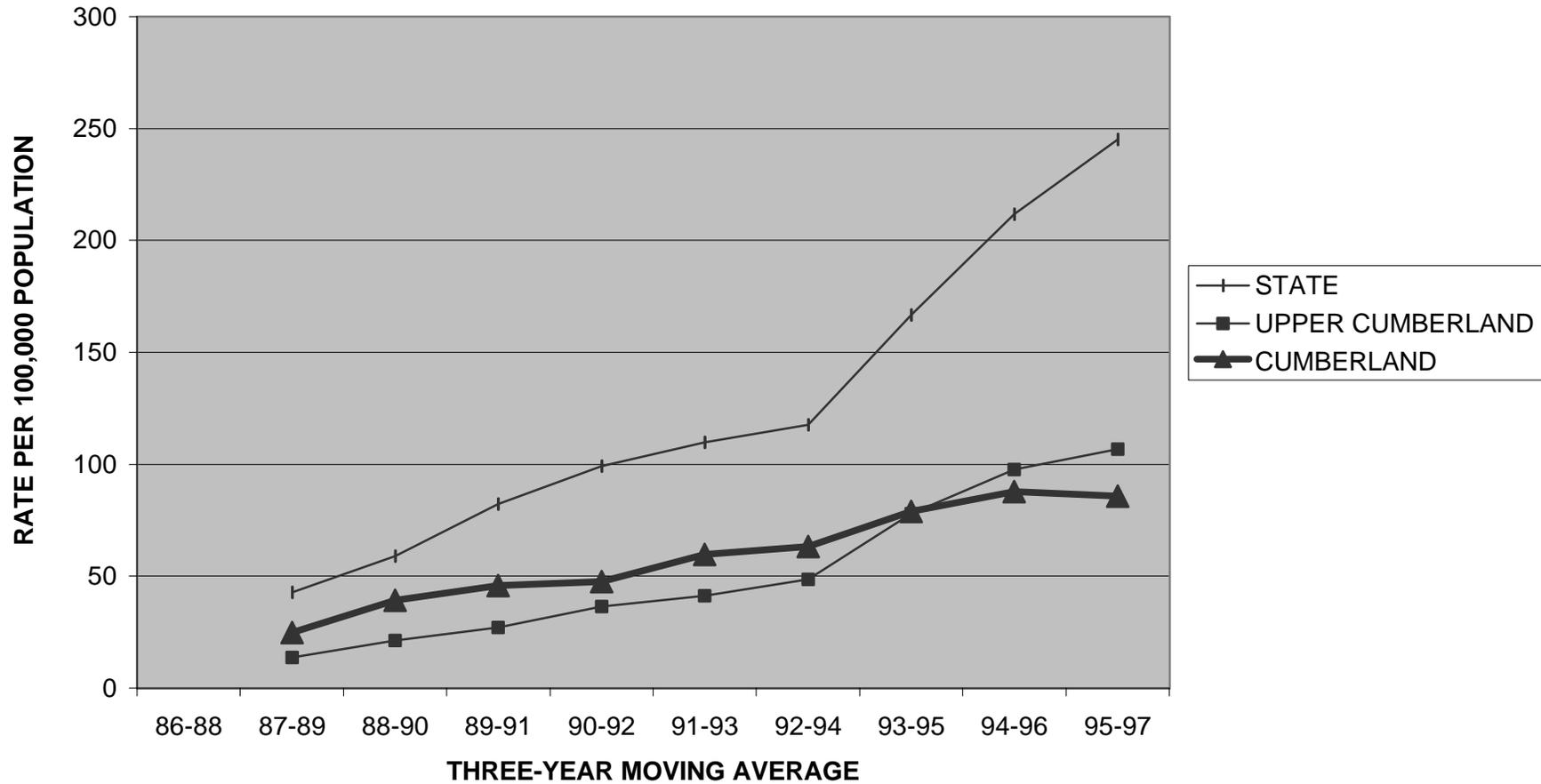
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	12.7	12.6	12.5	12.1	11.4	11.0	10.5	9.9	9.4	9.0
UPPER CUMBERLAND	20.0	18.4	16.5	14.4	12.1	12.0	10.8	11.8	10.3	9.7
CUMBERLAND	10.1	8.0	8.8	8.6	7.4	5.4	4.4	7.6	8.2	8.7

TUBERCULOSIS DISEASE RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)



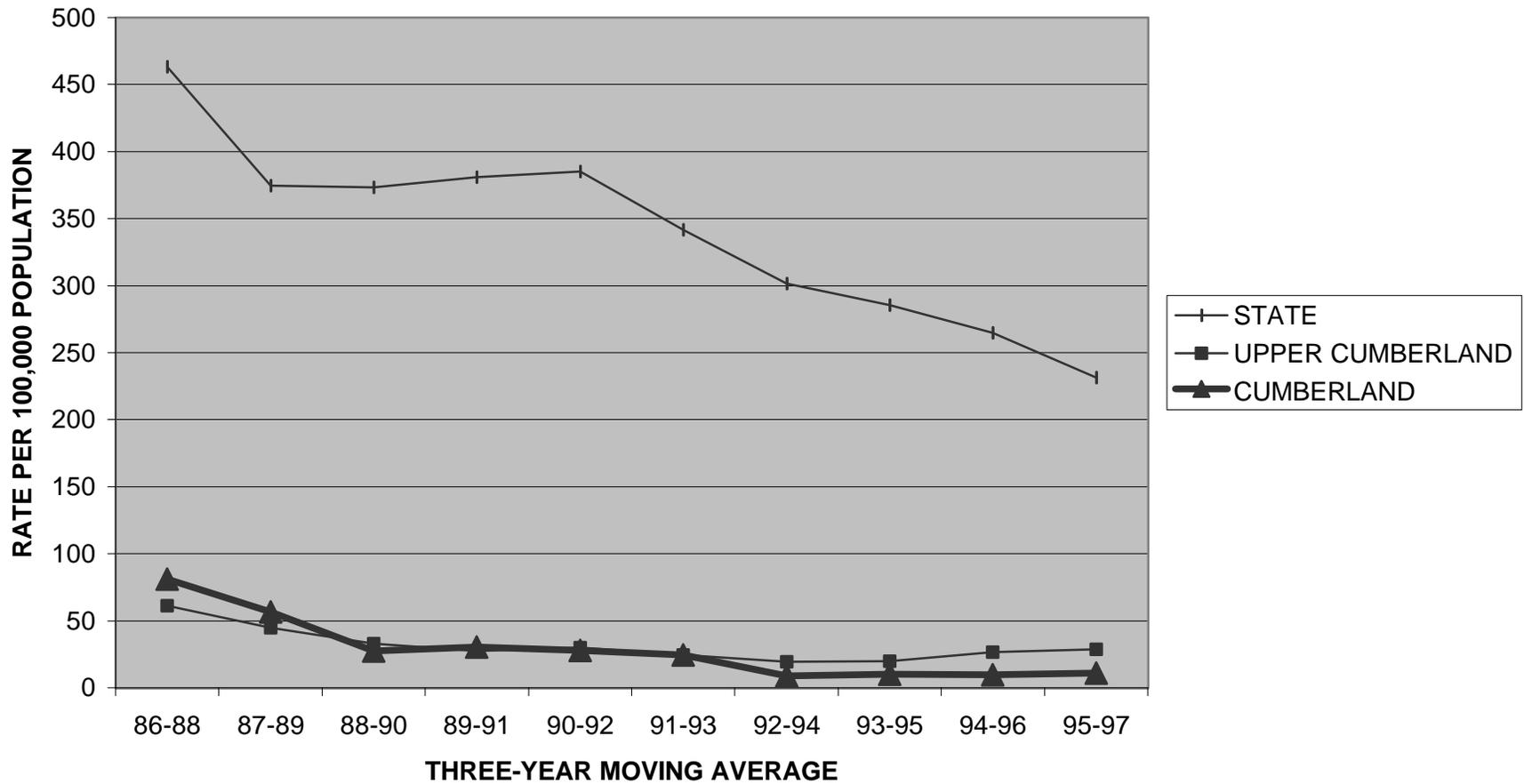
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE		42.8	58.8	82.3	99.1	109.9	117.7	166.7	211.8	245.0
UPPER CUMBERLAND		13.6	21.4	27.0	36.4	41.1	48.5	77.9	97.7	106.8
CUMBERLAND		24.9	39.1	45.8	47.4	59.6	63.1	78.9	87.7	85.8

CHLAMYDIA RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)



	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	463.3	374.6	373.3	380.9	385.0	341.5	301.5	285.3	264.7	231.4	
UPPER CUMBERLAND	61.1	44.8	33.1	27.5	30.0	24.6	19.6	19.7	26.5	28.8	
CUMBERLAND	81.1	56.7	27.4	30.5	27.9	24.4	8.8	10.2	9.8	11.1	

GONORRHEA RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)



Appendix 6

Verbiage and Internet Address of HIT

Health Information Tennessee Web page created as a partnership between the TN Department of Health and the UTK Community Health Research Group can be located at www.Server.to/hit