

DEKALB COUNTY

COMMUNITY DIAGNOSIS DOCUMENT

A GUIDE TO HEALTHY COMMUNITIES

1998-1999

Compiled by

Upper Cumberland Regional Health Office

Community Development

200 West 10th Street

Cookeville, TN 38501

Phone: (931) 528-7531

Email: mparsons@mail.state.tn.us

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	14
<i>Health Issues and Priorities</i>	19
Community Process	19
DeKalb County Priorities	22
<i>Future Planning</i>	24
<i>Appendices</i>	26

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 DeKalb 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 which 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 DeKalb 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:

- **Identify 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 DeKalb County Community Diagnosis Document, which details the process the DeKalb County community utilized to assess its strengths, weaknesses, and gaps in resources. A very thorough analysis of health statistical data, community surveys, resources, and key leaders perceptions of DeKalb 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 Tennessee Department of Health Community Development Staff established the DeKalb County Health Council in February 1998 with an initial group of thirteen community representatives. The DeKalb County Health Council has now developed into a council of fifty-five members. This council consists of various community leaders such as the mayor, 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 Department of Health Community Development Staff facilitates the Community Diagnosis Process. 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 and Analyze the Community Health Assessment Surveys**
- **Score/Rank health problems**
- **Design interventions**
- **Develop funding strategies**
- **Assess development and effectiveness of interventions**

During the course of the Community Diagnosis Process, the DeKalb 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 Monday of each month from 12:00 to 1:00 p.m. where meetings are open to the public.

County Description

Geographic

- DeKalb County is located in the Upper Cumberland Region of middle Tennessee.
- DeKalb County is located 60 miles from Nashville, 40 miles from Murfreesboro and 28 miles from Cookeville.
- This county is predominantly rural and is surrounded by rolling hills and valleys.
- Smith, Wilson, Cannon, Warren, White, and Putnam counties in Tennessee surround DeKalb County.
- The county is 14 miles from Interstate 40 and accessible to state highways 56, 146 and 83.
- The average temperature in July is 76.3 degrees and the average in January is 35.6 degrees with annual average precipitation being 54.57 inches.
- DeKalb County has an elevation of 1,032 feet above sea level.

Land Area

- DeKalb County is often called “Tennessee’s Beauty Spot” the county is blessed with hills, valleys, forests, rivers, Center Hill Lake, and Edgar Evans State Park.
- DeKalb County consists of 291 square miles.
- Nursery stock production is a major agri-business activity for DeKalb County.

Economic Base

- The county’s median family personal income is \$22,956.
- The county’s median household personal income is \$19,388.
- DeKalb County’s per capita personal income is \$19,181.
- The average weekly income of 1997 wages was \$391.
- The individual poverty rate for DeKalb County is 20.3%.
- The family poverty rate for DeKalb County is 16.3%.
- The 1998 average labor-force total was 8,310, of those, 7,790 were employed and 520 were unemployed giving DeKalb County an unemployment rate of 6.30%.
- The major employers in DeKalb County include Federal Moqual, Kingston Timer, SW Manufacturing, Smithville Manufacturing, and Texas Boot Company.

Demographics

- DeKalb County's public education system consists of Smithville Elementary, DeKalb West (K-8), DeKalb Middle, and DeKalb High School.
- The total number of TennCare enrollees in DeKalb County as of 05-07-99 was 5,007.
- The 1998 population estimate for DeKalb County was 15,943 with projected population for the year 2000 being 16,109.
- The median age for a DeKalb County resident is 36.5 years.

Medical Community

- DeKalb County has one local hospital that has a total of 71 licensed beds.
- The 1997 resident health profile indicates that 45.5% of DeKalb County residents utilize the local county hospital and 18.2% use Davidson County hospitals.
- There are two nursing homes and two retirement centers located in DeKalb County.
- There are thirty-five doctors and four dentists practicing in DeKalb County.

References: Tennessee Department of Health, Upper Cumberland Development District

Community Needs Assessment

Primary Data

DeKalb 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 services 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 DeKalb County based on the survey results.

		Top Ten Issues Highlighted
Teen Pregnancy	77%	
Teen Alcohol/Drug Abuse	75%	
Adult Alcohol Abuse	69%	
Smoking	68%	
Adult Drug Abuse	68%	
Stress	55%	
High Blood Pressure	53%	
Smokeless Tobacco	53%	
Heart Conditions	52%	
Domestic Violence	50%	
Crime	49%	
Child Abuse/Neglect	46%	
Obesity	46%	
Depression	46%	
Diabetes	45%	
Arthritis	44%	
Lack of Sex Education	42%	
Sexually Transmitted Diseases	37%	
Youth Violence	35%	
Lung Cancer	35%	
Other Cancer	35%	
Motor Vehicle Deaths	34%	
Poverty	34%	
School Dropouts	33%	
Poor Nutrition for Children	32%	

Poor Nutrition for Elderly	31%
Breast Cancer	31%
Asthma	30%
HIV/AIDS	30%
Unemployment	27%
Colon Cancer	27%
Pneumonia	27%
Eating Disorders	25%
Influenza	23%
School Safety	22%
Prostrate	22%
Air Pollution	20%
Water Pollution	18%
Adult Suicide	18%
Teen Suicide	18%
Gangs	14%
Other Accidental Deaths	14%
Homicide	13%
Toxic Waste	12%
On the Job Safety	11%
Hepatitis	11%
Tuberculosis	9%
Lack of Childhood Vaccinations	7%
Homelessness	5%

DeKalb County Availability of Services

“Adequate” (50% or greater)		“Not Adequate” (25% or greater)	
1) Pharmacy Services	91%	1) Recreational Activities	56%
2) Dental Care	77%	2) Women’s Health Services	45%
3) Eye Care	74%	3) Specialized Doctors	44%
4) Local Family Doctors	71%	4) Child Abuse/Neglect Services	41%
5) Ambulance/Emergency Services	68%	5) Alcohol/Drug Treatment	39%
6) Hospital Care	65%	6) Mental Health Services	38%
7) Home Health Care	63%	7) School Health Services	36%
8) Emergency Room Care	61%	8) Adult Day Care	32%
9) County Health Department	55%	9) Health Education/Wellness Services	31%
10) Nursing Home Care	54%	10) Pediatric Care	28%
10) Child Day Care	54%	10) Family Planning	28%
11) Health Insurance	53%	11) Health Insurance	25%

Personal Information

- The majority of the people completing the survey were from Smithville, and 74% have lived in the county for more than ten years.
- The average age for the survey respondents was between 18-49 years of age with 27% being single and 62% married.
- The participant response noted that 93% had health insurance, 10% were TennCare enrollees, and 3% receive either SSI or AFDC.
- The personal information reported on the survey revealed that 90% of the respondents were currently employed, 10% were not employed.

The Community Health Assessment Surveys were given to members of the DeKalb County Health Council and these members distributed the survey through out the community. There were a total of 173 questionnaires returned for analysis. The council felt that the survey results were indicative of the perceptions of the health care needs and issues in Dekalb County. The result of the Community Health Assessment Survey was discussed with the council members along with profile information about the survey respondents. The council members discussed the teen pregnancy issue in great detail. The findings of the survey revealed that **teen pregnancy, teen alcohol/drug abuse, adult alcohol abuse, smoking and adult drug abuse** are perceived as top community concerns.

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. Approximately 200 interviews were obtained from DeKalb 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:

Issue	Percentage	Top Ten Issues Highlighted
Tobacco Use	57%	
Teen Pregnancy	42%	
Drug Abuse	40%	
Alcohol Abuse	39%	
Cancer	33%	
Arthritis	31%	
Obesity	31%	
Heart Conditions	30%	
High Blood Pressure	28%	
Health Problems of the Lungs	16%	
Environmental Issues	15%	
Animal Control	14%	
Diabetes	13%	
Mental Health Problems	9%	
Other Violence	8%	
STD's	7%	
Violence in the Home	7%	
Suicide	6%	

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

Transportation to Health Care	9%
Access to Physicians or Doctors	7%
Access to Nursing Home Care	6%
Access to Prenatal Care	5%
Access to Assisted Living Services	5%
Access to Birth Control Methods	4%
Access to Hospitals	2%

Access to Dental Care	2%
Access to Pharmacies, Medicines	1%

Other Issues to Consider

Tobacco Use

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

Yes:	51%
No:	48%

Percent of respondents that report current cigarette use:

Daily Use:	59%
Some Use:	4%
Not At All:	37%

Questions Regarding Mammograms

Percent of women reporting having a mammogram:

Yes:	57%
No:	41%

Reasons reported for not having a mammogram:

Doctor not recommended:	11%
Not needed:	16%
Too young:	43%
No reason:	23%
Not sure/other:	4%

When was last mammogram performed:

In last year:	59%
1-2 years:	23%
> than 2 years:	18%

The survey included health risks, utilization and screening services, and perception of health problems. The findings of the survey revealed that the community perceives **tobacco use, teen pregnancy, drug abuse, alcohol abuse, cancer, and arthritis** as top health problems facing the community.

In analyzing the access to care issues as perceived by the community, **transportation to health care, access to physicians or doctors, and access to nursing home care** were identified as the top concerns.

Secondary Data

Summary of Data Use

Health Indicator Trends DeKalb County, Tennessee 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, and reflect a ten-year trend.

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

10. Percent of live births classified as very low birthweight	Unstable	Below	Below
11. Percent births w/ 1 or more high risk characteristic	Unstable	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
- Number of pregnancies/1000 females ages 15-17
- Percent of pregnancies to unwed women

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.

HEALTH INDICATOR	COUNTY TREND	COUNTY COMPARED TO REGION	COUNTY COMPARED TO STATE
14. White male age-adjusted mortality rate/100,000 population	Unstable	Above	Above
15. Other races male age-adjusted mortality rate/100,000 population	Unstable	Above	Below
16. White female age-adjusted mortality rate/100,000 population	Unstable	Above	Above
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	Unstable	Above	Above
19. Nonmotor vehicle accidental mortality rate	Unstable	Above	Above
20. Motor vehicle accidental mortality rate	Unstable	Above	Above
21. Violent death rates/100,000 population	Increasing	Above	Above

The above mortality data shows an increasing trend for:

- Violent death rates/100,000 population

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.

HEALTH INDICATOR	COUNTY TREND	COUNTY COMPARED TO REGION	COUNTY COMPARED TO STATE
22. Vaccine preventable disease rate/100,000 population	Stable	Below	Below
23. Tuberculosis disease rate/100,000 population	Unstable	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 data shows an increasing trend for:

- 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 DeKalb County. The data used for DeKalb County is based on 1994-96 three year moving averages.

Healthy People 2000 Compared to DeKalb County

Health Status Indicators	DeKalb County Rate	Tennessee Rate	Nation's Rate
Death from all causes	584.7	563.1	No Objective
Coronary Heart Disease	156.4	134.8	100
Deaths from Stroke	37.7	34	20
Deaths of Females from Breast Cancer	19.0	22.4	20.6
Deaths from Lung Cancer	50.0	47.5	42
Deaths from Motor Vehicle Accidents	32.6	23.6	16.8
Deaths from Homicide	7.0	12.1	7.2
Deaths from Suicide	39.2	12.6	10.5
Infant Deaths	7.2	9.6	7.0
Percent of Births to Adolescent Mothers	9.5	6.6	None
Low Birthweight	7.4	8.7	5.0
Late Prenatal Care	15.9	19.9	10.0
Incidence of AIDS	10.9	14.1	-----
Incidence of Tuberculosis	8.8	11.6	3.5

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

The health status indicators in bold are the rates for DeKalb County that are above the state's objective rates 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 pregnancies to unwed women**
- **Number of pregnancies/1000 females ages 15-17**
- **Violent death rates/100,000 population**
- **Chamydia rate/100,000 population**

In analyzing these trends, the council's awareness of these problems increased dramatically. There was much discussion among the council members regarding the increasing trends for pregnancies/births to unwed women in DeKalb County. The council requested age breakdowns on pregnancy and birth information.

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. In order to ensure the accuracy of the council's ranking, the Community Development staff developed a Prioritization Table that provided a means of comparison between all top issues addressed. This table presents the order ranking of each issue from both surveys and then compares the actual data to each issue. The data may either reinforce or refute the council's perceptions about their top concerns. The Prioritization Table is a culmination of the information presented to the council over the last several months and is provided in a concise and well-organized manner.

DEKALB COUNTY PRIORITIZATION TABLE

Priority Issue	BRFS	Comm. Quest.	Health Indicator Trends (Secondary Data)
Teen Pregnancy	(2)	(1)	The rate of teenage pregnancies has steadily increased since 87-89, with the rate for 94-96 being above the region and below the state. The rate for teenage pregnancies (ages 10-14) has been extremely unstable over the past 10 years. The rate for 94-96 is above the region, but below the state. In ages 15-17, the pregnancy rate has steadily increased since 87-89 with the rate for 94-96 being well above the region and the state. In ages 18-19, the pregnancy rate increased from 85-87 through 89-91. The rate then declined from that time until 92-94, but has since increased slightly with the 94-96 rate being above the region, but below the state.
Teen Alcohol/Drug Abuse	(3/4) Addressed Total Population	(2)	Deaths from suicide in ages 15-24 has dramatically increased from 90-92. The rate for 94-96 is well above both the state and the region.
Adult Alcohol Abuse	(4)	(3)	The suicide mortality rate in ages 25-44 has dramatically increased since 87-89. The rate for 94-96 is well above both the state and the region. Death rates from chronic liver disease and cirrhosis in ages 25-44 increased from 87-89 through 89-91 and remained high until 92-94. The rates since that time have decreased although the rate for 94-96 remains above both the state and the region. In ages 45-64, mortality rates from chronic liver disease and cirrhosis have dramatically increased since 89-91, with the rate for 94-96 being above the state and the region. Suicide rates for ages 45-64 have dramatically increased since 88-90, with the 94-96 rate being well above both the state and the region.
Tobacco Use/Smoking/ Smokeless Tobacco	(1)	(4) (6)	Rates for malignant neoplasms in ages 25-44 have steadily increased since 86-88, with the rate for 94-96 being well above both the state and the region. In ages 45-64, the rate has shown a decline over the past 10 years. The rate for 94-96 is below the state and the region. For ages 65+, mortality rates for malignant neoplasms have increased slightly over the past 10 years, with the rate for 94-96 being above the region and almost equal to the state. Lung cancer incidence rate for 1995 was 77.0, with the state's rate being 64.2. There were 16 reported cases for 1995.
Adult Drug Abuse	(3)	(4)	
High Blood Pressure	(9)	(6) Stress Ranked 5 th	The 10-year trend of mortality rates for cerebrovascular disease in ages 25-44 has been extremely unstable. The rates were stable from 85-87 through 89-91 at which time the rate dropped and no deaths were reported in 90-92. Since that time, the rates have increased to above both the region and the state for 94-96. Rates for ages 45-64 have shown a steady increase since 87-89, with the 94-96 rate being well above the state and the region. For ages 65+, the mortality rates have shown an increase since 88-90 with the rate for 94-96 being above the state and the region.

Priority Issue	BRFS	Comm. Quest.	Health Indicator Trends (Secondary Data)
Heart Conditions	(8)	(7)	In ages 25-44, death rates from diseases of the heart have declined since 89-91 with the rate for 94-96 being below the state and the region. Death rates for ages 45-64 have remained high over the past 10 years, and the rate for 94-96 is above the state and the region. Diseases of the heart mortality rates for ages 65+ have also remained high over the past 10 years with the rate for 94-96 being above both the state and the region.
Cancer Lung Cancer Other Cancer	(5)	(15) (15)	Rates for malignant neoplasms in ages 25-44 have steadily increased since 86-88, with the rate for 94-96 being well above both the state and the region. In ages 45-64, the rate has shown a decline over the past 10 years. The rate for 94-96 is below the state and the region. For ages 65+, mortality rates for malignant neoplasms have increased slightly over the past 10 years, with the rate for 94-96 being above the region and almost equal to the state. Lung cancer incidence rate for 1995 was 77.0, with the state's rate being 64.2. There were 16 reported cases for 1995. Other cancer incidence rate for 1995 was 7.6, with the state's rate being 31.3. There were 2 reported cases for 1995.
Obesity	(7)	(10)	See High Blood Pressure: Cerebrovascular Disease trends See Heart Conditions: Diseases of the Heart trends
Domestic Violence	(16)	(8)	(Law enforcement)
Crime Other Violence	(15)	(9)	(Law enforcement)
Depression	Not Addressed	(10)	Deaths from suicide in ages 15-24 has dramatically increased from 90-92. The rate for 94-96 is well above both the state and the region. The suicide mortality rate in ages 25-44 has dramatically increased since 87-89. The rate for 94-96 is well above both the state and the region. Suicide rates for ages 45-64 have dramatically increased since 88-90, with the 94-96 rate being well above both the state and the region.
Child Abuse/Neglect	Not Addressed	(10)	In 1996, there were 100 reported referrals to DHS for DeKalb County. There were 36 indicated cases, and 64 unfounded cases.
Health Problems of the Lungs	(10)	Lung Cancer Ranked 15th	Trends of mortality rates for chronic obstructive pulmonary disease for ages 45-64 have been very unstable over the past 10 years. The rates increased from 90-92 through 94-96. The rate for 94-96 is above both the state and the region. Rates in ages 65+ have shown an increasing trend over the past 10 years with the rate for 94-96 being just below the state and the region. Lung cancer incidence rate for 1995 was 77.0, with the state's rate being 64.2. There were 16 reported cases for 1995.

DeKalb County Priorities

In order to ensure that all health problems were addressed in the same manner, the council utilized a process termed “Score and Rank”. This process is an objective, reasonable and easy to use procedure that determines the priority issues. Each health and social concern is assigned a rank based on the size and the seriousness of the problem in conjunction with the knowledge about the effectiveness of potentially available interventions. The Score and Rank Process is outlined below:

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 14.

Seriousness: The most serious problem will be ranked 1.

The least serious problem will be ranked 14.

Keep in mind:

- What is the emergent nature of the health problem? Is there an urgency to intervene? Is their 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)

14 being the lowest rank (the smallest percentage)

Assign a rank for seriousness.

1 being the most serious

14 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 14.

The results of the Score and Rank Process were:

TOP ISSUES

- 1) Teen Pregnancy
- 2) Teen Alcohol and Drug Abuse
- 3) Tobacco Use/Smoking/Smokeless Tobacco
- 4) Adult Alcohol abuse
- 5) Adult Drug Abuse
- 6) Child Abuse/Neglect
- 7) Domestic Violence
- 8) Heart Conditions
- 9) Cancer (Lung and Other)
- 10) Crime and Other Violence
- 11) High Blood Pressure
- 12) Health Problems of the Lungs
- 13) Depression
- 14) Obesity

At this point in the prioritization process, the DeKalb County Health Council members performed the PEARL TEST. Once health problems have been rated for size, seriousness and effectiveness of available interventions, they should be judged on the factors of: Propriety, Economics, Aceptability, Resources and Legality. The initial letters of these factors make up the acronym **PEARL**. The PEARL TEST is an additional way to gain a consensus of the council for the priority issue. The following is a brief description of the PEARL TEST.

- Propriety:*** Is a Program for the health problem suitable?
- Economics:*** Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
- Acceptability:*** Will the community accept a program? Is it wanted?
- Resources:*** Is funding available or potentially available for a program?
- Legality:*** Do current laws allow program activities to be implemented?

The top issues according to the PEARL Test were:

- 1) **Alcohol and Drug Abuse**
- 2) **Crime/Violence**
- 3) **Teen Pregnancy**

Future Planning

Through the Community Diagnosis Process, it was determined that the top issue of concern was the teen alcohol and drug problem in DeKalb County. The future plans of the DeKalb County Health Council are to go through the action planning 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 **Target 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 **Implementation, 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 Ongoing.**

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

Appendices

Appendix 1

Council Makeup

DeKalb County Health Council

Aubrey Turner
Superintendent of Schools
110 South Public Square
Smithville, TN 37166

Larry Webb
County Executive
DeKalb County Courthouse
Smithville, TN 37166

Theresa Ormes
Mediguard Special Projects
Building 606, 7th Avenue
Smyrna, TN 37167

Randy Trammel
Union Planters
P.O. Box 250
Smithville, TN 37166

Tom Bristol
Union Planters Bank
Hwy 70, South Mountain Street
Smithville, TN 37166

Tucker Hendrix
DeKalb County High School
1130 West Broad Street
Smithville, TN 37166

Helen Lee
DeKalb County High School
1130 West Broad Street
Smithville, TN 37166

Cheri Dees
DeKalb County Middle School
1132 West Broad Street
Smithville, TN 37166

Linda Bush
Smithville Elementary School
321 East Bryant Street
Smithville, TN 37166

Dale Cantrell
P.O. Box 27
Liberty, TN 37095

Hoyte Hale
1938 Lee Braswell Road
Smithville, TN 37166

Lillie Vaughn
UCHRA
City Hall
Smithville, TN 37166

Danny McGuinness
503 Red Bud Road
Smithville, TN 37166

Mayor Cecil Burger
104 East Main Street
Smithville, TN 37166

Van Knotts
DeKalb County Health Department

Merill Harris
1064 Cathcart Road
Dowelltown, TN 37059

Joyce Mulinax
110 South Public Square
Smithville, TN 37166

Thomas Janney
P.O. Box 548
Smithville, TN 37166

Gary Cripps
P.O. Box 248
Smithville, TN 37166

David Gash, Dare Officer
613 Gill Street
Smithville, TN 37166

Mayor Ricky Baker
104 West Main Street
Alexandria, TN 37012

Mayor Edward Hale
P.O. Box 8
Liberty, TN 37095

Cathy Lester
LBJ&C Headstart
118 Kimberly Lane
Smithville, TN 37166

Gina Denman, Denny Lamp Co.
P.O. Box 455
Smithville, TN 37166

Danny Parkenson
DeKalb West School
11327 Nashville Highway
Liberty, TN 37095

Jim McCormick
2948 Jacob's Pillar Road
Smithville, TN 37166

Dr. J.K. Twilla
525 Golf Club Road
Smithville, TN 37166

Carl Young
Sunny Point Nursing Home
P.O. Box 549
Smithville, TN 37166

Richard Jennings, Police Chief
P.O. Box 72
Smithville, TN 37166

Becky Hawks, TN Dept. of Health
Bureau of Health Services Admin.
4th Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37247-4501

Mayor Danny Curtis
285 Curtis Street
Dowelltown, TN 37059

Cheryl Owens
LBJ&C Headstart
118 Kimberly Lane
Smithville, TN 37166

Scott Odom
1130 West Broad Street
Smithville, TN 37166

Jerry King, Designs by Norvell
P.O. Box 37
Alexandria, TN 37012

Kim Johnson
P.O. Box 247
Alexandria, TN 37012

Rick Wilson, Tri Star Aluminum
P.O. Box 68
Alexandria, TN 37012

Bill Doughman
Walker Manufacturing
P.O. Box 119
Smithville, TN 37166

Mike Pritchard, Ind. Mach. Services
100 Industrial Road
Alexandria, TN 37012

Stephen Officer, Ag. Ext. Agency
2830 Nashville Highway
Smithville, TN 37166

Allan and Laura Webb
1029 South College Street
Smithville, TN 37166

Billy Rhody
1064 Dry Creek Road
Smithville, TN 37166

Mark Ashburn
P.O. Box 228
Smithville, TN 37166

Vicki Messick
P.O. Box 272
McMinnville, TN 37111

Jean Myers
P.O. Box 670
Smithville, TN 37166

Paul Blair
P.O. Box 547
Smithville, TN 37166

Karen Carpenter
107 East Main
Smithville, TN 37166

Barbara Hylton
P.O. Box 808
Smithville, TN 37166

Elaine Lockhart
414 Hooper Street
Smithville, TN 37166

Patrick Cripps
1132 West Broad Street
Smithville, TN 37166

Karen Maloney
DeKalb County Health Department

Carol Hendrix
1132 West Broad
Smithville, TN 37166

Dwayne Page
WJLR
2606 McMinnville Highway
Smithville, TN 37166

Angie Beaty
American Cancer Society
508 State Street
Cookeville, TN 38501

Gingie Braswell
Baptist DeKalb Hospital
P.O. Box 640
Smithville, TN 37166

Donna Emmons
470 Four Seasons Road
Smithville, TN 37166

Kathy Merz
2148 Jefferson Road
Smithville, TN 37166

Kerry D. Hale
620 Davis Lane
Alexandria, TN 37012

Kirk Reeve
358 Relax Drive
Smithville, TN 37166

Christy Driver
Smithville Elementary School
221 East Bryant Street
Smithville, TN 37166

Kim Turner
Smithville Elementary School
221 East Bryant Street
Smithville, TN 37166

Jen Sherwood
501 Ed Taft Drive
Smithville, TN 37166

Kimberly Freeland
Regional Health Office

Kim Kompel
Smith County Health Department

Rev. Leland Carden
P.O. Box 95
Smithville, TN 37166

Julie Tuillen
Genesis House
P.O. Box 1180
Cookeville, TN 38501

Donny Green
P.O. Box 526
Smithville, TN 37166

Clay Farler
110 South Public Square
Smithville, TN 37166

Sherry Beaty
732 Scott Acres Road
Smithville, TN 37166

Elizabeth Parsley
1113 Potts Camp Road
Smithville, TN 37166

Garey Evans
706 Crestview Drive
Sparta, TN 38583

Appendix 2

BY LAWS FOR DEKALB COUNTY HEALTH COUNCIL

ARTICLE I. NAME

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

ARTICLE II PURPOSE AND GOALS

The overall mission of the Council is to assist the Department of Health by advising the Department regarding the health problems of Dekalb 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:

1. Developing a community health assessment which includes health problems and needs identification.
2. Developing goals, objectives, and plans of action to meet these needs along with identifying and securing resources to address these needs.
3. Establishing priorities for all identified health problems.
4. Identifying department/organization work teams and community agencies which should coordinate efforts with respect to the health problems identified.
5. Drafting and presenting to the Department of Health the community health assessment.
6. Promoting and supporting the importance of reducing the health problems to the Department and the community.
7. Maintaining good communications with the Department via periodic reports from the Council through the Regional Health Council Representative and Community Development Staff.

ARTICLE III. AUTHORITY

1. The Council shall exist as an advisory and support body to Tennessee Department of Health solely for the purposes stated herein and shall not be vested with any legal authority described to Tennessee Department of Health, the State of Tennessee or any of its political subdivisions. Recommendations of the Council will not be binding upon Tennessee

Department of Health and the Council is not granted authority to act on behalf of The Department of Health without specific prior written authorization.

2. The Council shall not have the authority to generate, or otherwise, receive funds or property on its own behalf. Further, the Council shall not generate or receive any moneys or property on behalf of Tennessee Department of Health without specific prior approval in writing. Should such authorization be issued, any moneys or property thereby arising shall be designated for and relinquished directly to Tennessee Department of Health for appropriate accounting and allocation according to Tennessee Department of Health applicable Department of Health policy.
3. The Council shall provide Tennessee Department of Health a strict accounting of all financial transaction arising from Council activities. The financial records and accounts of the Council will be made available to Tennessee Department of Health and/or its official auditors for examination at any time upon reasonable request.

ARTICLE IV. MEMBERS

Membership in the Council shall be voluntary and by invitation to serve. The Council shall consist of an adequate number of voting members as to be effectively representative of all segments of the community. 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. The Council shall have the right to remove Council members for good cause shown after notice and hearing before the Council as a whole. A two-thirds (2/3) majority is required for removal. Automatic removal results when a member misses three (3) consecutive meetings or six (6) meetings in a calendar year. Recommendations for membership will be accepted from any source.

ARTICLE V. OFFICERS

Section 1: Officers

The officers of the Council shall consist of the Chairman, Vice-Chairman, and Secretary/Treasurer.

The Secretary/Treasurer will be selected by majority vote of the Council from nominees among its members. The Secretary/Treasurer will record the business conducted at meetings of the Council in the form of minutes, will issue notice of all meetings and perform such duties as assigned by the Council. The Secretary/Treasurer shall keep account of all money arising from Council activities. No less than annually, or upon request, the Secretary/Treasurer shall issue a financial report to the membership. The Secretary/Treasurer shall perform such duties incidental to this office.

Section 6: Term of Office

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 assigned by the Chairman.

Section 4: Secretary/Treasurer

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 VI. MEETINGS

Section 1: Regular Meetings

The Council will conduct regularly scheduled meetings at intervals of no less than once every three (3) 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 deemed appropriate, upon five (5) days written notice to the membership.

Section 3: Quorum

A quorum shall consist of one-half (1/2) the voting membership of the council.

Section 4: Voting

All issues before the Council shall be decided by majority vote of those members and present at the meeting. A member not present may not vote by proxy. Each member shall be entitled to one (1) vote.

Section 5: Public Character of Meeting

All Council meetings will be held open to the public and at a location which is available to all community residents who might seek health care services. All meetings will be appropriately announced for public notice.

Section 6: Rules of Order

The latest published edition of Roberts Rules of Order shall be the authority for questions pertaining to the conduct of Council business.

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. COUNCILS

Subcommittees may be appointed specializing in concerns relative to specific populations or subject matter.

ARTICLE IX. TASK FORCE

Task forces may be appointed as needed to accomplish specific short-term objectives.

ARTICLE X. BOOKS AND RECORDS

The Council shall keep minutes of all proceedings of the Council and such other books and records as may be required for the proper conduct of its business and affairs.

ARTICLE XI. APPROVAL AND AMENDMENTS

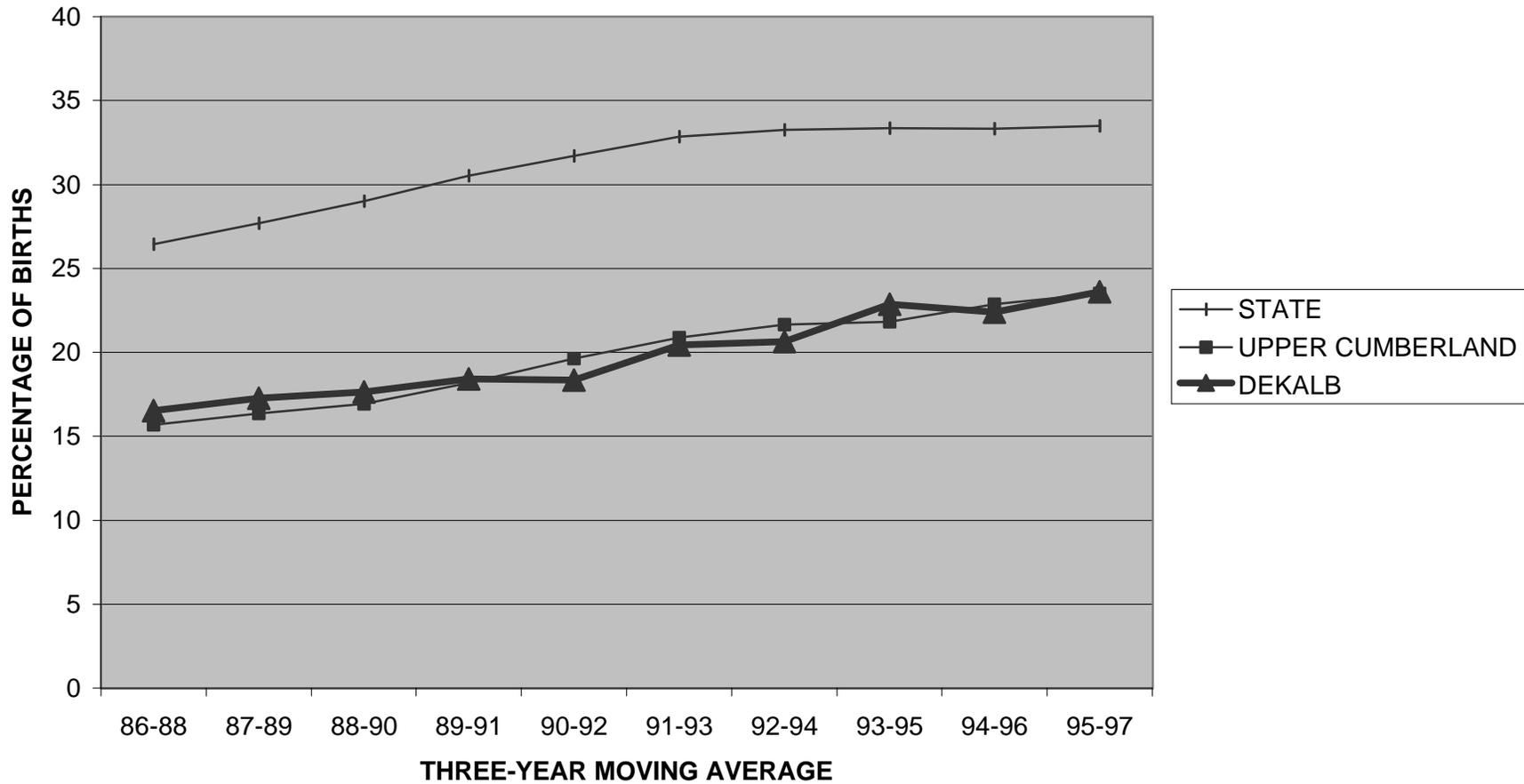
These Bylaws will become effective upon approval by a majority vote of the membership of the Council. Thereafter, these Bylaws may be amended or repealed at any regular or special meeting called for the purpose by a majority vote of the voting members present, provided that the proposed additions, deletions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

Appendix 3

Pregnancy and Birth Data

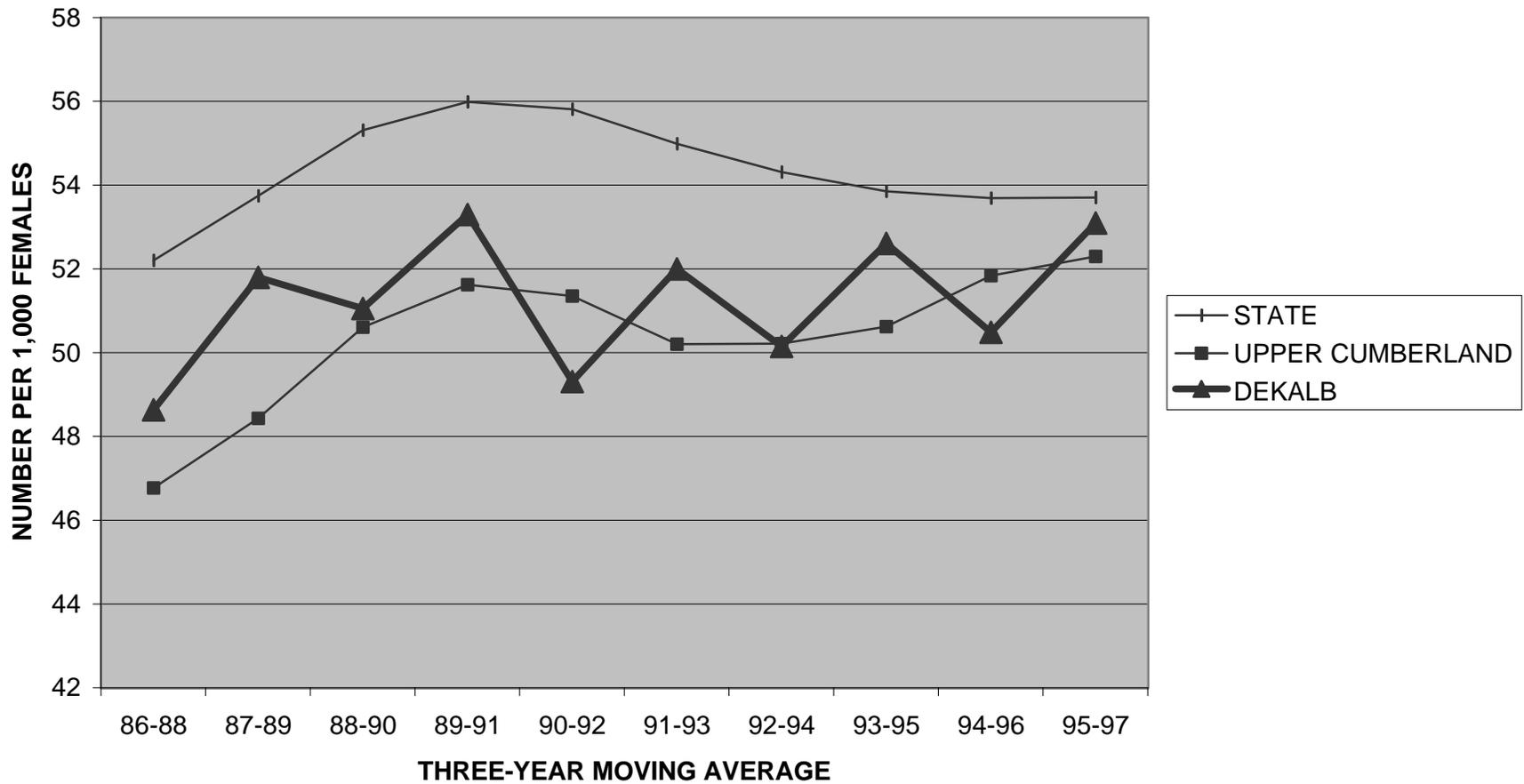
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	26.4	27.7	29.0	30.5	31.7	32.8	33.2	33.4	33.3	33.5	
UPPER CUMBERLAND	15.7	16.4	16.9	18.2	19.6	20.9	21.7	21.8	22.9	23.5	
DEKALB	16.5	17.3	17.6	18.4	18.4	20.4	20.6	22.9	22.4	23.6	

PERCENTAGE OF LIVE BIRTHS TO UNWED MOTHERS AGES 10-44



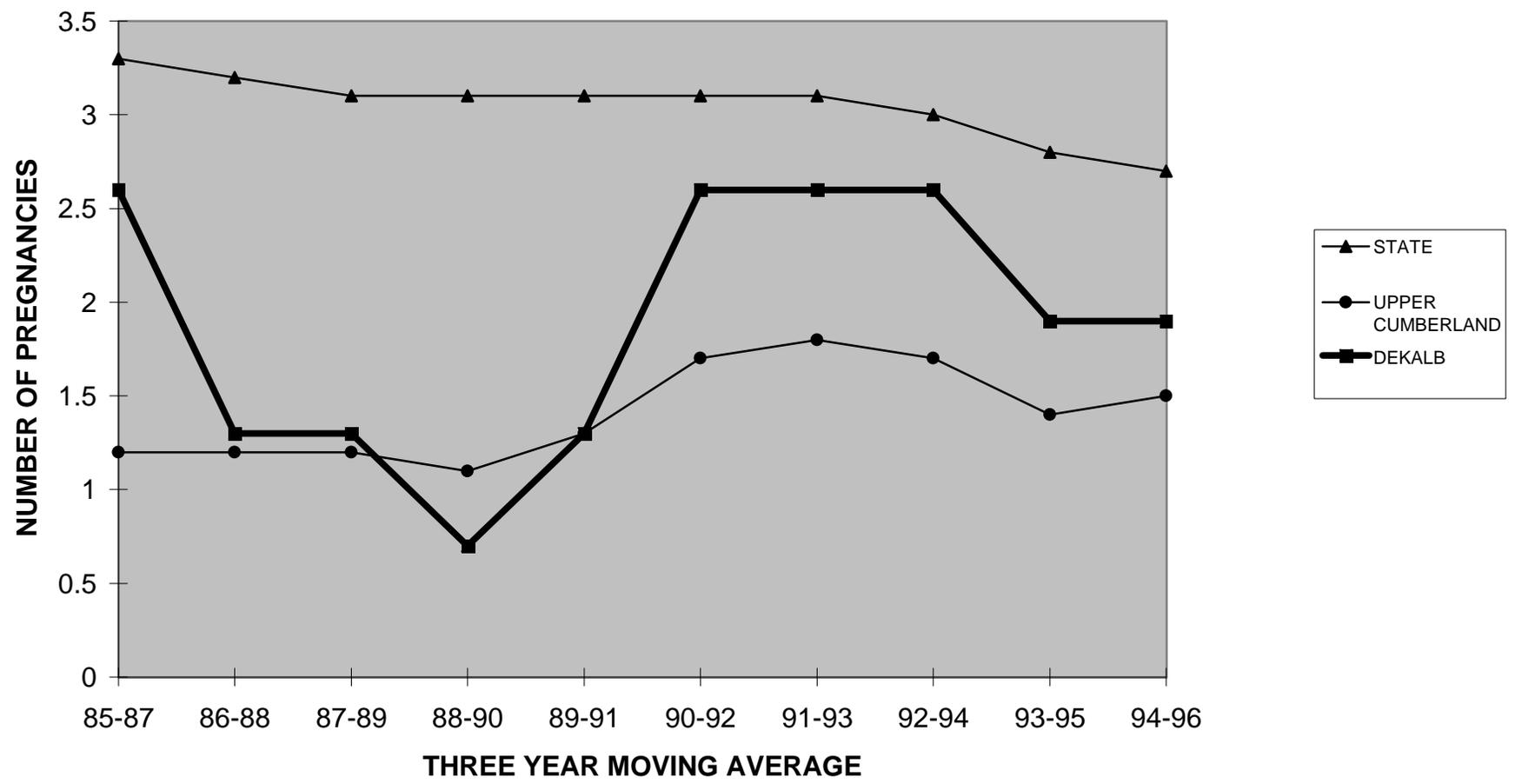
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	52.2	53.7	55.3	56.0	55.8	55.0	54.3	53.9	53.7	53.7	
UPPER CUMBERLAND	46.8	48.4	50.6	51.6	51.4	50.2	50.2	50.6	51.8	52.3	
DEKALB	48.6	51.8	51.1	53.3	49.3	52.0	50.1	52.6	50.5	53.1	

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



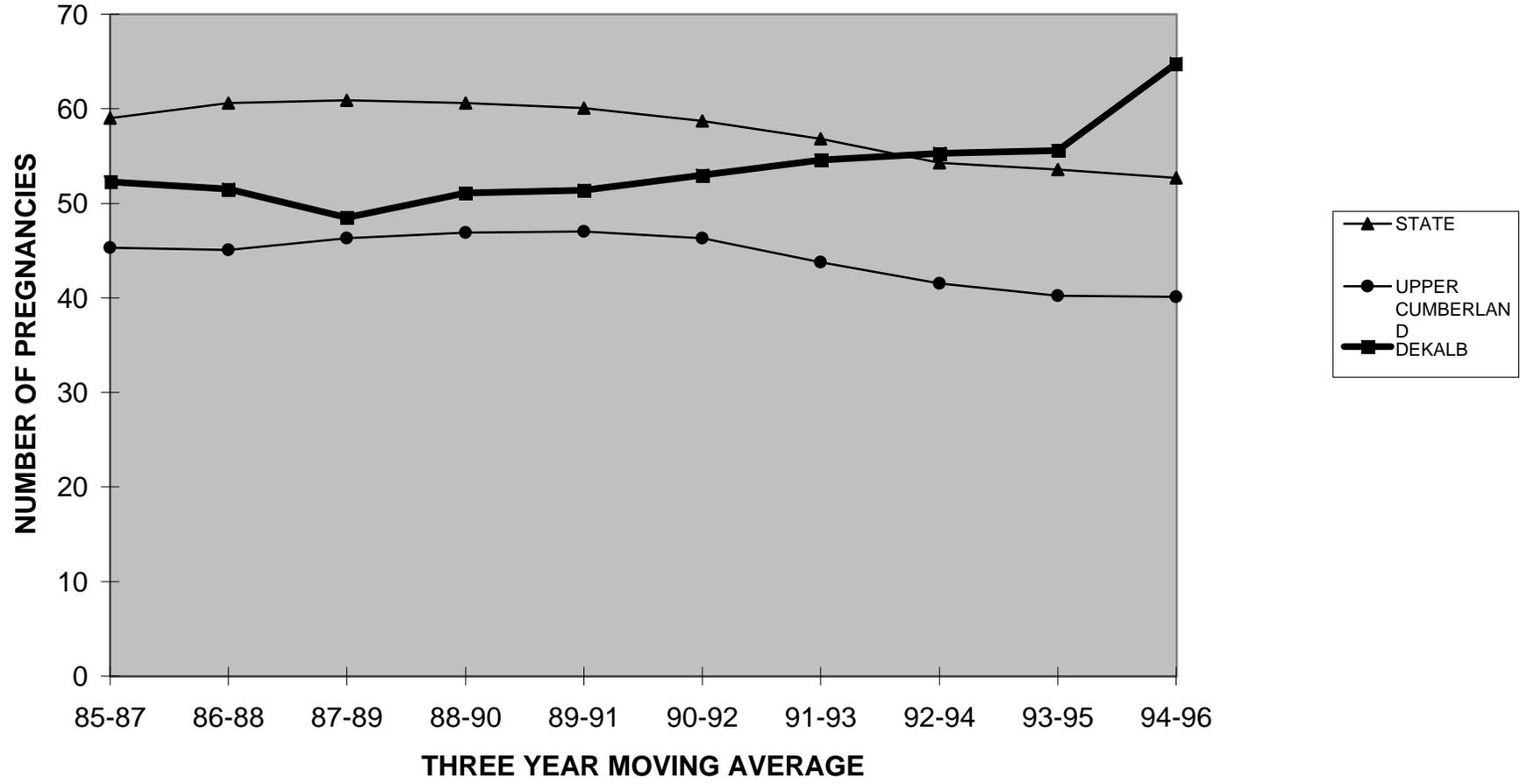
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	3.3	3.2	3.1	3.1	3.1	3.1	3.1	3	2.8	2.7	
UPPER CUMBERLAND	1.2	1.2	1.2	1.1	1.3	1.7	1.8	1.7	1.4	1.5	
DEKALB	2.6	1.3	1.3	0.7	1.3	2.6	2.6	2.6	1.9	1.9	

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



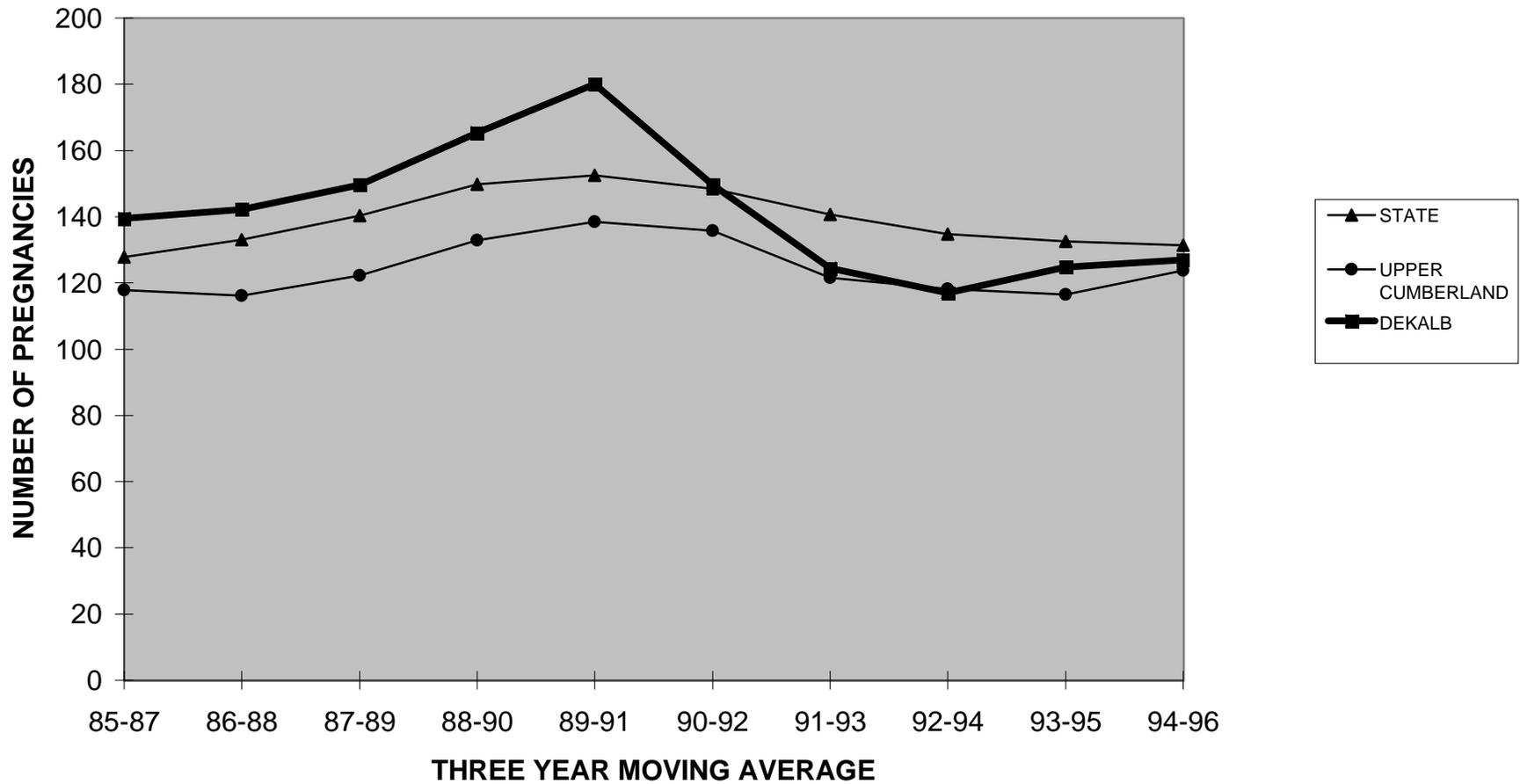
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	59	60.6	60.9	60.6	60.1	58.7	56.8	54.3	53.6	52.7	
UPPER CUMBERLAND	45.3	45.1	46.3	46.9	47	46.3	43.8	41.5	40.2	40.1	
DEKALB	52.3	51.5	48.5	51.1	51.4	53.0	54.6	55.3	55.6	64.8	

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



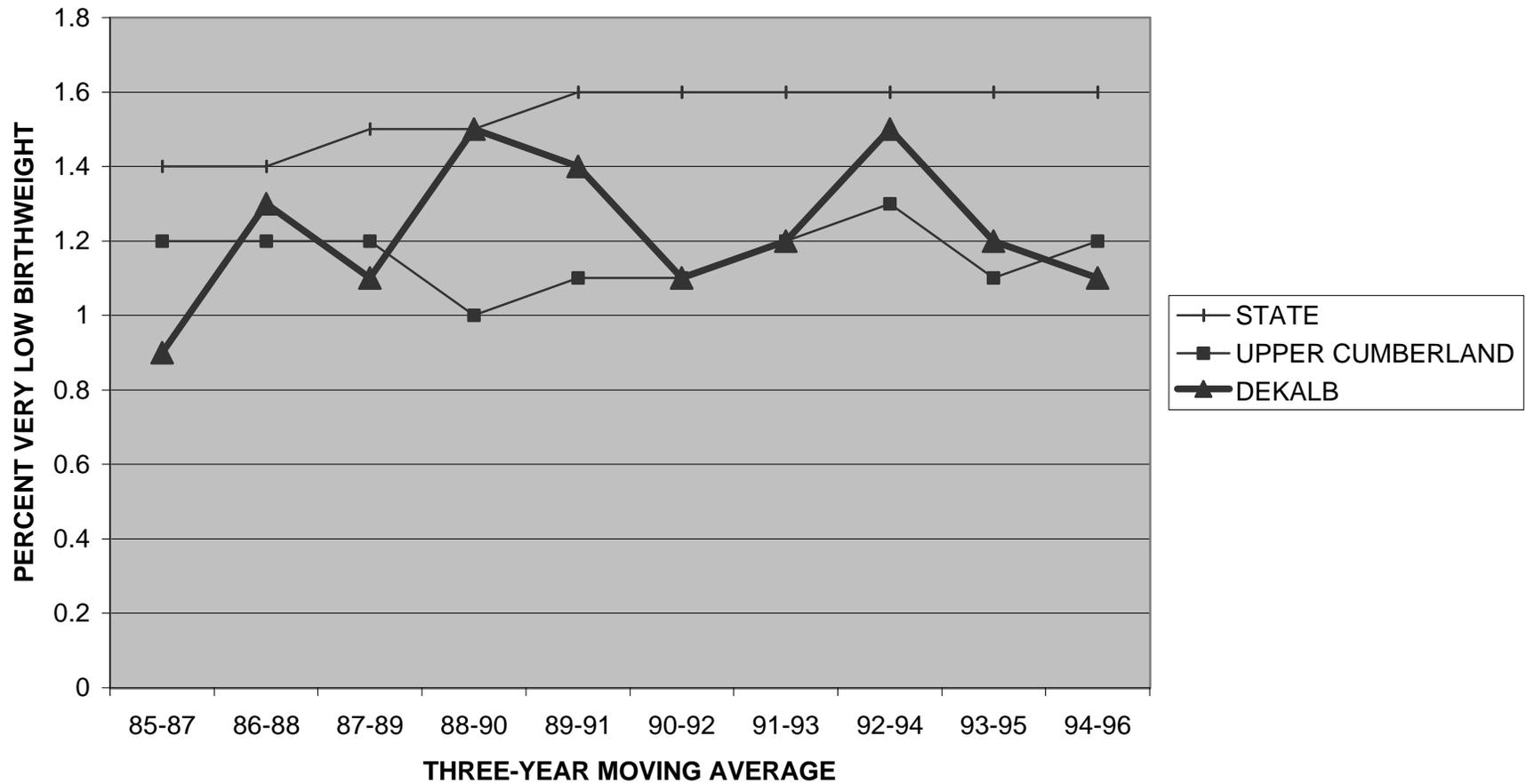
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	127.8	133	140.4	149.8	152.5	148.5	140.7	134.7	132.6	131.3	
UPPER CUMBERLAND	117.8	116.2	122.2	132.8	138.4	135.8	121.5	118.2	116.5	123.8	
DEKALB	139.4	142.2	149.7	165.3	180.0	149.6	124.4	117.0	124.8	127.0	

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

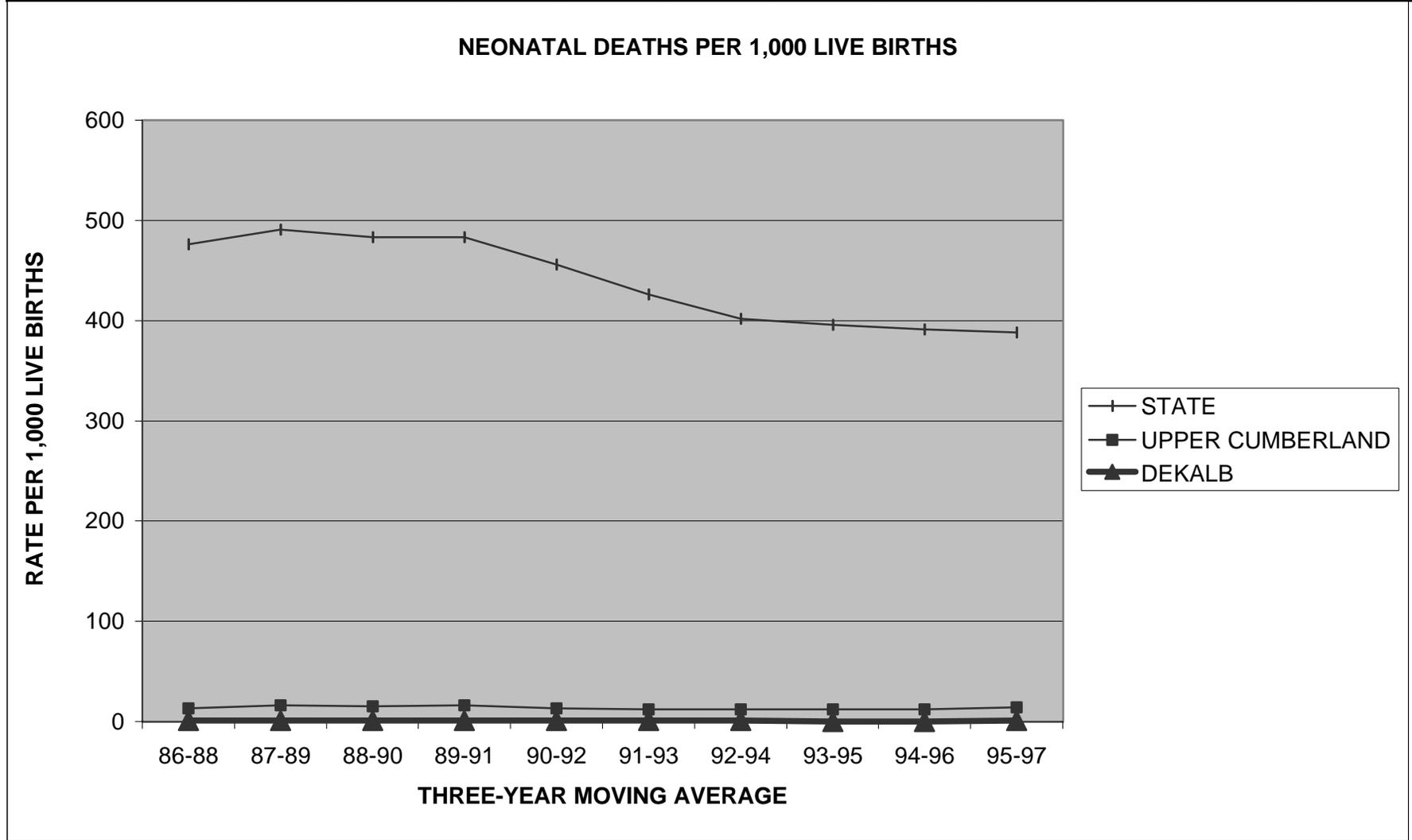


	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	1.4	1.4	1.5	1.5	1.6	1.6	1.6	1.6	1.6	1.6	
UPPER CUMBERLAND	1.2	1.2	1.2	1	1.1	1.1	1.2	1.3	1.1	1.2	
DEKALB	0.9	1.3	1.1	1.5	1.4	1.1	1.2	1.5	1.2	1.1	

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

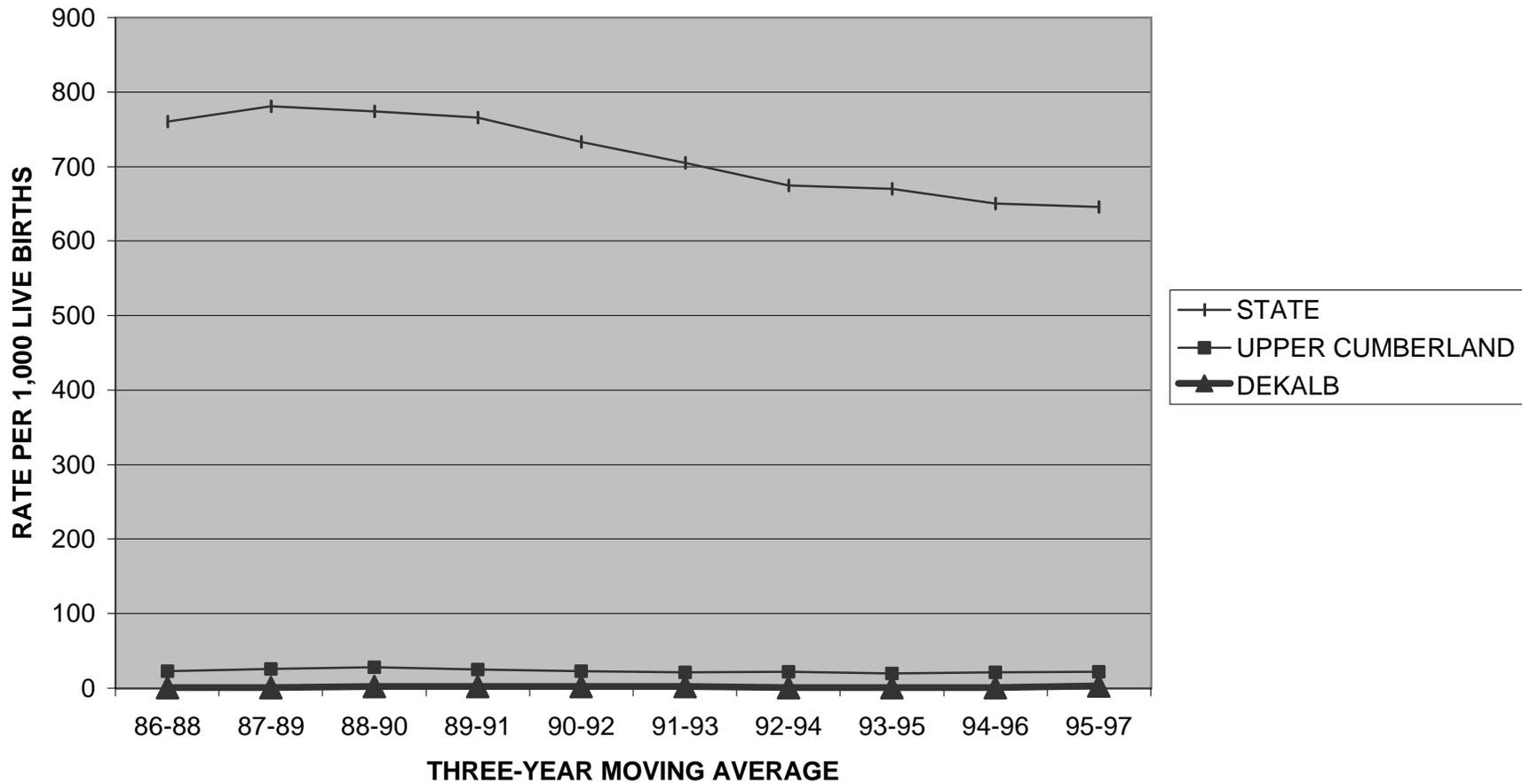


	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	476	491	483	483	456	426	402	396	391	388	
UPPER CUMBERLAND	13	16	15	16	13	12	12	12	12	14	
DEKALB	1	1	1	1	1	1	1	0	0	1	



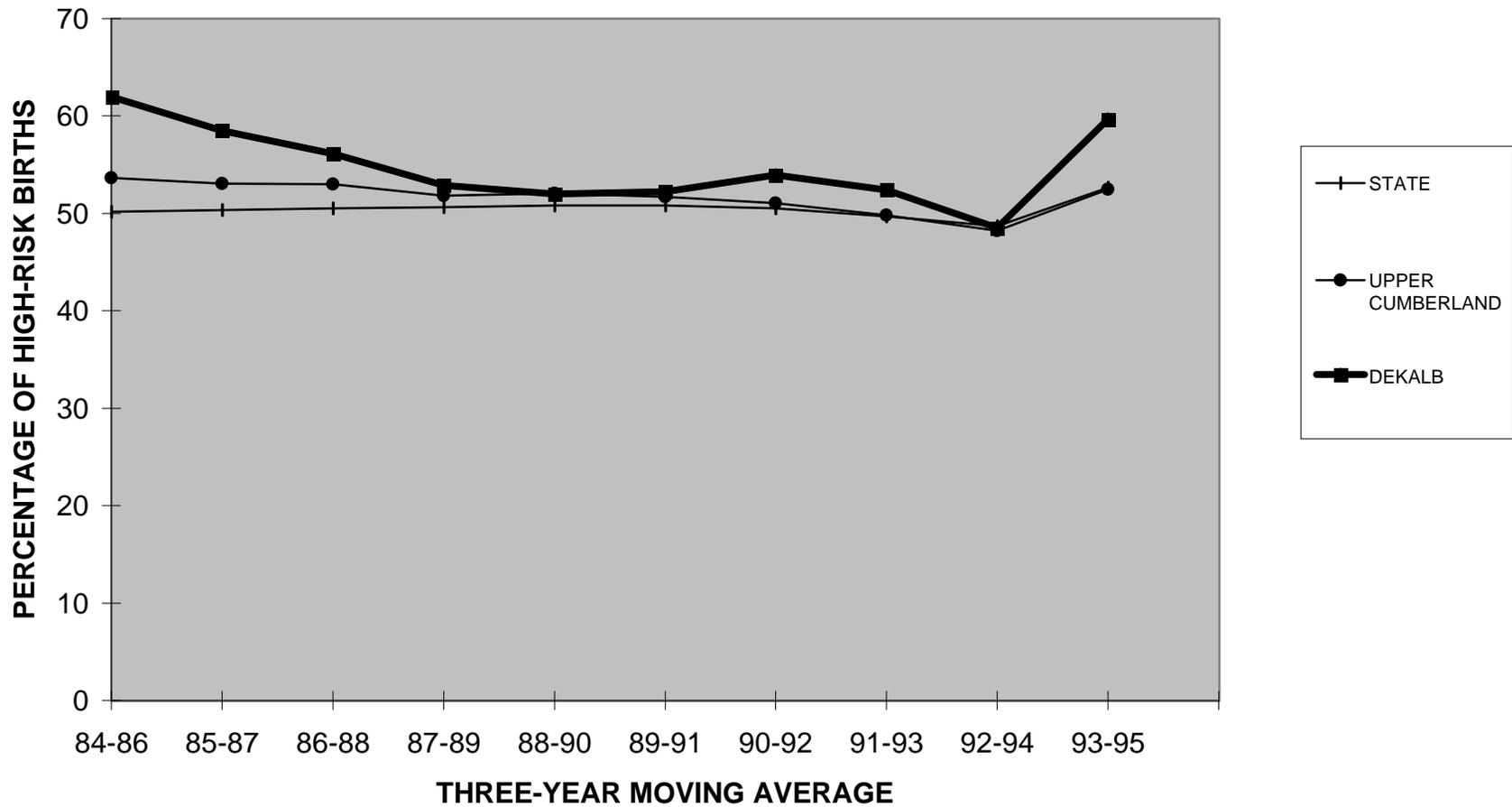
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	760	781	774	766	733	705	675	670	650	646	
UPPER CUMBERLAND	23	26	28	25	23	21	22	20	21	22	
DEKALB	1	1	2	2	2	2	1	1	1	3	

INFANT DEATHS PER 1,000 LIVE BIRTHS



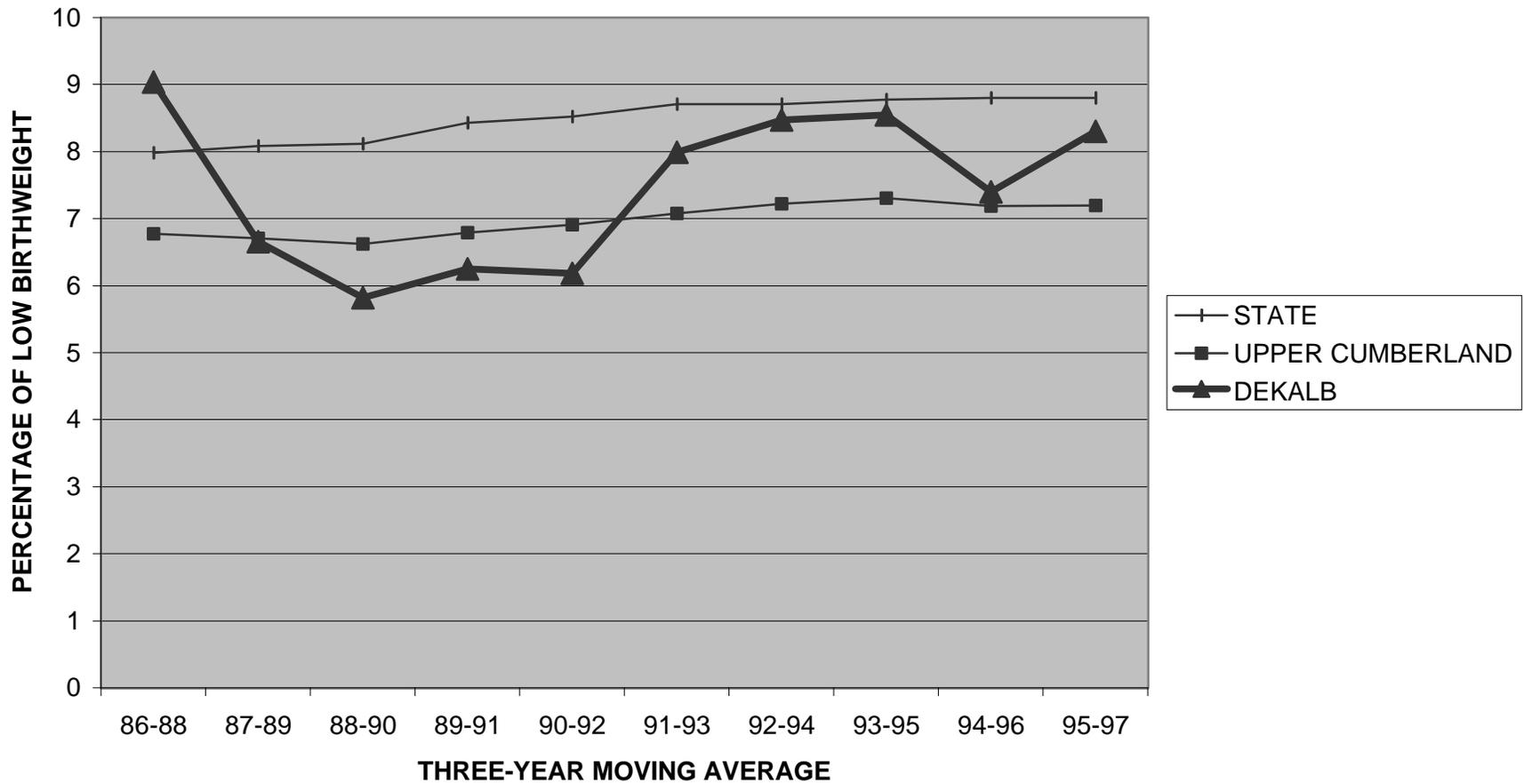
	84-86	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	
STATE	50.1	50.3	50.5	50.6	50.8	50.8	50.5	49.7	48.7	52.6	
UPPER CUMBERLAND	53.7	53.1	53.0	51.8	52.0	51.7	51.0	49.8	48.2	52.5	
DEKALB	62.0	58.5	56.2	52.9	52.0	52.3	53.9	52.4	48.5	59.7	

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



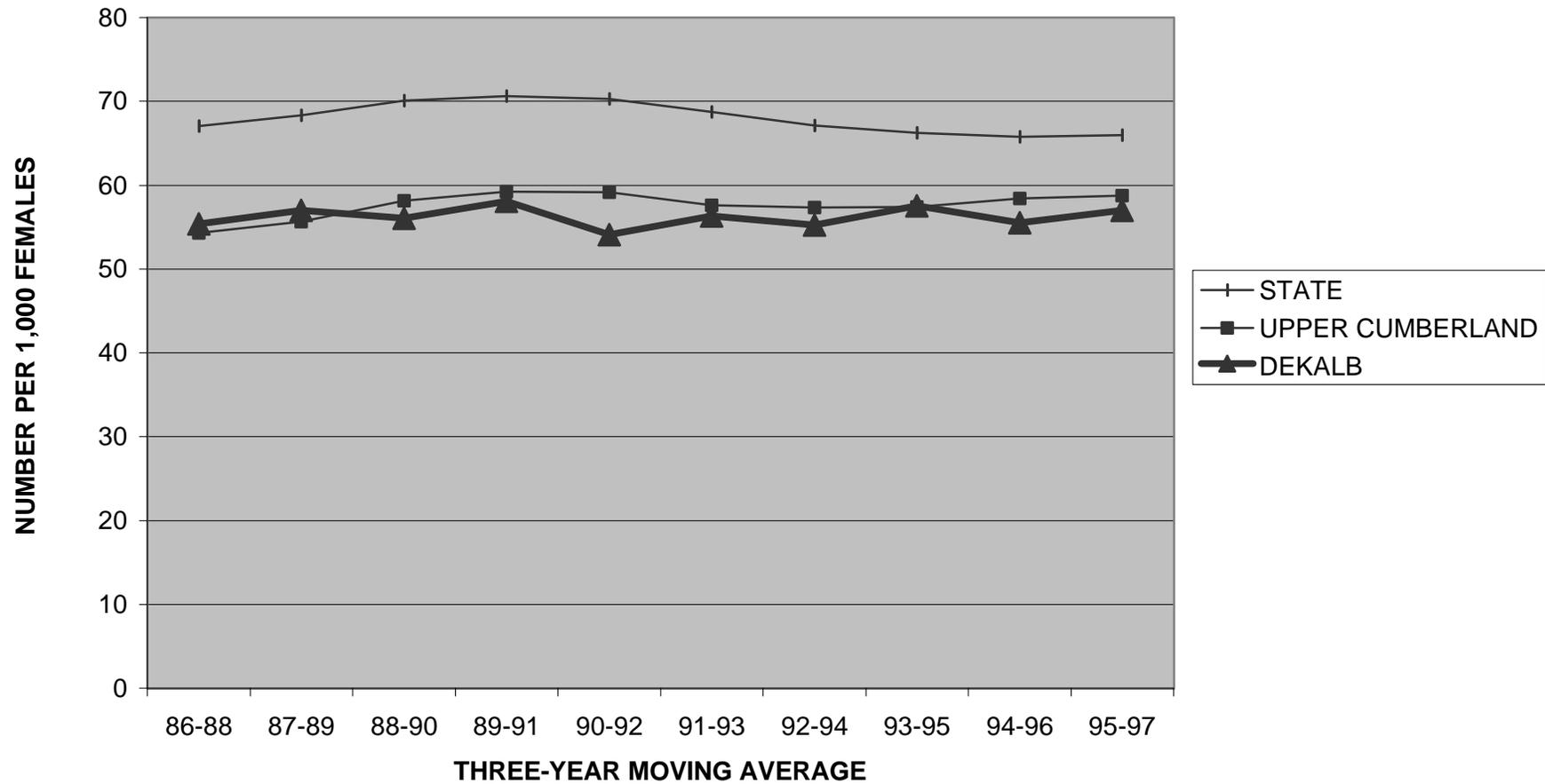
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	8.0	8.1	8.1	8.4	8.5	8.7	8.7	8.8	8.8	8.8
UPPER CUMBERLAND	6.8	6.7	6.6	6.8	6.9	7.1	7.2	7.3	7.2	7.2
DEKALB	9.0	6.7	5.8	6.3	6.2	8.0	8.5	8.6	7.4	8.3

PERCENTAGE OF BIRTHS WHICH WERE LOW BIRTHWEIGHT



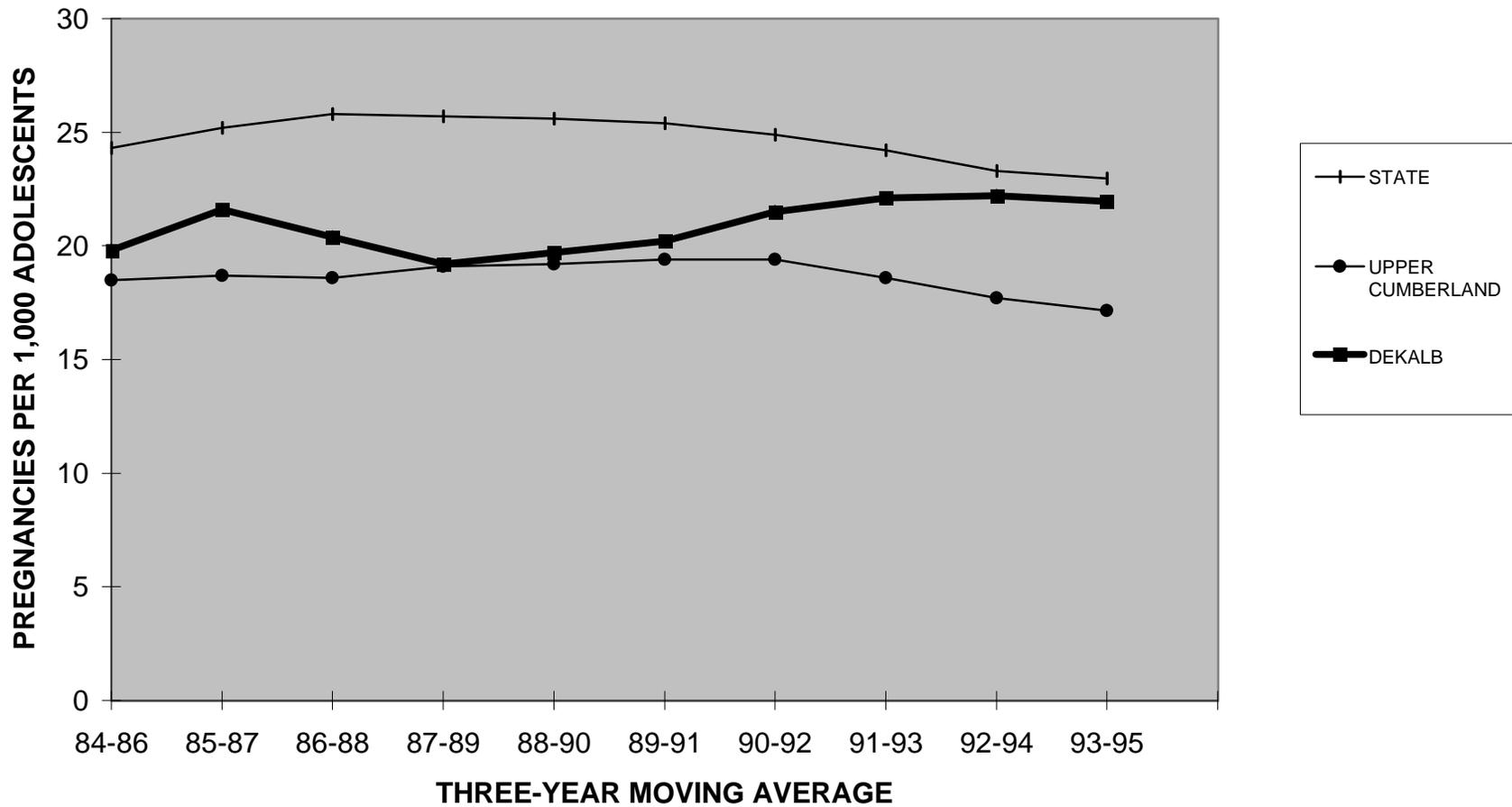
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	67.1	68.4	70.1	70.6	70.3	68.7	67.1	66.3	65.8	66.0
UPPER CUMBERLAND	54.3	55.6	58.2	59.2	59.2	57.6	57.3	57.4	58.4	58.7
DEKALB	55.4	57.0	56.1	58.1	54.1	56.3	55.2	57.6	55.5	57.0

NUMBER OF PREGNANCIES PER 1,000 FEMALES AGS 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	
DEKALB	19.8	21.6	20.4	19.2	19.7	20.2	21.5	22.1	22.2	22.0	

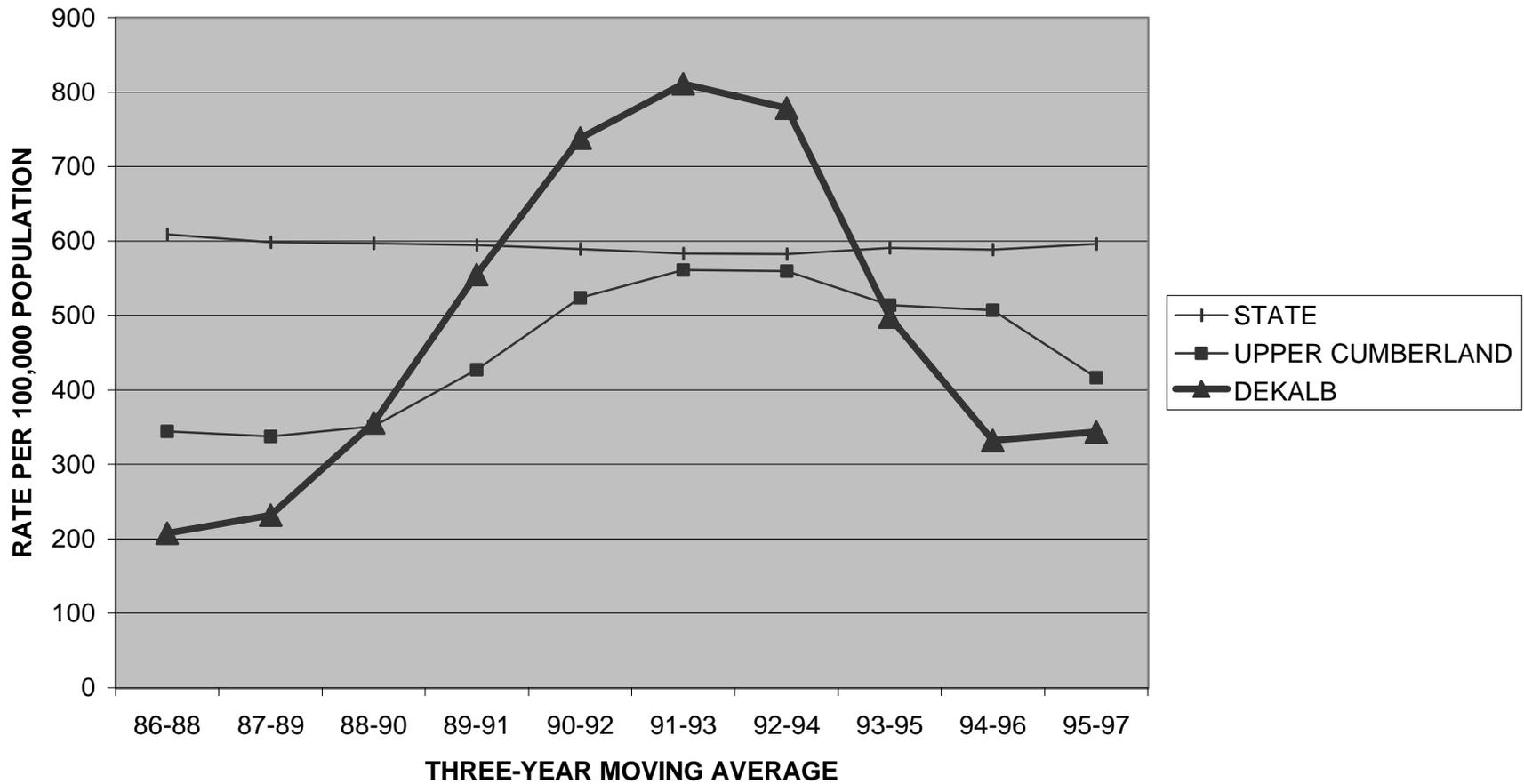
TOTAL NUMBER OF TEENAGE PREGNANCIES PER 1,000 FEMALES AGES 10-17



Appendix 4
Mortality Data

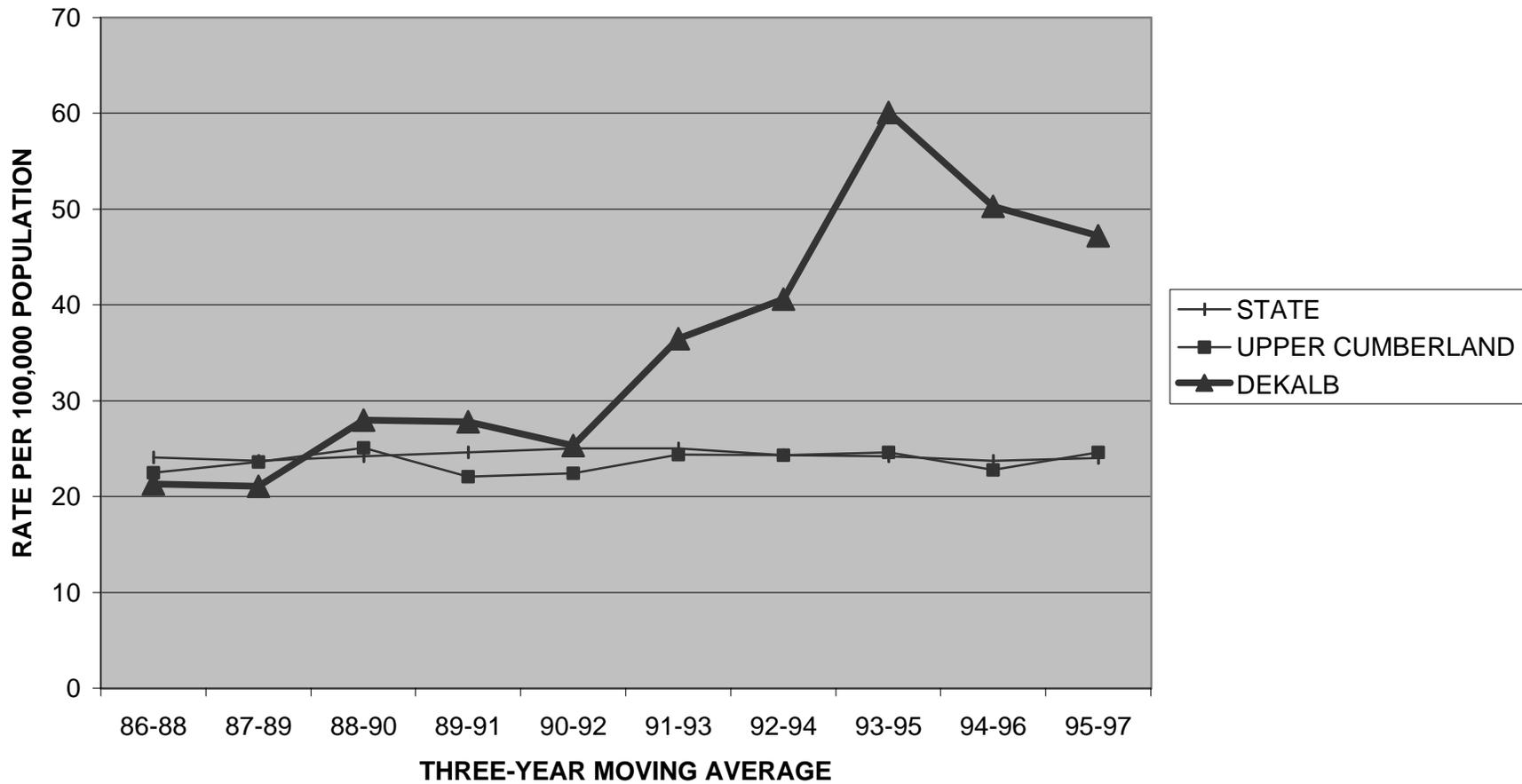
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	608.9	598.3	596.8	594.4	588.8	582.7	582.2	590.6	588.7	595.7
UPPER CUMBERLAND	344.0	337.6	351.2	427.2	523.4	560.8	559.5	514.1	506.7	416.7
DEKALB	207.5	231.9	356.0	554.6	738.2	811.0	778.1	497.8	331.9	343.3

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



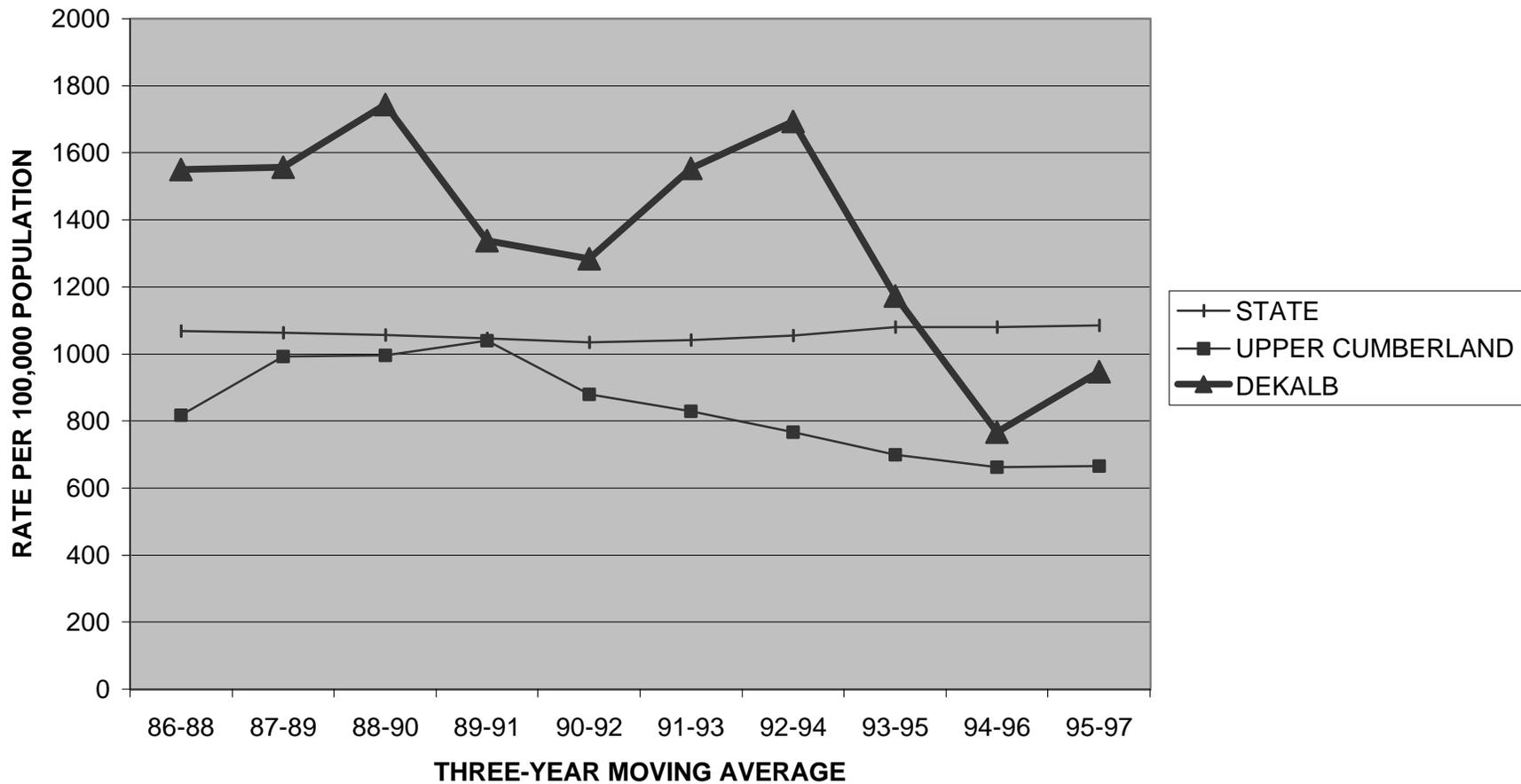
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	24.1	23.7	24.2	24.6	25.0	25.0	24.3	24.2	23.7	24.0
UPPER CUMBERLAND	22.5	23.6	25.1	22.1	22.4	24.4	24.3	24.6	22.8	24.6
DEKALB	21.3	21.1	28.0	27.8	25.3	36.5	40.6	60.1	50.3	47.2

VIOLENT DEATH RATE PER 100,000 POPULATION



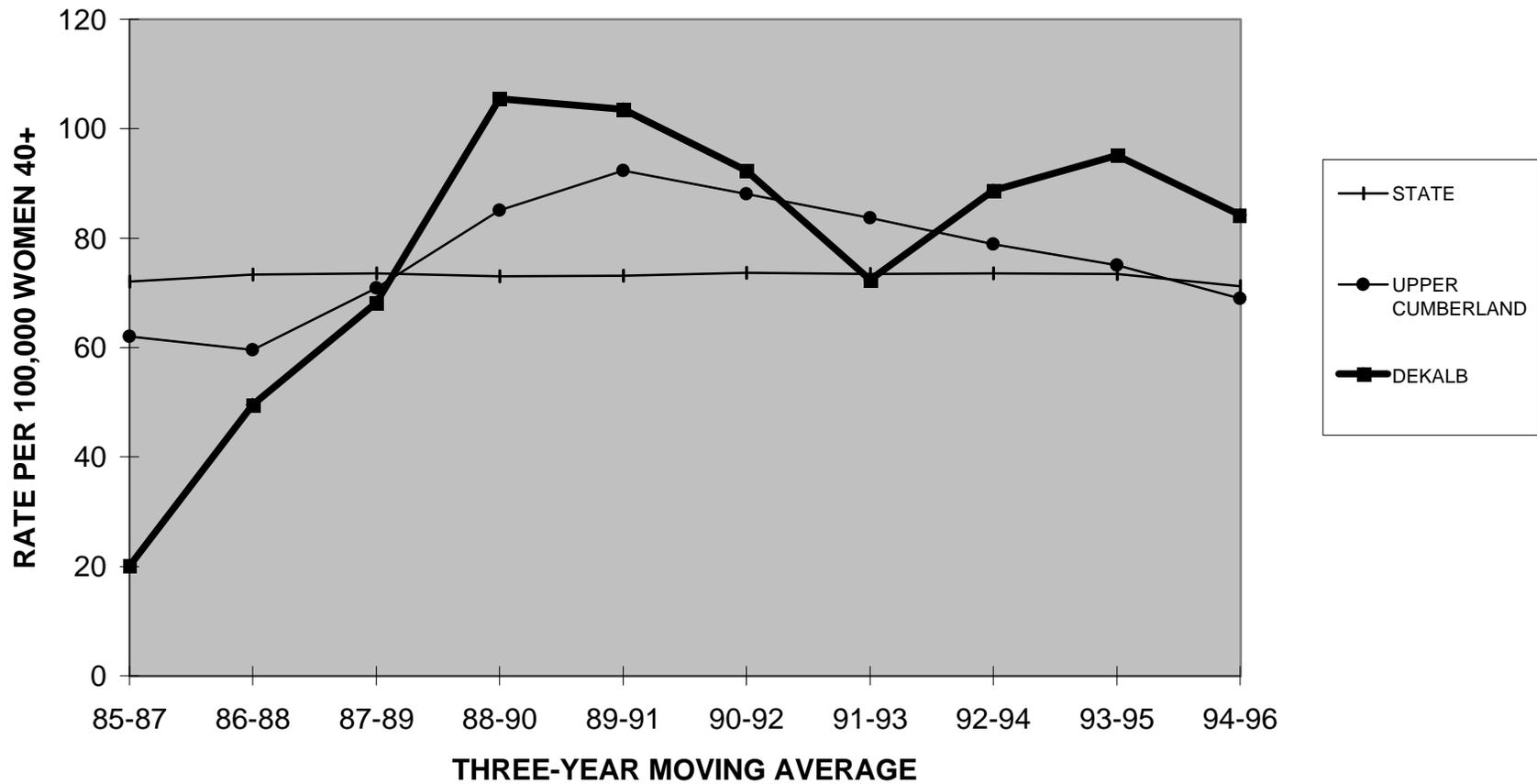
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	1,068.8	1,063.0	1,056.2	1,046.5	1,034.4	1,040.8	1,054.3	1,079.7	1,080.0	1,085.8
UPPER CUMBERLAND	817.8	992.0	995.6	1,039.8	878.9	829.4	766.8	699.8	663.0	665.1
DEKALB	1,549.7	1,557.4	1,743.2	1,337.2	1,284.3	1,553.9	1,693.6	1,172.5	765.8	946.2

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



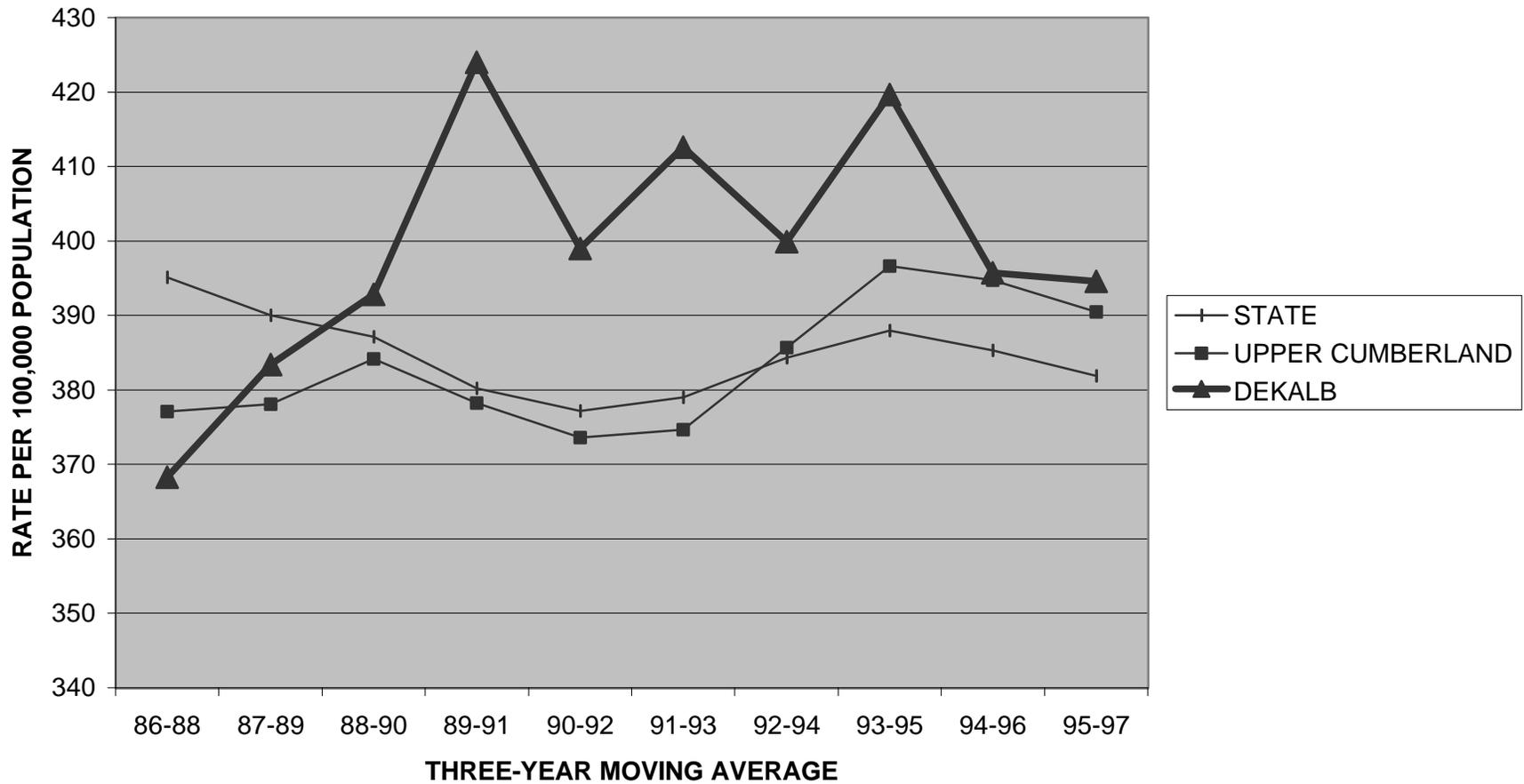
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	72.1	73.3	73.6	73	73.1	73.7	73.4	73.6	73.5	71.2	
UPPER CUMBERLAND	62	59.6	70.9	85.1	92.4	88.1	83.7	78.9	75.1	69	
DEKALB	20.1	49.5	68.2	105.5	103.6	92.4	72.4	88.7	95.1	84.2	

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



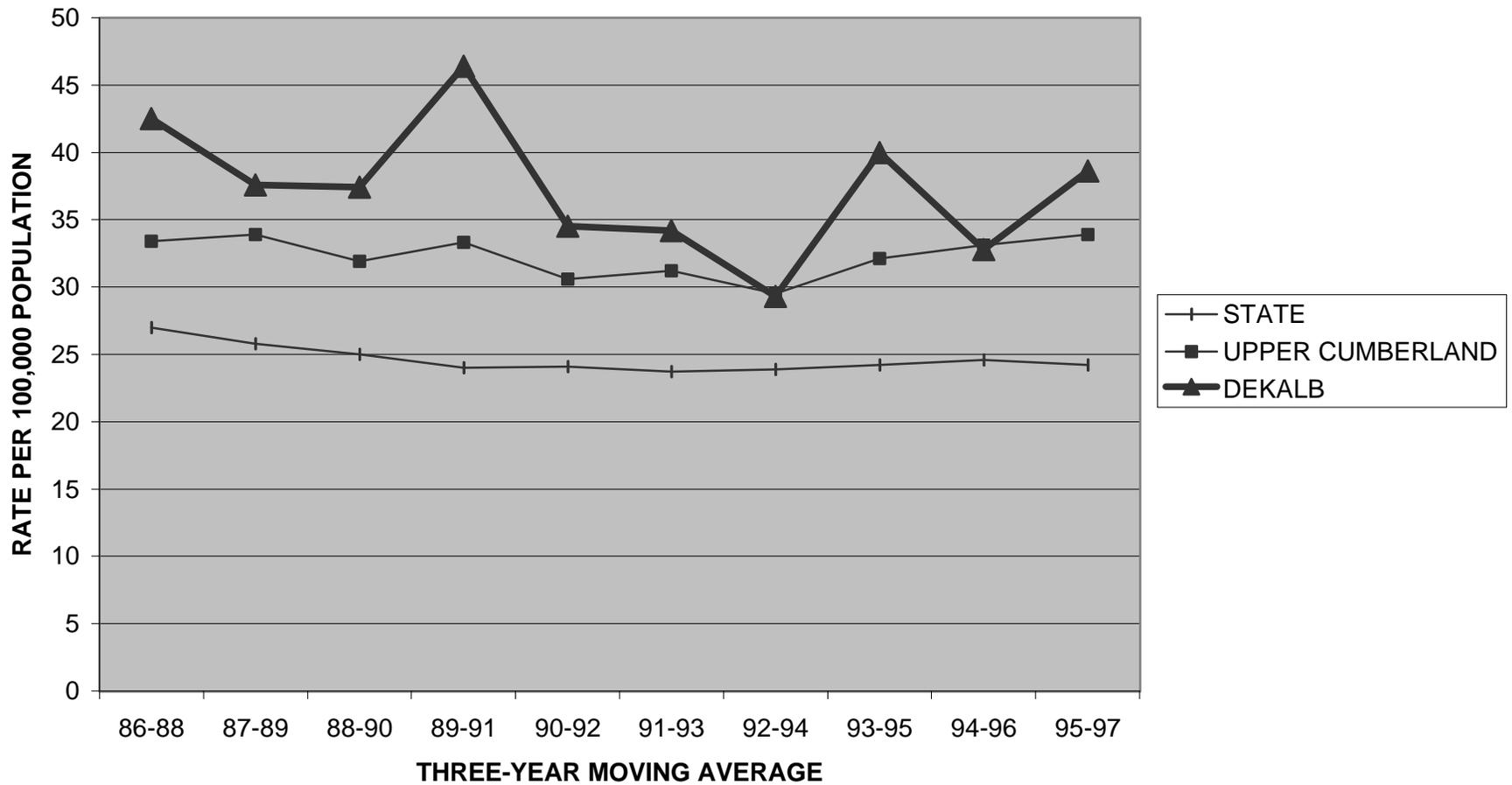
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	395.1	390.0	387.1	380.2	377.2	379.0	384.3	388.0	385.3	381.9
UPPER CUMBERLAND	377.1	378.1	384.2	378.2	373.6	374.7	385.7	396.6	394.7	390.5
DEKALB	368.3	383.4	392.8	424.0	399.0	412.6	399.9	419.7	395.7	394.6

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



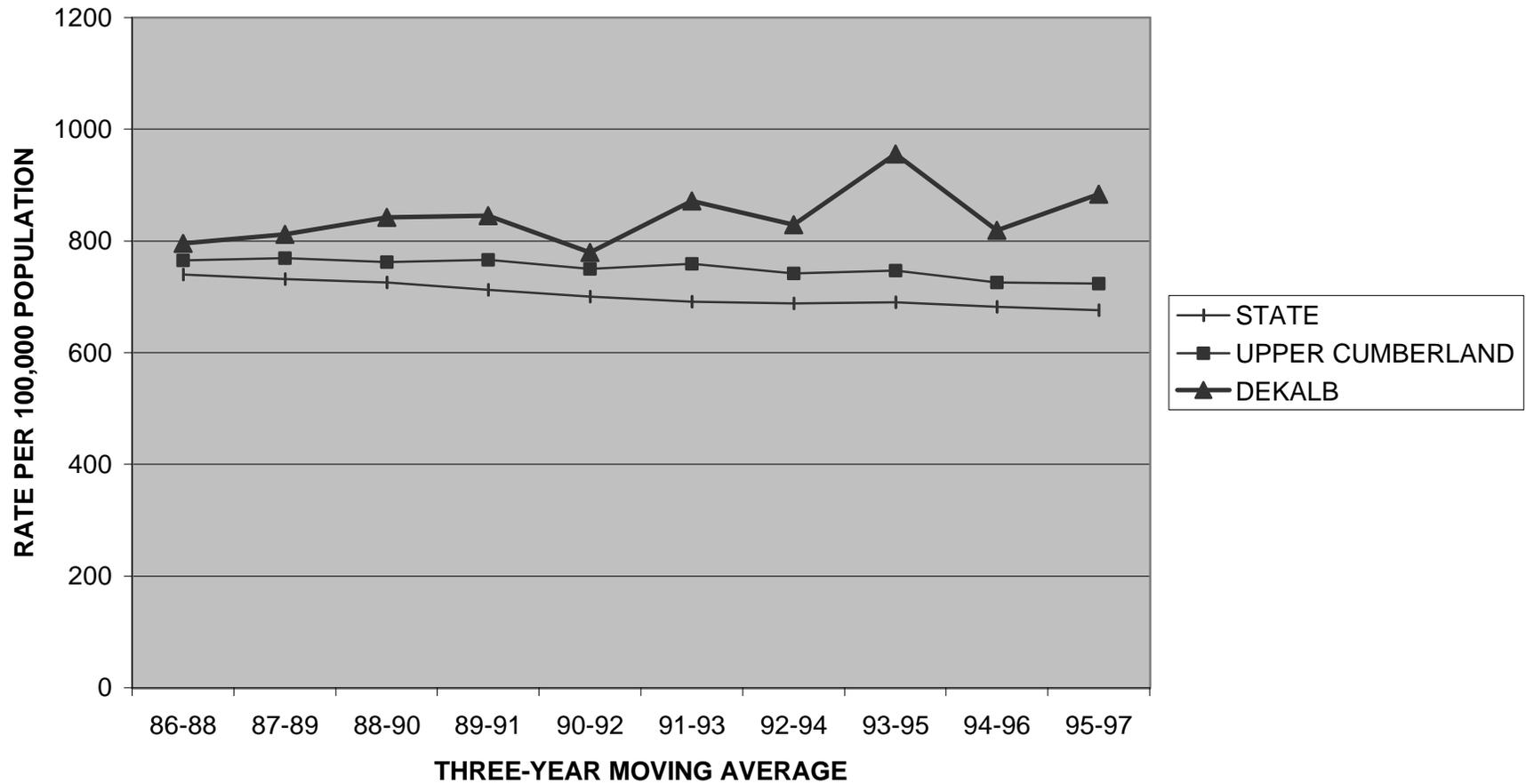
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	27.0	25.8	25.0	24.0	24.1	23.7	23.9	24.2	24.6	24.2	
UPPER CUMBERLAND	33.4	33.9	31.9	33.3	30.6	31.2	29.5	32.1	33.1	33.9	
DEKALB	42.5	37.6	37.4	46.4	34.5	34.2	29.3	40.0	32.8	38.6	

MOTOR VEHICLE ACCIDENTAL MORALITY 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	
DEKALB	795.7	812.3	842.4	845.2	779.1	872.0	829.4	955.4	818.5	883.7	

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

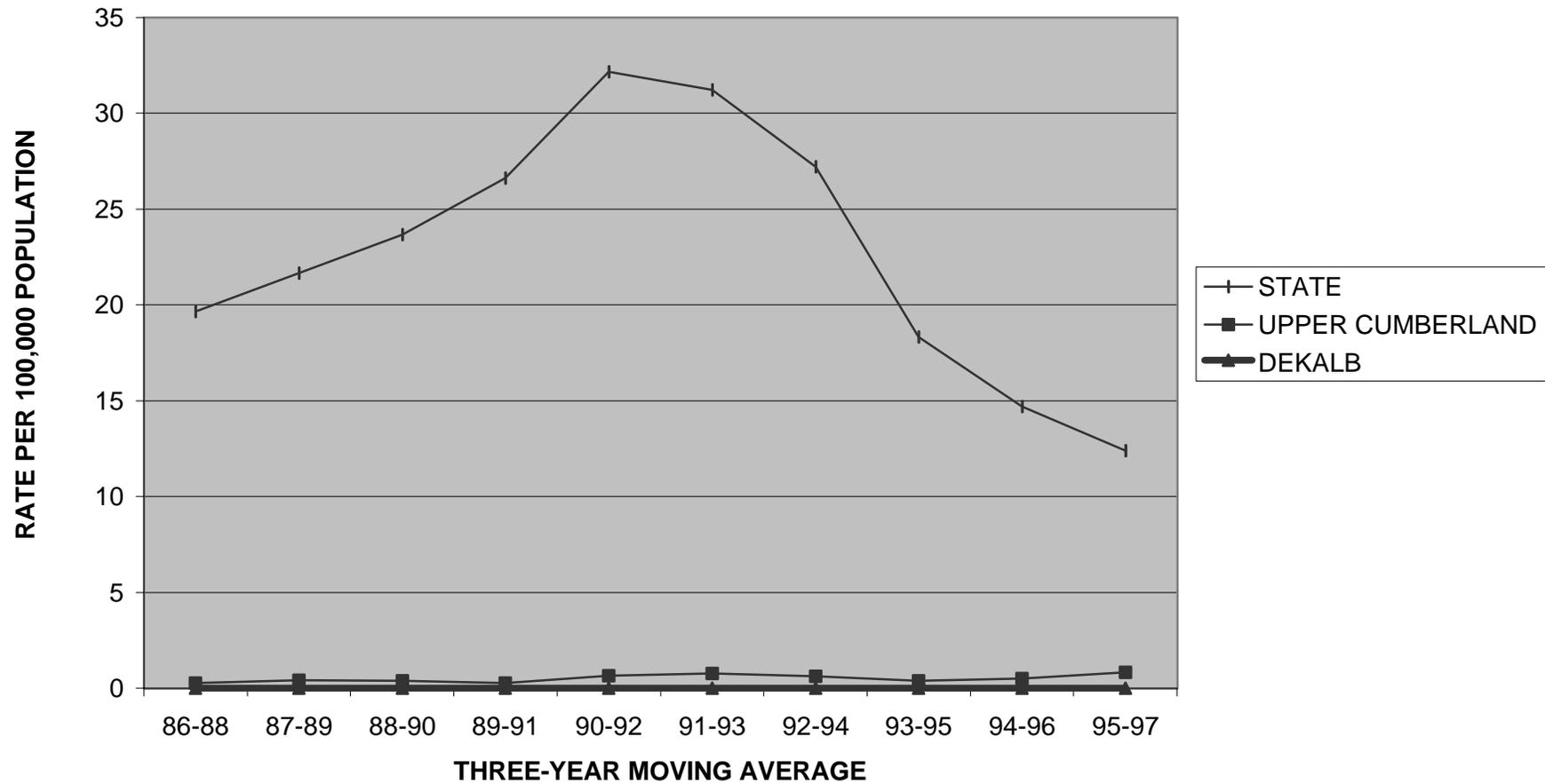


Appendix 5

Morbidity Data

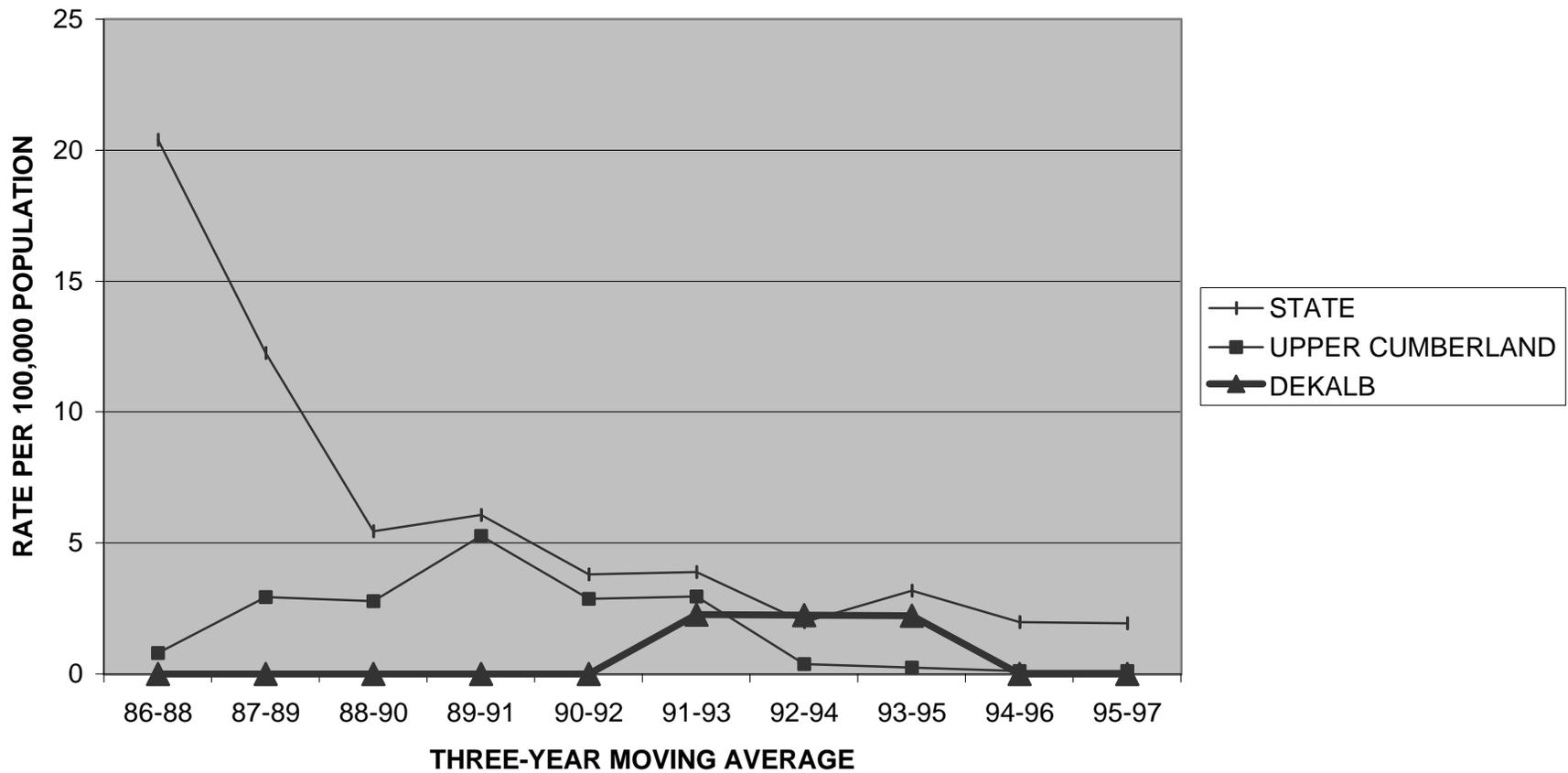
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	19.6	21.7	23.7	26.6	32.2	31.2	27.2	18.3	14.7	12.4	
UPPER CUMBERLAND	0.3	0.4	0.4	0.3	0.7	0.8	0.6	0.4	0.5	0.8	
DEKALB	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

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



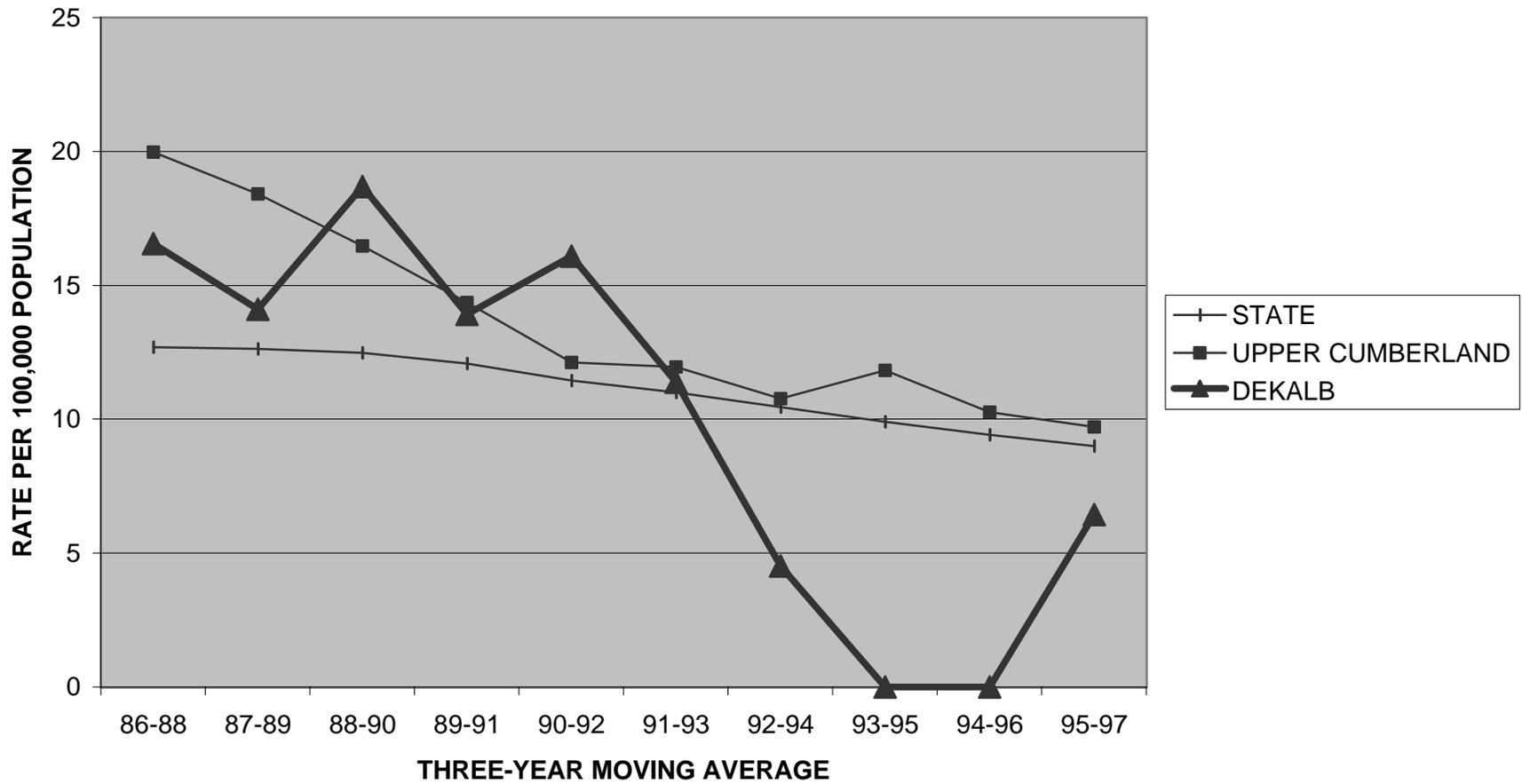
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	20.4	12.3	5.5	6.1	3.8	3.9	2.0	3.2	2.0	1.9
UPPER CUMBERLAND	0.8	2.9	2.8	5.3	2.9	3.0	0.4	0.2	0.1	0.1
DEKALB	0.0	0.0	0.0	0.0	0.0	2.3	2.3	2.2	0.0	0.0

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



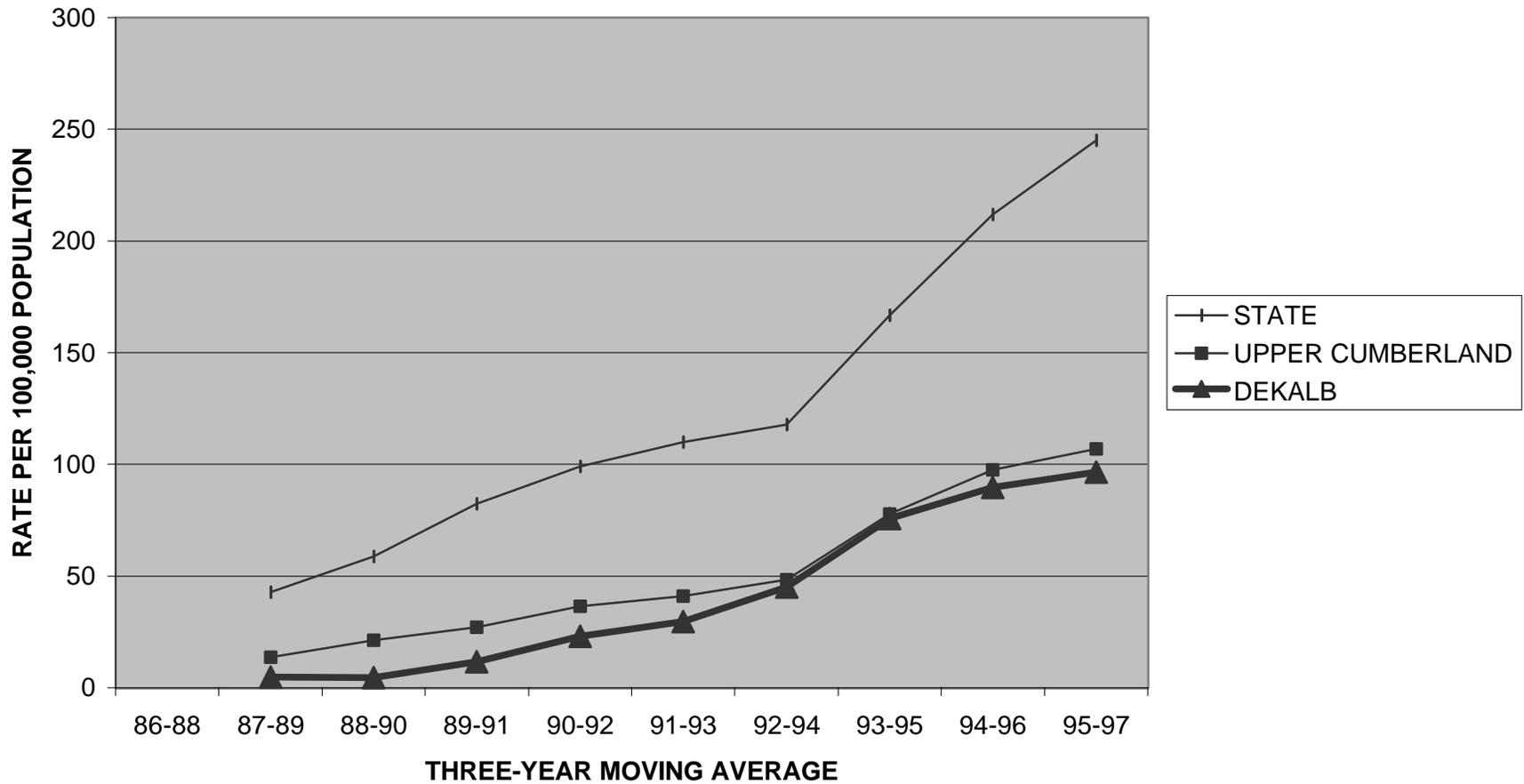
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	12.7	12.6	12.5	12.1	11.4	11.0	10.5	9.9	9.4	9.0
UPPER CUMBERLAND	20.0	18.4	16.5	14.4	12.1	12.0	10.8	11.8	10.3	9.7
DEKALB	16.5	14.1	18.7	13.9	16.1	11.4	4.5	0.0	0.0	6.4

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



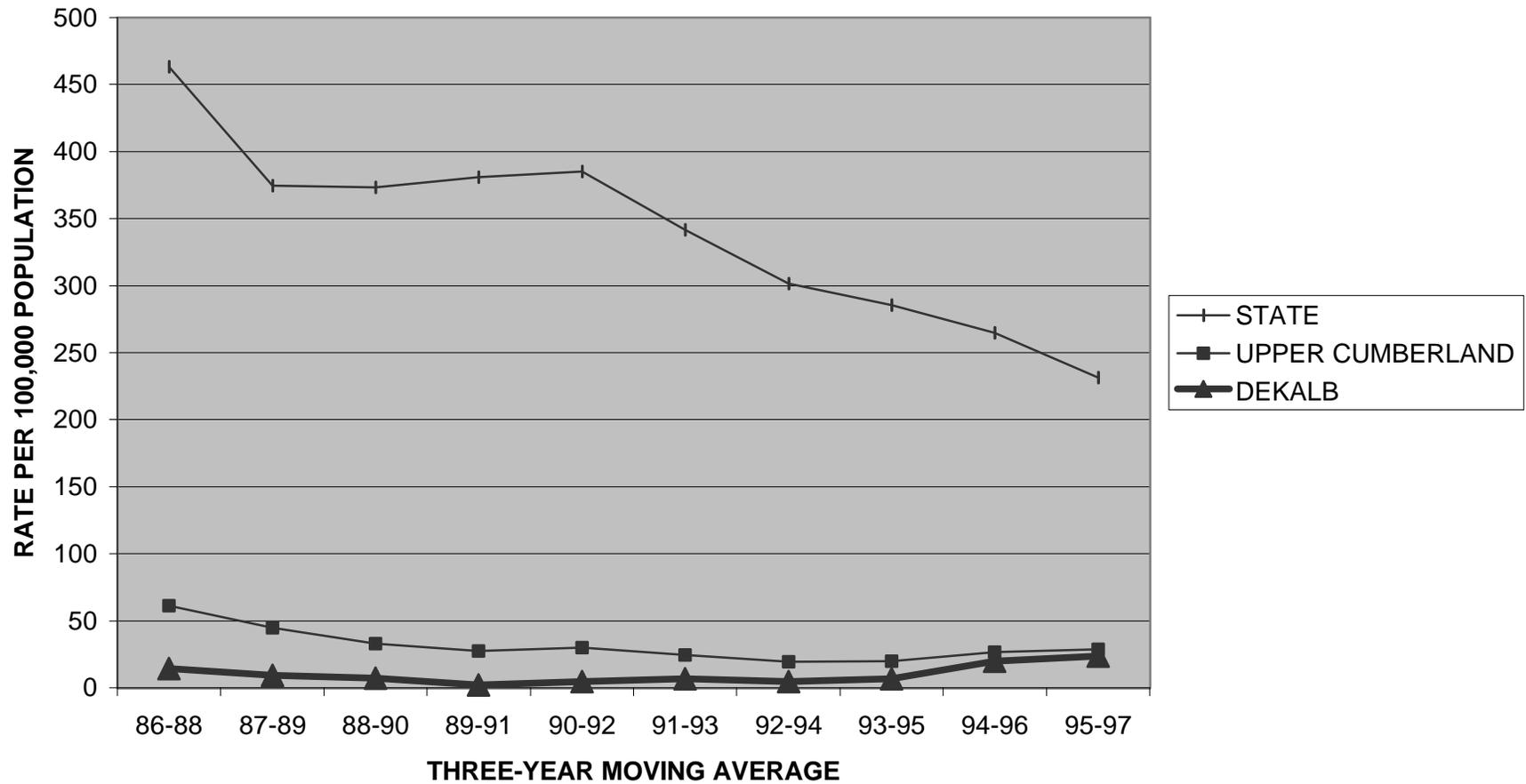
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE		42.8	58.8	82.3	99.1	109.9	117.7	166.7	211.8	245.0
UPPER CUMBERLAND		13.6	21.4	27.0	36.4	41.1	48.5	77.9	97.7	106.8
DEKALB		4.7	4.7	11.6	23.0	29.6	45.1	75.6	89.7	96.6

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	
DEKALB	14.2	9.4	7.0	2.3	4.6	6.8	4.5	6.7	19.7	23.6	

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: Server.to/hit