

SMITH COUNTY

COMMUNITY DIAGNOSIS DOCUMENT

A GUIDE TO HEALTHY COMMUNITIES

1998-1999

Compiled by

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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 Smith 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 Smith 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 Smith County Community Diagnosis Document, which details the process the Smith 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 Smith 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 Smith County Health Council was established in January 1998 by the Tennessee Department of Health Community Development Staff with an initial group of thirteen community representatives. The Smith County Health Council has now developed into a council of thirty-nine 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 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 Smith 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 3rd Monday of each month from 12:00 to 1:00 p.m. where meetings are open to the public.

County Description

Geographic

- Carthage , the county seat of Smith County, Tennessee, is situated on the north bank of the Cumberland River approximately one mile below the junction of the Caney Fork River.
- Smith County is located 50 miles from Nashville.
- This county is predominantly rural and agricultural.
- Smith County is surrounded by Putnam, Jackson, Trousdale, Dekalb, Macon, and Wilson counties in Tennessee.
- The Cordell Hull Dam is located in Smith County upstream from Carthage.
- Smith County is accessible and close to Interstate 40 and other U.S. and State Highways.
- The average high temperature in August is 80.8 degrees and the average low in December is 37.5 degrees with annual average precipitation being 58.0 inches.

Land Area

- Smith County is a farming community consisting of 314.4 square miles with population density being 45 people per square mile.
- The cultivation of tobacco is the major cash crop of the county.
- Smith County is located on the Cumberland River, which is an integral part of its growth and history.

Economic Base

- The county's median family personal income is \$27,393.
- The county's median household personal income is \$23,255.
- Smith County's per capita personal income is \$10,950.
- The average weekly income of 1997 wages was \$454.
- The individual poverty rate for Smith County is 14.5%.
- The family poverty rate for Smith County is 20.6%
- The 1999 average labor-force total is 10,150, of those, 9,860 are employed and 290 are unemployed giving Smith County an unemployment rate of 2.9%.

- The major employers in Smith County include William Bonnell, Savage Zinc, EFP South Corp., and Dana Corporation.

Demographics

- Smith County's public education system consists of 7 elementary schools and 2 Junior High/Senior High Schools with an approximate enrollment of 2900 students.
- The number of TennCare enrollees in Smith County for 1999 is 2,338.
- The 1998 population estimate for Smith County is 16,368.
- The median age for a Smith County resident is 35.2 years

Medical Community

- There are two hospital facilities operating in Smith County with a total of 92 licensed beds.
- The local county hospitals are the most used by Smith County residents, second Davidson County and third is Sumner County.
- There is one nursing home located in Smith County that has a total of 128 licensed beds.
- Smith County has sixteen medical doctors and three dentists practicing in the county.

References: Tennessee Department of Health, Upper Cumberland Development District

Community Needs Assessment

Primary Data

Smith 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 Smith County community based on the survey results.

		Top Ten Issues Highlighted
Smoking	62%	
High Blood Pressure	50%	
Heart Conditions	46%	
Stress	46%	
Arthritis	45%	
Adult Alcohol Abuse	44%	
Teen Alcohol Abuse	43%	
Obesity	42%	
Teen Pregnancy	39%	
Smokeless Tobacco	37%	
Adult Drug Abuse	35%	
Other Cancers	32%	
Breast Cancer	28%	
Depression	28%	
Lung Cancer	28%	
Pneumonia	26%	
Lack of Sex Education	26%	
Domestic Violence	26%	
Child Abuse/Neglect	25%	
Crime	22%	
Motor Vehicle Deaths	21%	

Prostrate Cancer	21%
Influenza	20%
Prostrate Cancer	21%
School Dropout	19%
Eating Disorders	19%
Poor Nutrition for Elderly	18%
Colon Cancer	18%
Youth Violence	17%
Sexually Transmitted Diseases	16%
Poverty	16%
Poor Nutrition for Children	16%
School Safety	13%
Water Pollution	13%
Unemployment	12%
HIV/AIDS	10%
On the Job Safety	10%
Air Pollution	10%
Other Accidental Deaths	9%
Lack of Childhood Vaccinations	7%
Hepatitis	6%
Homicide	5%
Gangs	5%
Teen Suicide	4%
Toxic Waste	4%
Tuberculosis	4%
Adult Suicide	3%
Homelessness	3%

Smith County Availability of Services

“Adequate” (50% or greater)		“Not Adequate” (25% or greater)	
1) Pharmacy Services	92%	1) Recreational Activities	40%
2) Ambulance/Emergency Services	88%	2) Specialized Doctors	27%
3) Local Family Doctors	86%	2) Alcohol/Drug Treatment	27%
4) Hospital Care	81%	3) Adult Day Care	26%
4) Emergency Room Care	81%	4) Mental Health Services	25%
5) County Health Department Services	77%		
6) Child Day Care	75%		
6) Home Health Care	75%		
7) Dental Care	73%		
8) Health Insurance	67%		
9) Eye Care	65%		
10) Pediatric Care	64%		
11) Transportation to Medical Care	63%		
12) Medical Equipment Supplier	61%		
13) Pregnancy Care	60%		
14) Nursing Home Care	58%		
15) Women’s Health Services	55%		
16) Specialized Doctors	54%		

Personal Information

- The majority of the people completing the survey were from Carthage and 68% have lived in the county for more than ten years.
- The average age for the community participants was between 35-44 years of age with 10% being single and 72% married.
- The participant response noted that 85% had health insurance, 20% were TennCare enrollees, and 7% receive either SSI or AFDC.

The Community Health Assessment Survey was distributed to 265 persons in the Smith County community and 200 persons were interviewed by telephone making a total of 465 respondents. The survey was tabulated and prepared by the Lancaster Consulting Group. The council reviewed the top ten community issues and community resources perceived as not adequate by the respondents. The Lancaster Group conducted focus groups in the Smith County area to ascertain the feelings as to what the greatest health related needs are of the community and to determine what the community can do to address the needs.

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. 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	62%	
Arthritis	34%	Top Ten Issues Highlighted
Cancer	32%	
Teen Pregnancy	29%	
High Blood Pressure	28%	
Obesity	26%	
Alcohol Abuse	26%	
Heart Conditions	25%	
Drug Abuse	22%	
Health Problems of the Lungs	18%	
Diabetes	15%	
Animal Control	11%	
Environmental Issues	9%	
Violence in the Home	8%	
STD’S	6%	
Mental Health Problems	6%	
Other Violence	2%	
Suicide	0%	

Smith County’s Access to Care Issues Percent Saying Definite Problem

Transportation to Health Care	8%
Access to Nursing Home Care	8%
Access to Assisted Living Services	7%
Access to Pharmacies, Medicines	5%
Access to Prenatal Care	3%
Access to Hospitals	3%
Access to Birth Control Methods	2%

Access to Dental Care	2%
Access to Physicians or Doctors	2%

Other Issues to Consider

Tobacco Use

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

Yes: 48%

No: 52%

Percent of respondents that report current cigarette use:

Daily Use: 61%

Some Use: 3%

Not At All: 36%

Questions Regarding Mammograms

Percent of women reporting having a mammogram:

Yes: 52%

No: 48%

Reasons reported for not having a mammogram:

Doctor not recommended: 15%

Not needed: 2%

Too young: 56%

No reason: 23%

Not sure/other: 4%

When was last mammogram performed:

In last year: 58%

1-2 years : 13%

> Than 2 years: 29%

The Behavioral Risk Factor Survey is a random telephone survey conducted by the University of Tennessee, which takes approximately 20 minutes. Approximately 200 interviews were obtained from the Smith County community. The findings of the survey revealed that the community respondents perceive tobacco use, cancer, high blood pressure, arthritis, and heart conditions as top health problems facing their county. The council discussed in length the issues surrounding tobacco use to include the following topics:

- Age
- Gender
- Race of Respondent
- Hispanic Origin
- Martial Status
- Kids
- Respondent Education
- Respondent Employment Status

In analyzing the access to care issues as perceived by the survey respondents, transportation to health care and access to nursing homes were identified as the top two concerns. The council discussed at length the top issues by age, sex, definite problem, somewhat a problem, and not a problem.

Secondary Data

Summary of Data Use

Health Indicator Trends Smith County, Tennessee 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	Above	Above
2. Percent births to unwed women	Increasing	Above	Below
3. Number teenage pregnancies	Increasing	Above	Below
4. Number pregnancies/1,000 females	Increasing	Above	Below
5. Number of pregnancies/1000 females ages 10-14	Increasing	Above	Above
6. Number of pregnancies/1000 females ages 15-17	Increasing	Above	Below
7. Number of pregnancies/1000 females ages 18-19	Increasing	Above	Above
8. Percent pregnancies to unwed women	Increasing	Above	Below
9. Percent of live births classified as low birthweight	Increasing	Above	Below
10. Percent of live births classified as very low birthweight	Unstable	Equal	Below
11. Percent births w/1 or more high risk characteristics	Increasing	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 teenage pregnancies
- Number of pregnancies/1000
- Number of pregnancies/1000 females ages 10-14
- Number of pregnancies/1000 females ages 15-17
- Number of pregnancies/1000 females ages 18-19
- Percent of pregnancies to unwed women
- Percent of live births classified as low birth weight
- Percent births w/1 or more high risk characteristics

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	Unstable	Above	Above
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	Above	Above
17. Other races female age adjusted mortality rate/100,000 population	Unstable	Above	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	Decreasing	Below	Below

The above mortality data shows an increasing trend for:

- White female age adjusted mortality rate/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.

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

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

Healthy People 2000 Compared to Smith County

Health Status Indicators	Smith County Rate	Tennessee Rate	Nation's Rate
Death from all causes	582.7	563.1	No Objective
Coronary Heart Disease	125.4	134.8	100
Deaths from Stroke	39.8	34	20
Deaths of Females from Breast Cancer	24.1	22.4	20.6
Deaths from Lung Cancer	45.3	47.5	42
Deaths from Motor Vehicle Accidents	31.0	23.6	16.8
Deaths from Homicide	11.8	12.1	7.2
Deaths from Suicide	5.6	12.6	10.5
Infant Deaths	5.1	9.6	7.0
Percent of Births to Adolescent Mothers	6.1	6.6	None
Low Birthweight	6.9	8.7	5.0
Late Prenatal Care	18.7	19.9	10.0
Incidence of AIDS	*	14.1	-----
Incidence of Tuberculosis	10.9	11.6	3.5

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

The indicators that are in bold are Smith 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**
- **Number teenage pregnancies**
- **Number pregnancies/1000 females**
- **Number pregnancies/1000 females ages 10-14**
- **Number pregnancies/1000 females ages 15-17**
- **Number pregnancies/1000 females ages 18-19**
- **Percent pregnancies to unwed women**
- **Percent of live births classified as low birth weight**
- **Percent of births w/1 or more high risk characteristics**
- **White female age-adjusted mortality rate/100,000 population**
- **Chlamydia rate/100,000 population**

In analyzing these trends, the council's awareness of these problems increased dramatically. The council members expressed concern with the issues surrounding pregnancies in their county specifically, teen pregnancies. The data reflects that females at a younger age are becoming pregnant, and certainly this is a concern for the community.

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.

PRIORITIZATION TABLE

Priority Issue	BRFS	Comm. Quest.	Health Indicator Trends (Secondary Data)
Tobacco Use/Smoking/ Smokeless Tobacco	(1)	(1) (10)	In ages 25-44, the trend of deaths from malignant neoplasms has been unstable, with the rate for 94-96 being well below the state and the region. In ages 45-64, deaths from malignant neoplasms have been steadily increasing over the past 10 years, with rates above the region and the state since 90-92. The mortality rates for ages 65+ are below the state and the region, but have remained high for the past 10 years. The lung cancer incidence rate for 1995 was 61.3, with the state's rate being 64.2. There were 12 reported cases for 1995.
High Blood Pressure	(5)	(2) Stress Ranked 4 th	Deaths from cerebrovascular disease in ages 25-44 dramatically increased beginning in 90-92, and the rates have remained well above the state and the region. In ages 45-64, the mortality rates for cerebrovascular disease were above the state and the region from 85-87 through 91-93 at which time they dropped below the state and the region. The rates rose again in 94-96 with the rate being above both the state and the region. The rates for ages 65+ have remained above the state and the region for the past 10 years.
Heart Conditions	(7)	(3)	In ages 25-44, deaths from heart disease have dramatically increased since 91-93, but rates are below the state and the region. In ages 45-64, heart disease mortality rates steadily increased from 85-87 through 89-91, but have decreased every year since. The rate for 94-96 is below the region, but above the state. The rates for ages 65+ are high, and have remained above the state and the region for the past 10 years.
Arthritis	(2)	(5)	
Adult Alcohol Abuse	(6)	(6)	In ages 25-44, chronic liver disease and cirrhosis mortality rates were well above the state and region from 85-87 through 89-91, but have dramatically decreased since then. No deaths have been reported since 92-94. In ages 45-64, death rates from chronic liver disease and cirrhosis were above the state and the region in 85-87, but steadily decreased. No deaths were reported from 89-91 through 92-94. Mortality rates have increased since then, but the rates continue to be below the region and the state. Chronic liver disease and cirrhosis were not listed as a leading cause of death for ages 65+.
Teen Alcohol Abuse	(6) Addressed Total Population	(7)	The rates for suicide for ages 15-24 have dramatically increased since 91-93, and rates have remained above both the state and the region since that time.

Priority Issue	BRFS	Comm. Quest.	Health Indicator Trends (Secondary Data)
Teen Pregnancy	(4)	(9)	The total number of teenage pregnancies for ages 10-17 has increased slightly over the past 10 years. In ages 10-14, rates have increased dramatically since 88-90 with the rate for 94-96 being well above the state and the region. Rates for ages 15-17 have remained fairly stable over the past 10 years with the rate for 94-96 being above the region, but below the state. In ages 18-19, rates have increased at a steady pace, with the rate for 94-96 being above the state and the region.
Cancer Other Cancer Breast Cancer Lung Cancer	(3)	(12) (13) (15)	In ages 25-44, the trend of deaths from malignant neoplasms has been unstable, with the rate for 94-96 being well below the state and the region. In ages 45-64, deaths from malignant neoplasms have been steadily increasing over the past 10 years with rates being above the region and the state since 90-92. The mortality rates for ages 65+ are below the state and the region, but have remained high for the past 10 years. The lung cancer incidence rate for 1995 was 61.3, with the state's rate being 64.2. There were 12 reported cases for 1995. Breast cancer incidence rate for 1995 was 71.1, with the state's rate being 94.4. There were 7 reported cases for Smith county. Incidence rate for "other sites" for 1995 was 31.2, with the states rate being 31.3. There were 5 reported cases for 1995.
Obesity	(6)	(8)	See Heart Conditions: Diseases of the Heart trends See High Blood Pressure: Cerebrovascular Disease trends
Drug Abuse	(8)	(11)	
Health Problems of the Lungs	(9)	Lung Cancer Ranked 15 th	In ages 45-64, mortality rates for chronic obstructive pulmonary disease have steadily increased over the past 10 years, with the rate for 94-96 being above the state and the region. Deaths rates in ages 65+ have shown an increasing trend for the past 10 years with the rate for 94-96 being above both the state and the region. . Lung cancer incidence rate for 1995 was 61.3, with the state's rate being 64.2. There were 12 reported cases for 1995.
Diabetes	(10)	(14)	In ages 25-44, no deaths from diabetes were reported from 85-87 through 89-91. Since that time mortality rates have dramatically increased with rates being well

			above the state and the region. In ages 45-64, mortality rates have been unstable over the past 10 years. The rate for 94-96 was below the state and the region. The mortality rates for diabetes have shown an increase over the past 10 years in ages 65+, with the rate for 94-96 being below both the state and the region.
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Smith 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 12.

Seriousness: The most serious problem will be ranked 1.
The least serious problem will be ranked 12.

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)
12 being the lowest rank(the smallest percentage)

Assign a rank for seriousness.

1 being the most serious
12 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 12.

The council then scored and ranked the following top issues.

TOP ISSUES

- 1) Tobacco Use/Smoking/Smokeless Tobacco
- 2) Teen Pregnancy
- 3) High Blood Pressure
- 4) Drug Abuse
- 5) Heart Conditions
- 6) Adult Alcohol Abuse
- 7) Obesity
- 8) Diabetes
- 9) Cancer(Other Breast, Lung)
- 10) Arthritis
- 11) Health Problems of the Lungs

The following is a brief description of the PEARL Test , a method used by the council to help further prioritize the issues.

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 are:

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

Future Planning

Through the Community Diagnosis Process, it was determined that the top issue of concern was **teen pregnancy** in Smith County. The future plans of the Smith 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 which 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

Smith County Health Council

Dr. David McDonald: Physician
P.O. Box 297
Carthage, TN 37030

**Joanna Carter, Food Bank
Community Resource**
P.O. Box 40
Hwy 25
Riddleton, TN 37151

Dr. David G. Petty: Physician
505 Jackson Avenue
Carthage, TN 37030

Anne F. Hughes, Community Volunteer
901 Main Street
Carthage, TN 37030

Regina Brooks, Chamber of Commerce
P.O. Box 70
130 W. 3rd Avenue
Carthage, TN 37030

Virginia Carter, Hospital Volunteer
513 Virginia Drive
Carthage, TN 37030

Dr. Earnest Jones, Physician
Smith County Professional Bldg.
Suite 200
133 Hospital Drive
Carthage, TN 37030

**Joe Vance
Community Bank**
1210 Main Street
Carthage, TN 37030

Billy Bass, County Executive
Turner Building
Spring Street
Carthage, TN 37030

Mayor David Bowman
314 Spring Street
Carthage, TN 37030

**Helen Owen
Vocational School**
135 Gordonsville, Hwy
Carthage, TN 37030

**Susan Gore
Smith County Board of Education**
Main Street
Carthage, TN 37030
Joyce Draper: Director
Smith County Health Department

**Wayne Winfree: Carthage General
Hospital Administrator**
33 House Circle
Carthage, TN 37030

**Eddie West
Carthage Courier**
P.O. Box 239
Carthage, TN 37030

Dr. Larry Turner, Physician
126 J&B Drive
Gordonsville, TN 38563

**Jim Tucker
Smith County Health Care Center**
112 Healthcare Drive
Carthage, TN 37030

**Jerry Futrell: Regional Health Council Rep.
Hospital Administrator**
Columbia Smith County Memorial Hospital
158 Hospital Drive
Carthage, TN 37030

**Steve Wilmore: Pharmacist
Smith County Drug Center**
23 Dixon Springs Highway
Carthage, TN 37030

Mayor Joe Anderson
63 East Main Street
Gordonsville, TN 38563

James Alcorn, Mayor, South Carthage
106 Main Street South
Carthage, TN 37030
**Kimberly Freeman
Regional Health Office**

Kathy Shea
Valley Ridge Mental Health Center
P.O. Box 297
Lafayette, TN 37083

Janie Pedigo
UT Ag. Extension Service
P.O. Box 296
Carthage, TN 37030-0296

Valerie Upchurch
SCMH
158 Hospital Drive
Carthage, TN 37030

Lyla Kittrell
Smith County Health Department

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

Kim Kompel
Smith County Health Department

Judy Maxwell: Concerned Citizen
90 Bradford Hill Road
Brush Creek, TN 38547

Steven Swords: Minister
213 Pea Ridge Road
Elmwood, TN 38560

Connie Wallace
DHS
P.O. Box 295
Gainesboro, TN 38562

Leslie Fitzpatrick
Smith County Health Department

Jane Cassetty, Teacher
135 Gordonsville Highway
Carthage, TN 37030

Melissa Ross
CGH
P.O. Box 319
Carthage TN 37030

Scott Winfree
Carthage Courier
P.O. Box 239
Carthage, TN 37030

Gary Young
The Center for Community Health
1831 Clinch Avenue
Knoxville, TN 37916

Becky Hawks: TN Dept. of Health
Cordell Hull Building, 4th Floor
425 5th Avenue North, Nashville, TN

Citizen Etheleen Gass: Concerned
273 Gordonsville Highway
Brush Creek, TN 38547

Sue Franklin
Smith County Health Department

Appendix 2

BY LAWS FOR SMITH COUNTY HEALTH COUNCIL

ARTICLE 1—NAME

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

ARTICLE II—PURPOSE

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

ARTICLE III—GOALS

The Council will promote the prevention of premature death, disability and illness by developing a Smith County community health plan for recommendation to the Department of Health. From its analysis of the health needs of the county, the Council will:

1. Formally define health care problems and needs within the community.
2. Develop goals, objectives and plans of action to address those needs.
3. Identify departmental/organizational work teams and community agencies which should coordinate efforts with respect to each health problem.
4. Establishing priorities for all identified health problems.
5. Evaluate successes or failures of priorities and report such to the community.

ARTICLE IV—AUTHORITY

The Council shall exist as an advisory and support body to the Tennessee Department of health solely for the purposes stated herein and not be vested with any legal authority described to the Tennessee Department of Health, the State of Tennessee or any of its political subdivisions. Recommendations of the Council will not be binding upon the Tennessee Department of Health and the Council is not granted authority to act on behalf of the Department of Health without specific written authorization.

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 monies or property on behalf of the Tennessee Department of Health without specific prior approval

in writing. Should such authorization be issued, any monies or property thereby arising shall be designated for and relinquished directly to the Tennessee Department of Health for appropriate accounting and allocation according to the Tennessee Department Health applicable Department of Health Policy. The Council shall provide the Tennessee Department of Health a strict accounting of all financial transactions arising from Council activities. The financial records and accounts of the Council will be made to the Tennessee Department of Health or its auditors for examination at any time upon reasonable request.

ARTICLE V—MEMBERSHIP

The Council shall consist of no less than 15 nor more than 30 members. A membership vacancy on the Council shall not prevent the Council from conducting business. Membership will be restricted to the residents of Smith County, Tennessee. The Council shall consist of an adequate number of voting members so 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, law enforcement and government may be invited to serve. Initial members of the Council shall be appointed by the Director of the Upper Cumberland Regional Office, Tennessee Department of Health upon receiving recommendation from County officials. Future members to fill Council vacancies will be appointed by the Council. 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 vote of the entire Council is required for removal. Automatic removal results when a member misses three (3) unexcused consecutive meetings or six (6) meetings in a calendar year. Members shall serve a term of 3 years. Additional terms may be served as deemed appropriate by the Council.

ARTICLE VI—OFFICERS

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

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

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

The Secretary will be selected by majority vote of the Council from nominees among its members. The Secretary will record the business conducted at meetings of the Council in the form of minutes and will issue notice of all meetings and perform such duties as assigned by the Council.

The Treasurer shall keep account of all monies arising from the Council activities. No less than annually, or upon request, the Treasurer shall issue a financial report to the membership.

Each officer will serve a one year term but may be re-elected.

ARTICLE VIII—MEETINGS

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

The Council chairperson may call a special meeting, as deemed appropriate, upon five working days written notice to the membership.

A Quorum shall consist of a majority of voting members present at the Council meeting. All Council meetings are open to the general public and the public is encouraged to attend.

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

ARTICLE VIII—COMMITTEES/COUNCILS/TASK FORCES

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

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

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

ARTICLE IX—APPROVAL AND AMENDMENTS

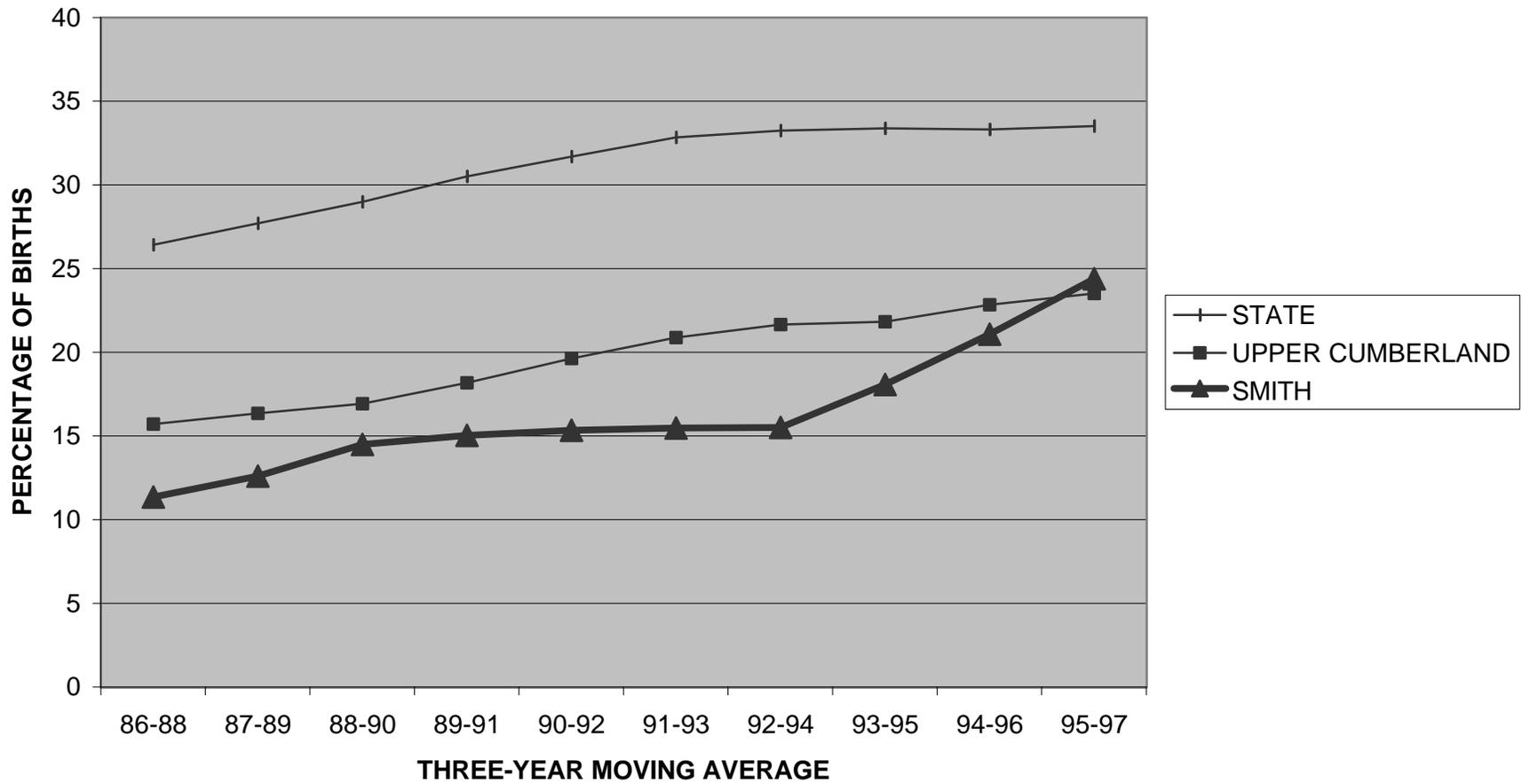
The Bylaws will become effective upon approval by a majority vote of the membership of the Council. Thereafter, these Bylaws may be amended or repealed at any regular or special meeting called for the purpose by a majority vote of the voting members present, provided that the proposed additions, deletions 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

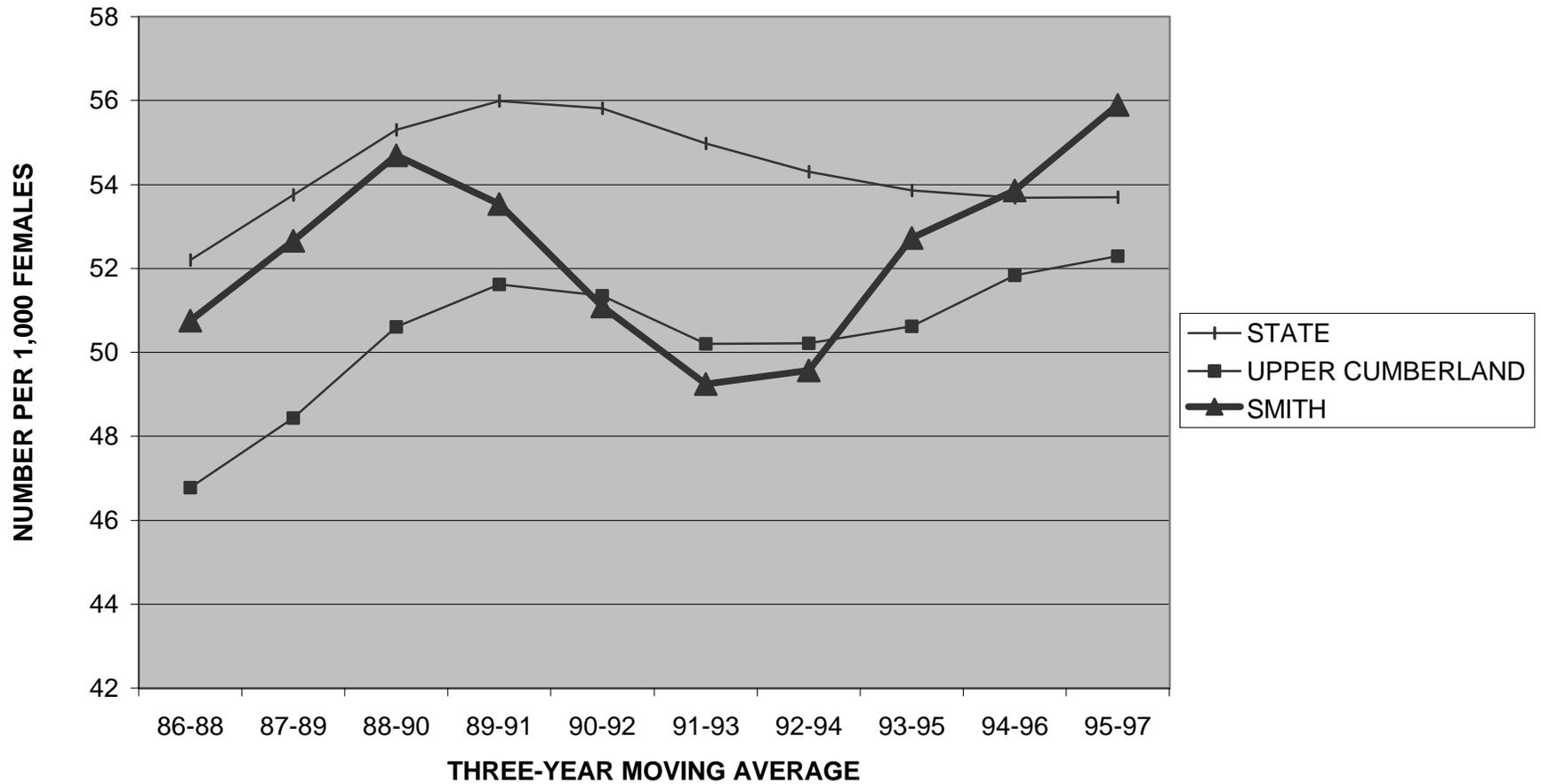
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	26.4	27.7	29.0	30.5	31.7	32.8	33.2	33.4	33.3	33.5	
UPPER CUMBERLAND	15.7	16.4	16.9	18.2	19.6	20.9	21.7	21.8	22.9	23.5	
SMITH	11.3	12.6	14.5	15.0	15.3	15.5	15.5	18.1	21.1	24.4	

PERCENTAGE OF LIVE BIRTHS TO UNWED MOTHERS AGES 10-44



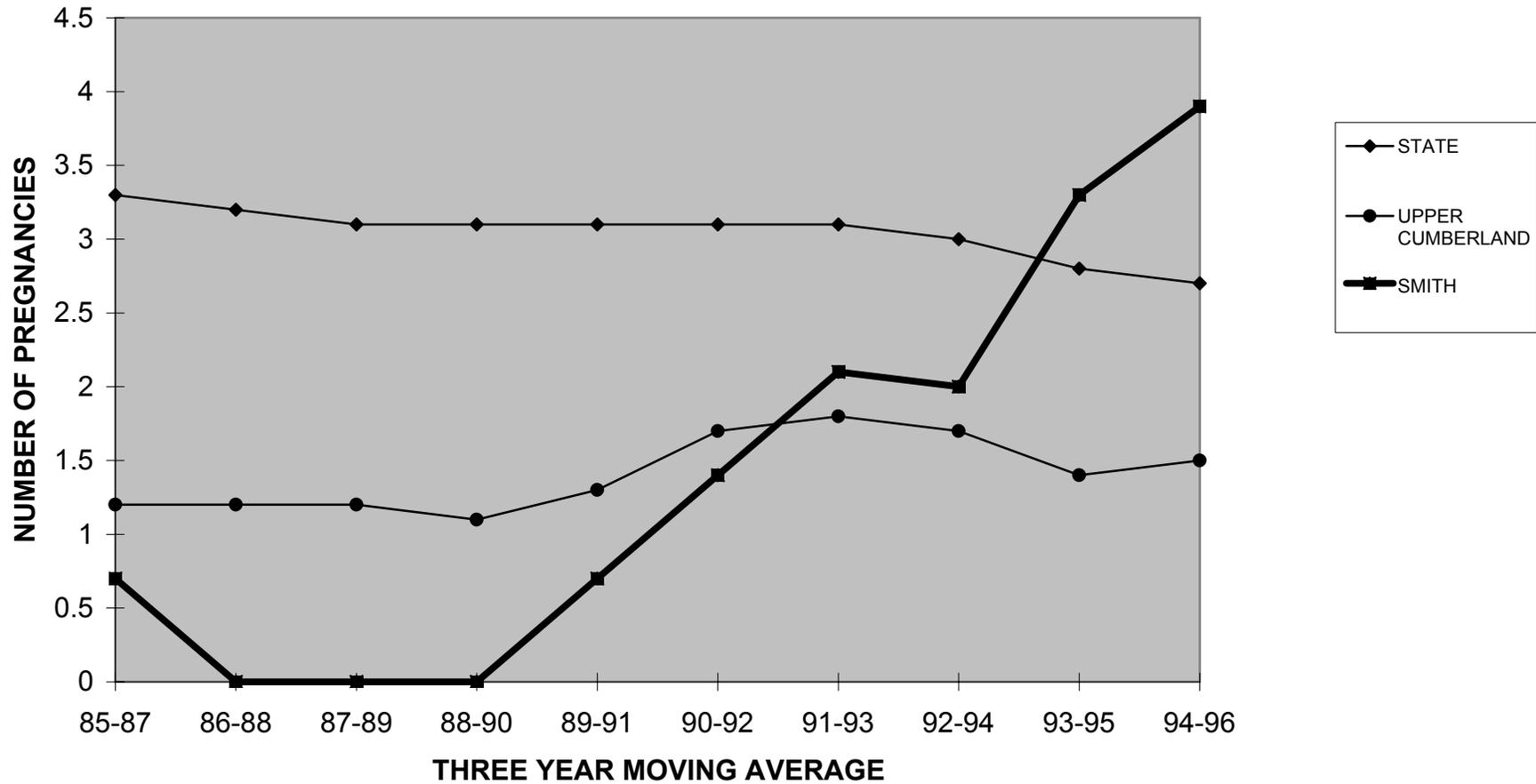
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	52.2	53.7	55.3	56.0	55.8	55.0	54.3	53.9	53.7	53.7	
UPPER CUMBERLAND	46.8	48.4	50.6	51.6	51.4	50.2	50.2	50.6	51.8	52.3	
SMITH	50.8	52.7	54.7	53.5	51.1	49.2	49.6	52.7	53.9	55.9	

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



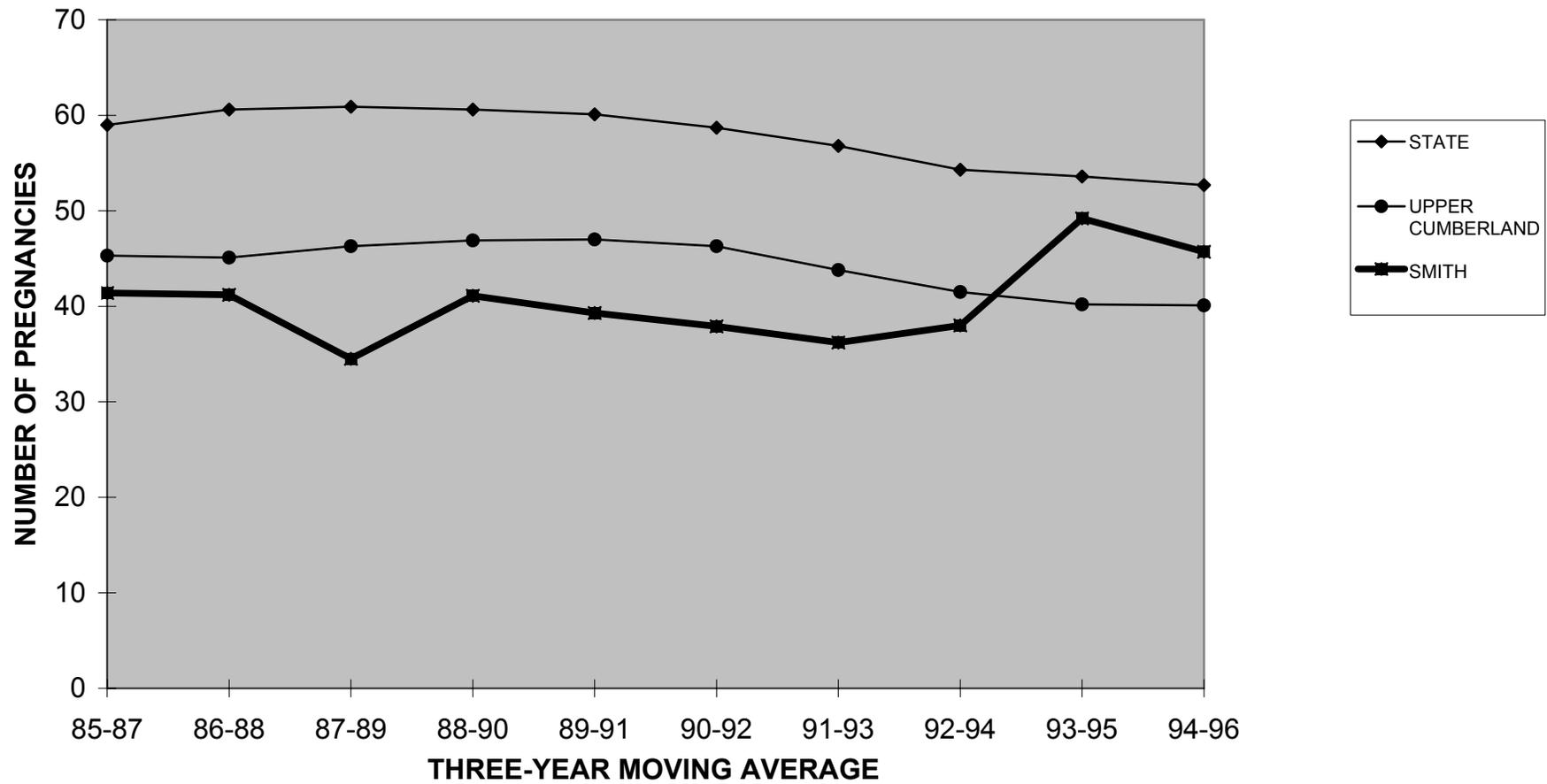
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	3.3	3.2	3.1	3.1	3.1	3.1	3.1	3	2.8	2.7	
UPPER CUMBERLAND	1.2	1.2	1.2	1.1	1.3	1.7	1.8	1.7	1.4	1.5	
SMITH	0.7	0	0	0	0.7	1.4	2.1	2	3.3	3.9	

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



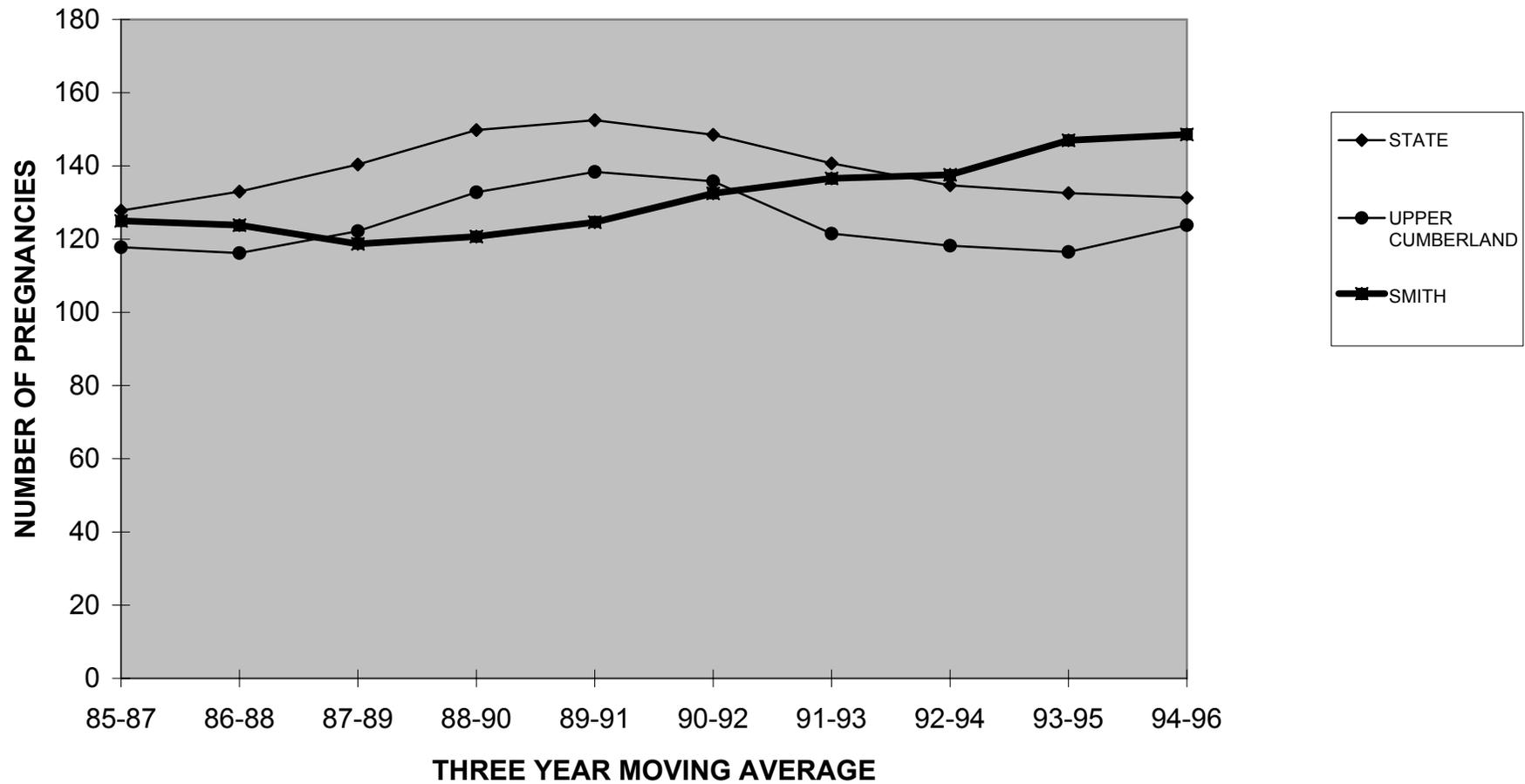
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	59	60.6	60.9	60.6	60.1	58.7	56.8	54.3	53.6	52.7	
UPPER CUMBERLAND	45.3	45.1	46.3	46.9	47	46.3	43.8	41.5	40.2	40.1	
SMITH	41.4	41.2	34.5	41.1	39.3	37.9	36.2	38	49.2	45.7	

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



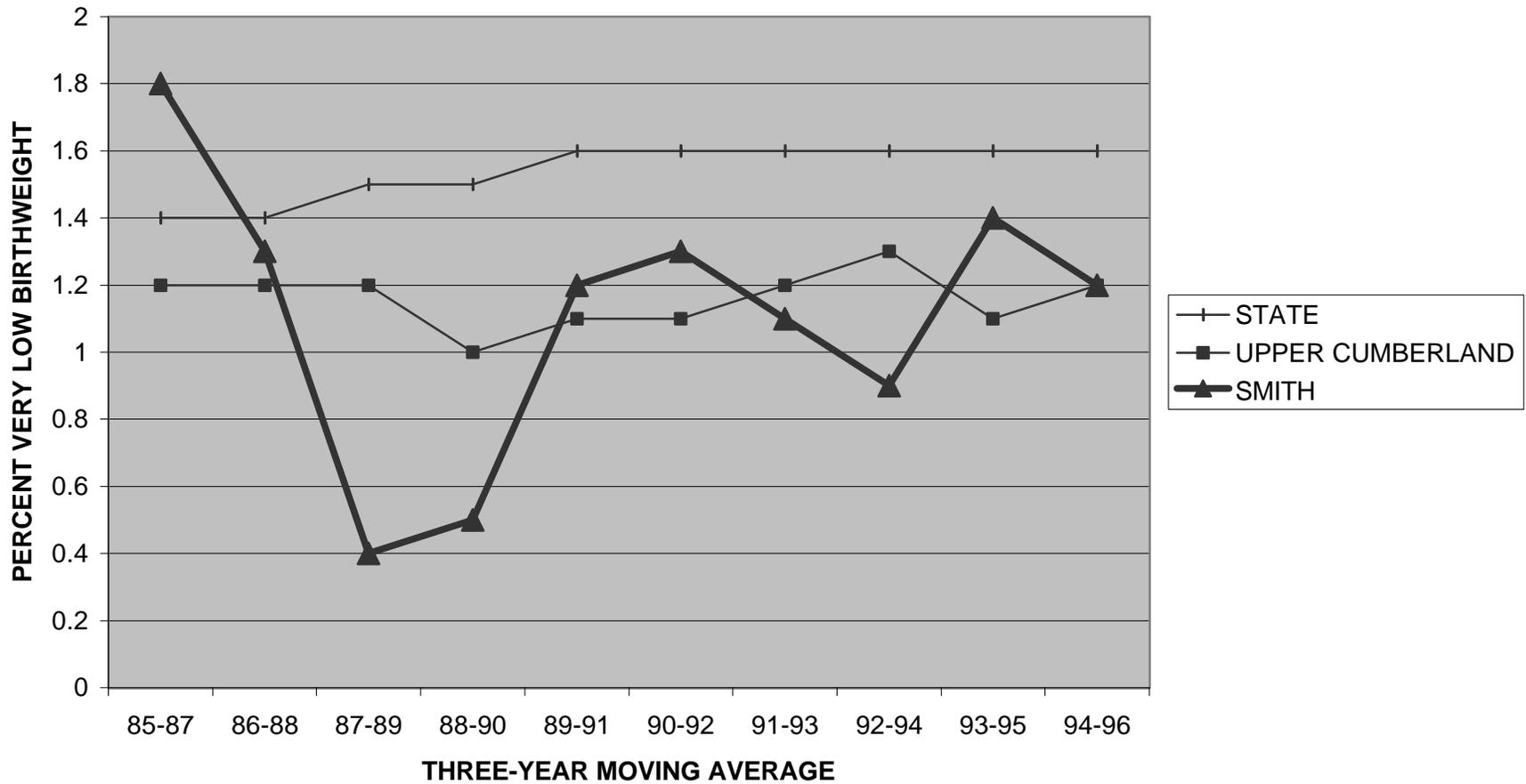
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	127.8	133	140.4	149.8	152.5	148.5	140.7	134.7	132.6	131.3	
UPPER CUMBERLAND	117.8	116.2	122.2	132.8	138.4	135.8	121.5	118.2	116.5	123.8	
SMITH	125	123.8	118.7	120.7	124.6	132.5	136.6	137.6	147	148.6	

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



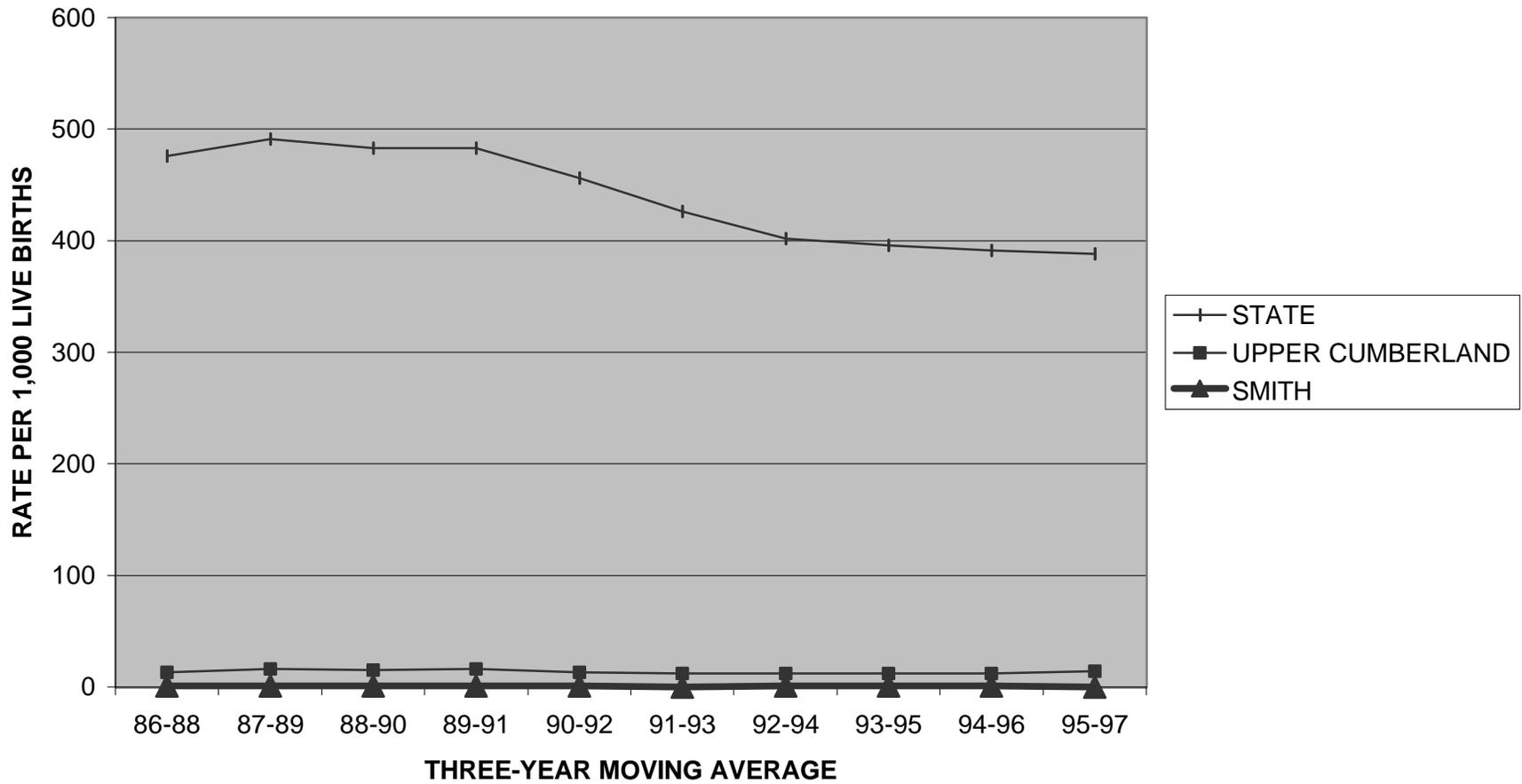
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96
STATE	1.4	1.4	1.5	1.5	1.6	1.6	1.6	1.6	1.6	1.6
UPPER CUMBERLAND	1.2	1.2	1.2	1	1.1	1.1	1.2	1.3	1.1	1.2
SMITH	1.8	1.3	0.4	0.5	1.2	1.3	1.1	0.9	1.4	1.2

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



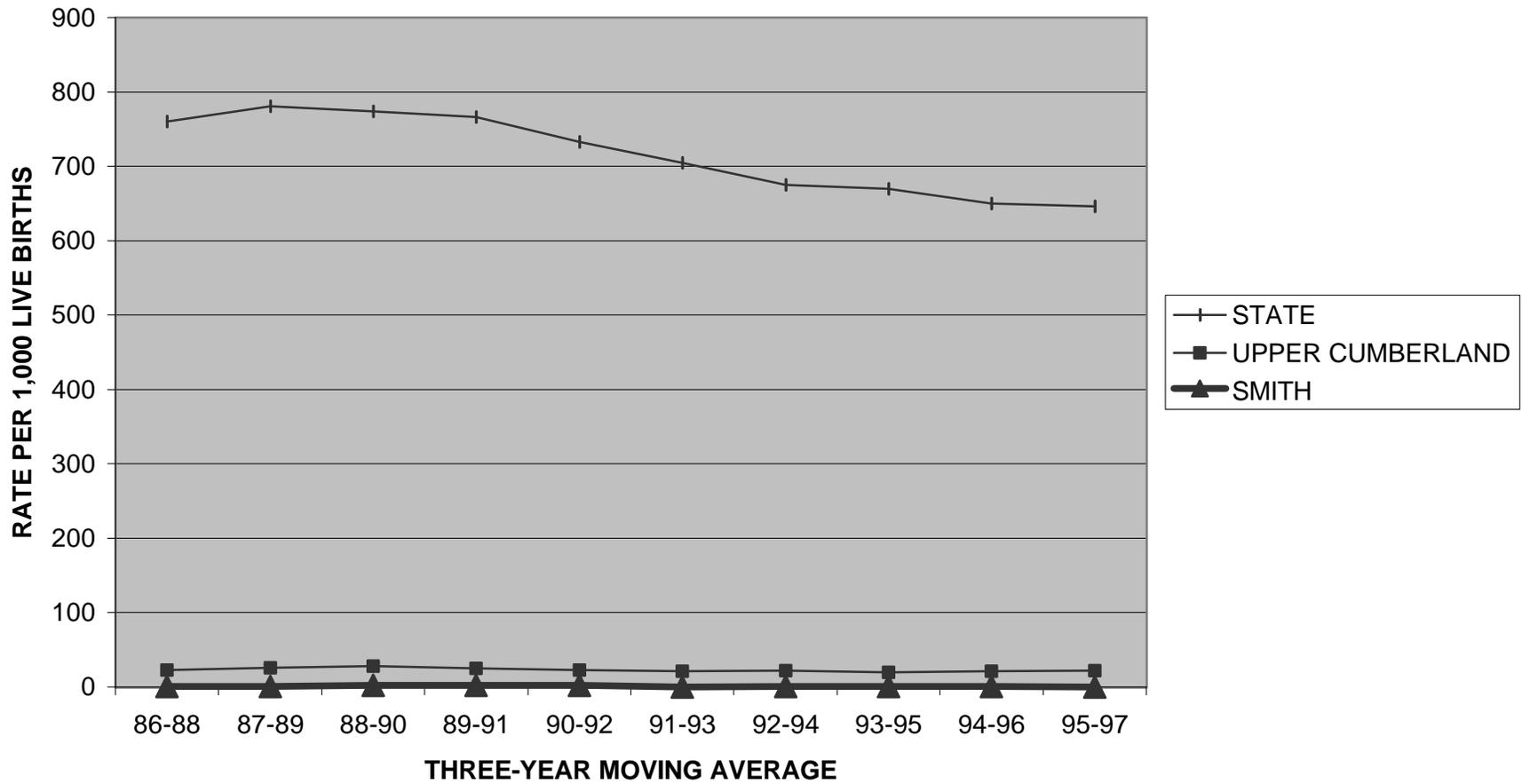
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	476	491	483	483	456	426	402	396	391	388	
UPPER CUMBERLAND	13	16	15	16	13	12	12	12	12	14	
SMITH	1	1	1	1	1	0	1	1	1	0	

NEONATAL DEATHS PER 1,000 LIVE BIRTHS



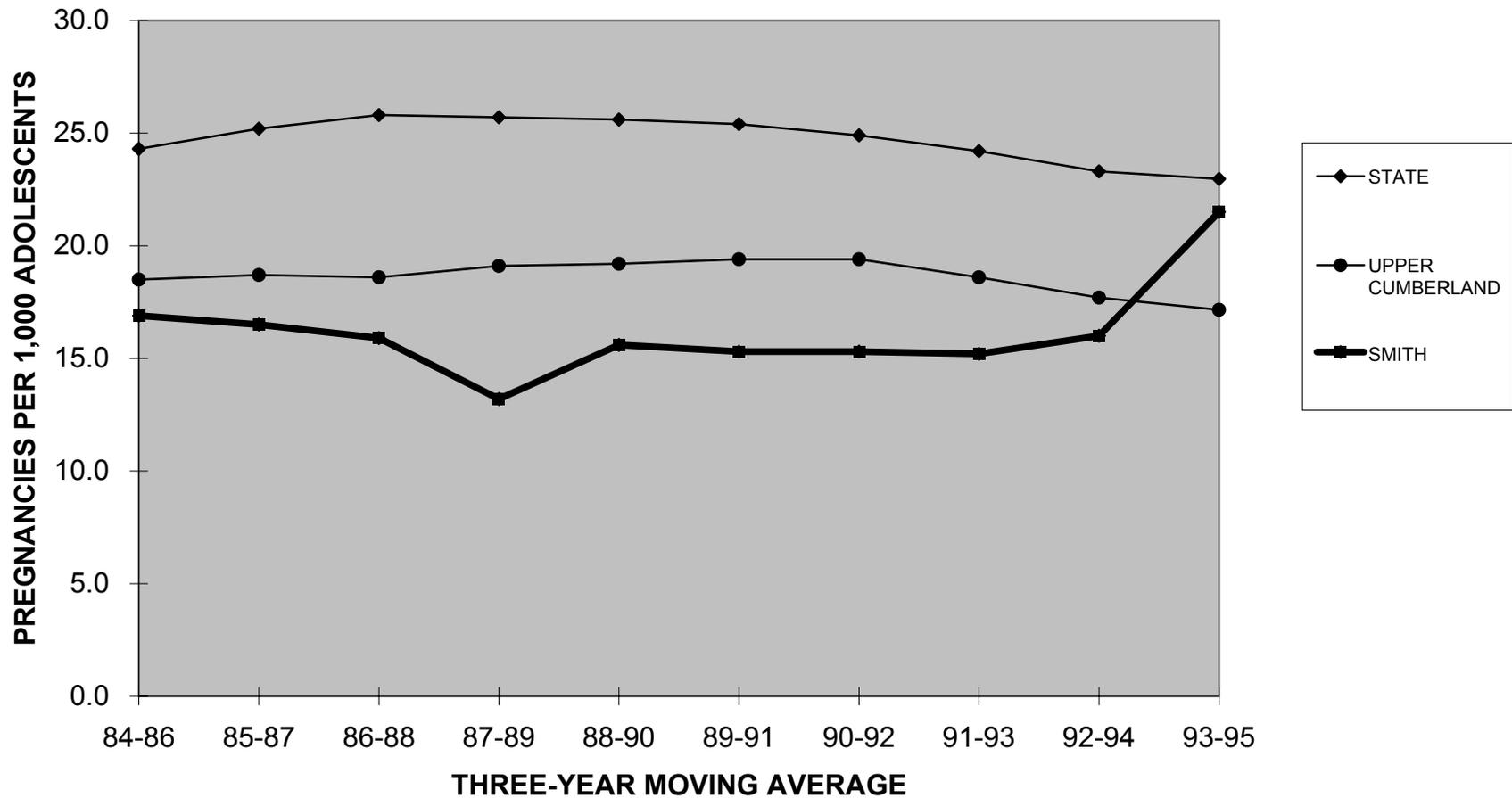
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	760	781	774	766	733	705	675	670	650	646	
UPPER CUMBERLAND	23	26	28	25	23	21	22	20	21	22	
SMITH	1	1	2	2	2	0	1	1	1	0	

INFANT DEATHS PER 1,000 LIVE BIRTHS



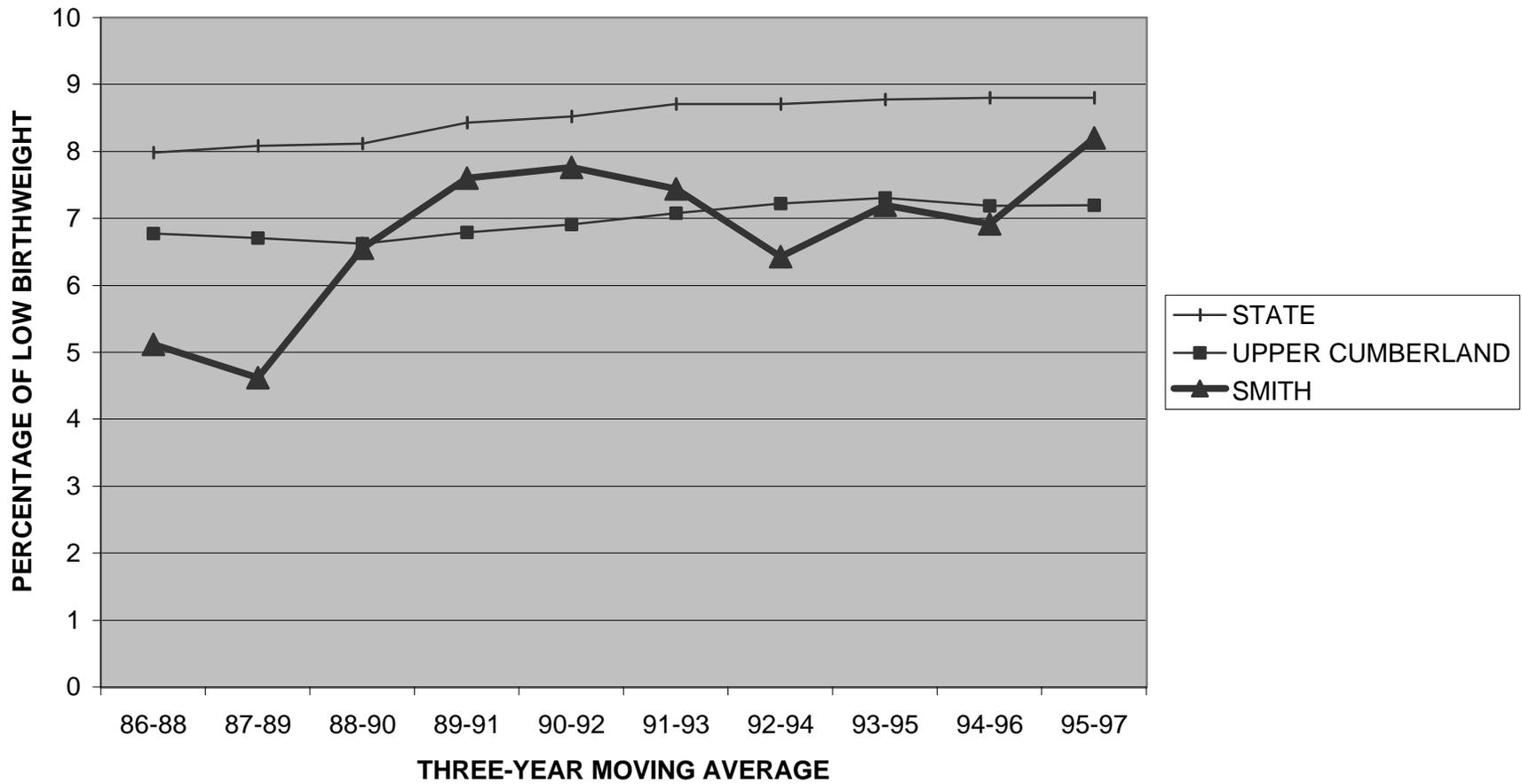
	84-86	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	
STATE	24.3	25.2	25.8	25.7	25.6	25.4	24.9	24.2	23.3	23.0	
UPPER CUMBERLAND	18.5	18.7	18.6	19.1	19.2	19.4	19.4	18.6	17.7	17.2	
SMITH	16.9	16.5	15.9	13.2	15.6	15.3	15.3	15.2	16.0	21.5	

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



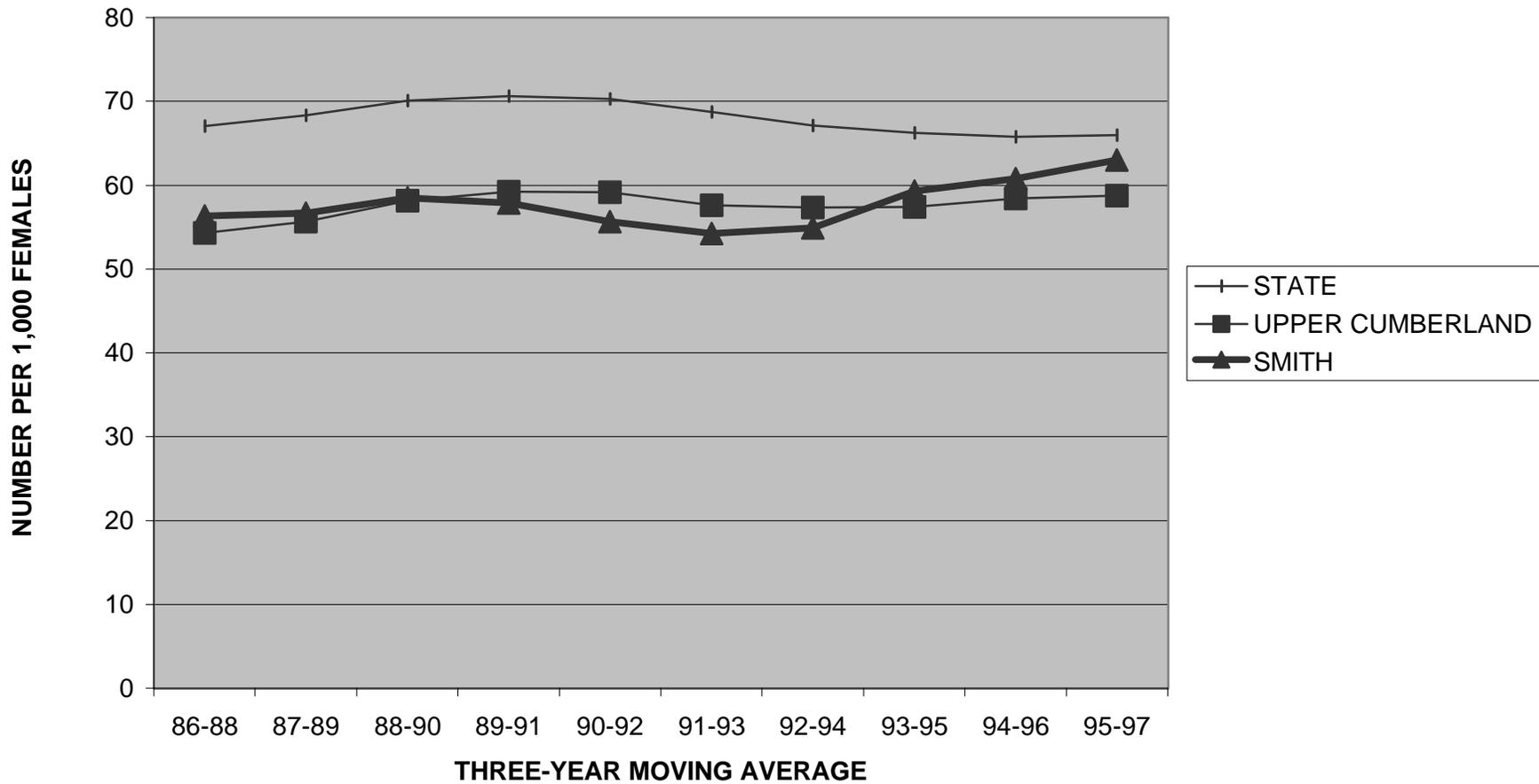
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	8.0	8.1	8.1	8.4	8.5	8.7	8.7	8.8	8.8	8.8
UPPER CUMBERLAND	6.8	6.7	6.6	6.8	6.9	7.1	7.2	7.3	7.2	7.2
SMITH	5.1	4.6	6.6	7.6	7.8	7.4	6.4	7.2	6.9	8.2

PERCENTAGE OF BIRTHS WHICH WERE LOW BIRTHWEIGHT



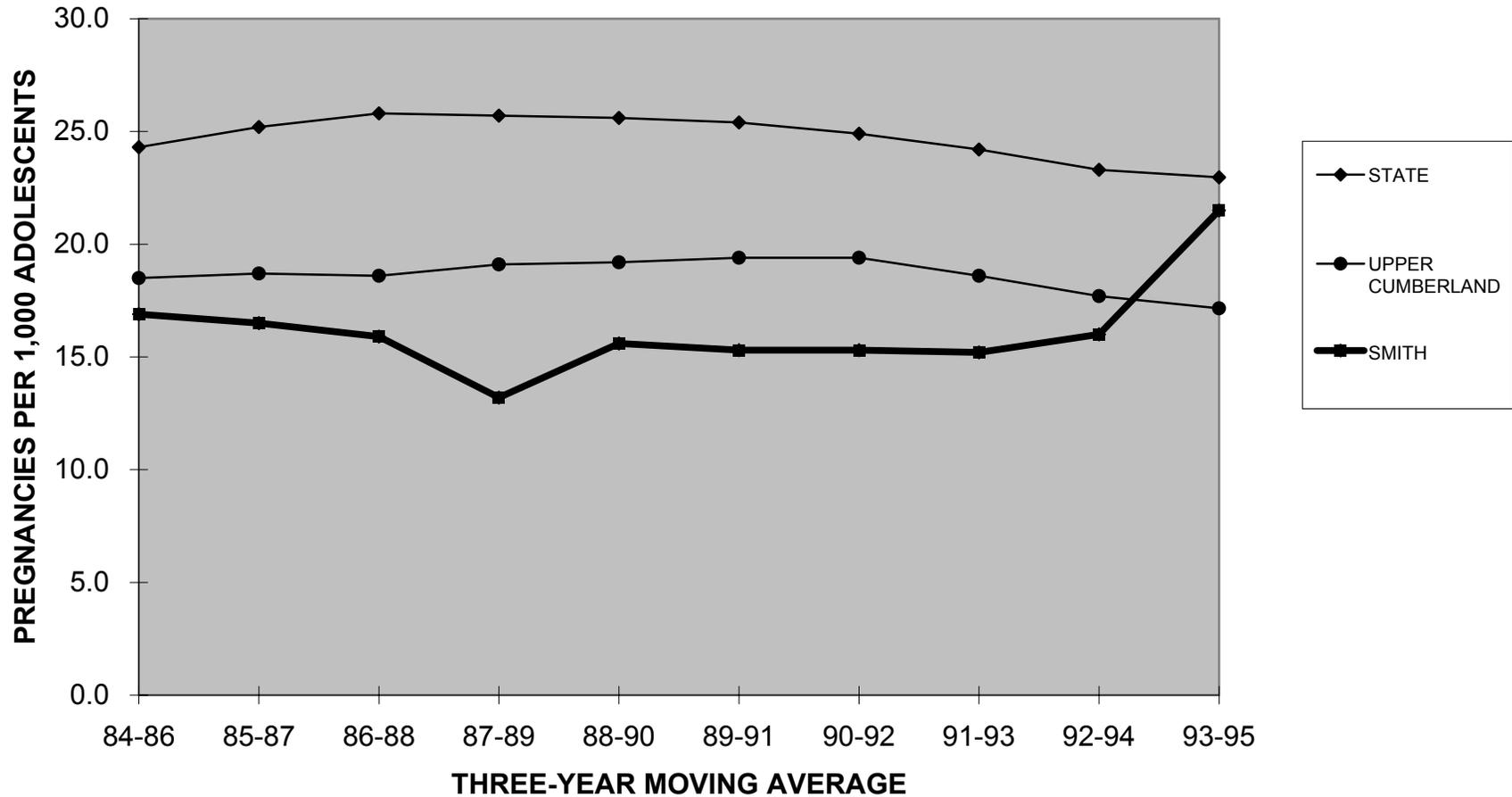
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	67.1	68.4	70.1	70.6	70.3	68.7	67.1	66.3	65.8	66.0	
UPPER CUMBERLAND	54.3	55.6	58.2	59.2	59.2	57.6	57.3	57.4	58.4	58.7	
SMITH	56.3	56.7	58.5	57.9	55.6	54.2	54.9	59.3	60.8	63.0	

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	
SMITH	16.9	16.5	15.9	13.2	15.6	15.3	15.3	15.2	16.0	21.5	

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

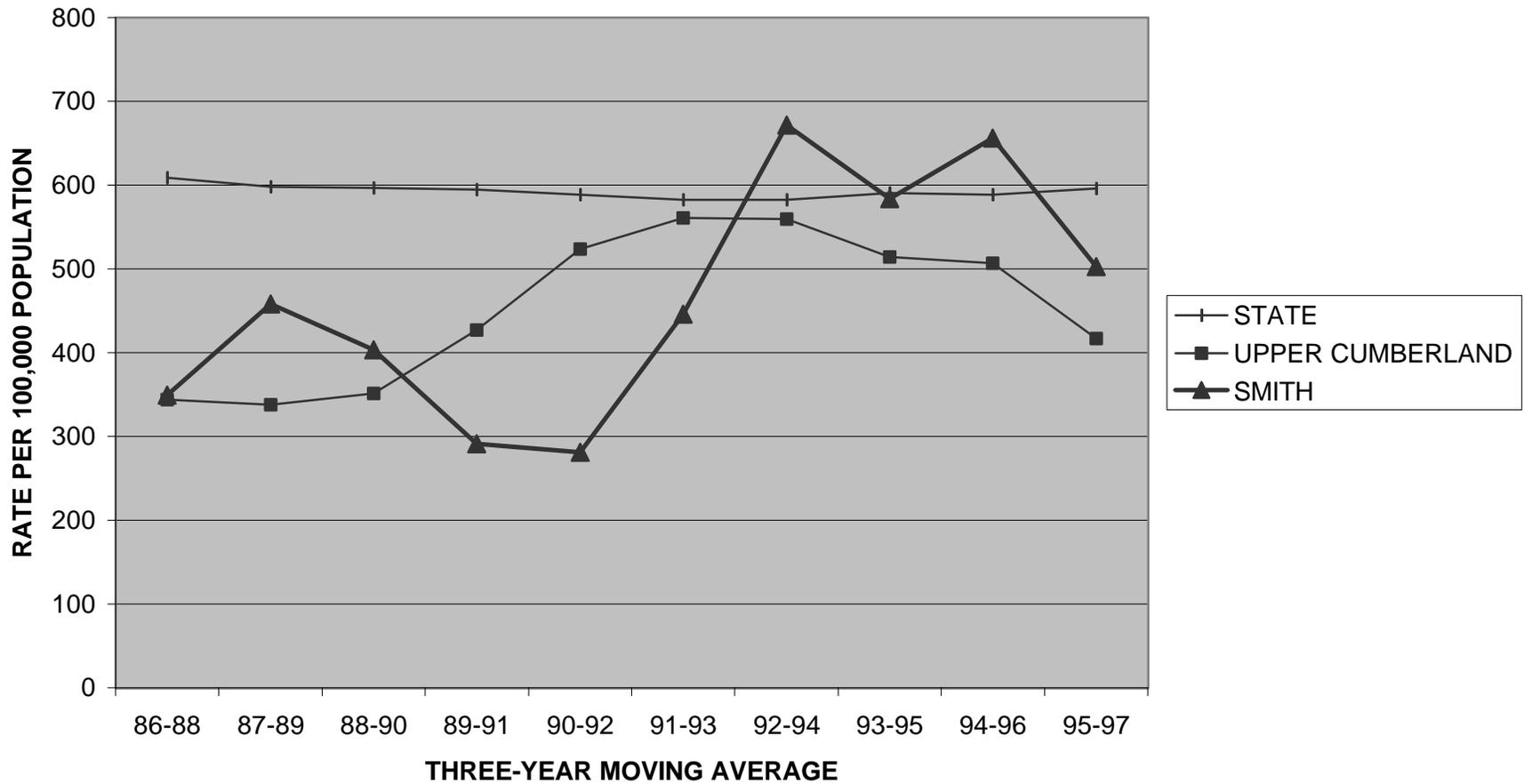


Appendix 4

Mortality Data

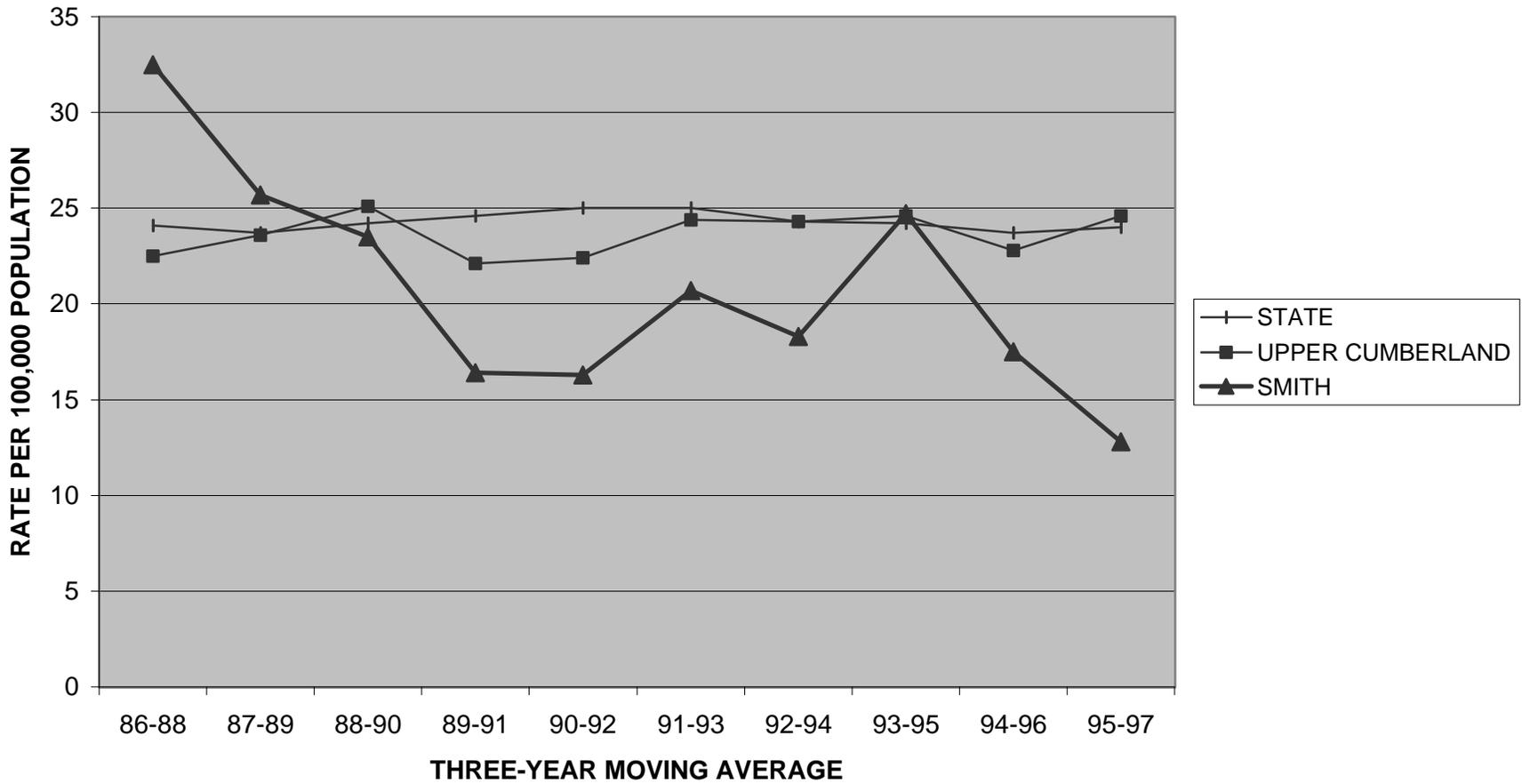
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	608.9	598.3	596.8	594.4	588.8	582.7	582.2	590.6	588.7	595.7
UPPER CUMBERLAND	344.0	337.6	351.2	427.2	523.4	560.8	559.5	514.1	506.7	416.7
SMITH	349.1	457.9	403.3	291.5	281.1	446.2	671.3	583.6	656.3	502.7

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



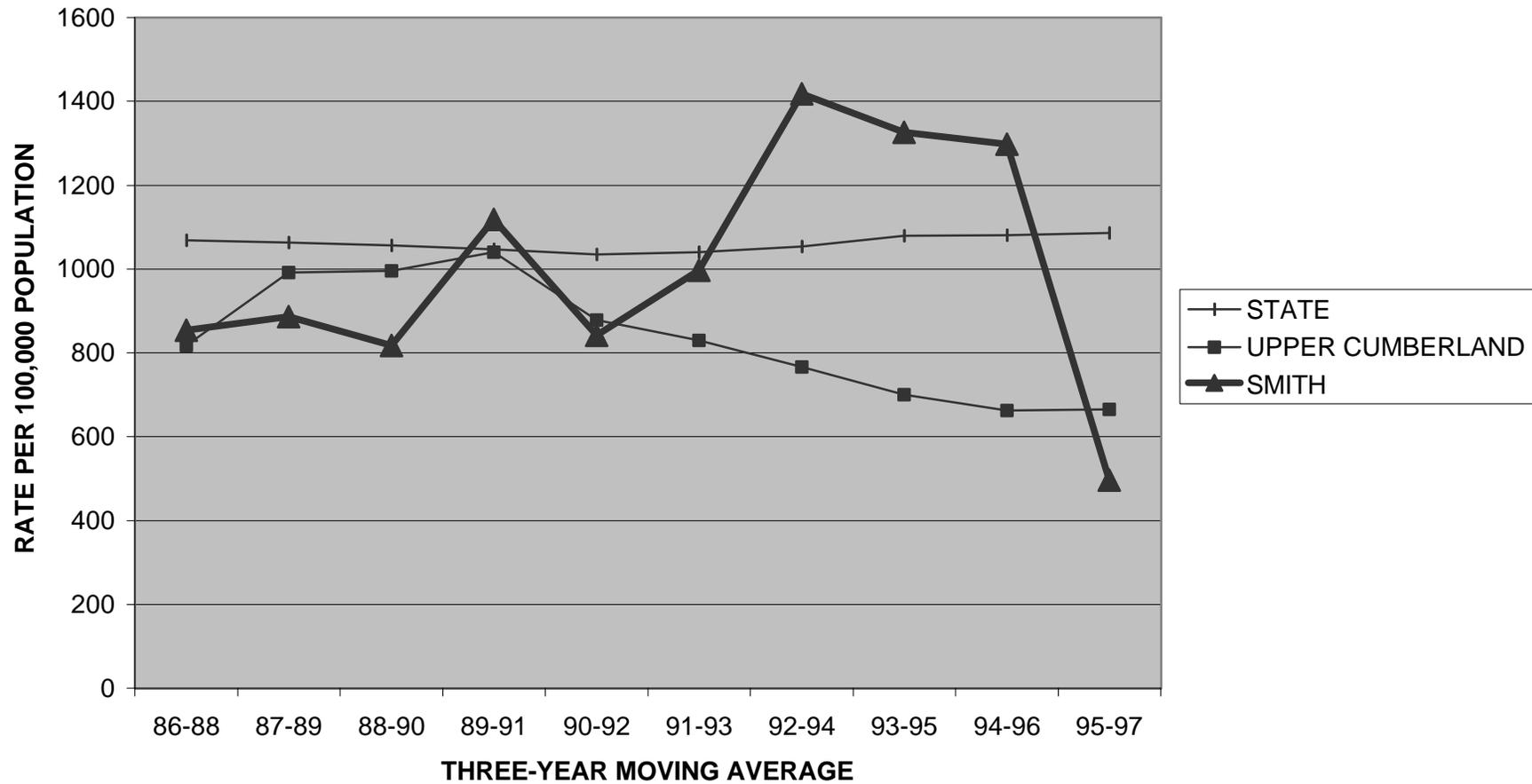
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	24.1	23.7	24.2	24.6	25.0	25.0	24.3	24.2	23.7	24.0	
UPPER CUMBERLAND	22.5	23.6	25.1	22.1	22.4	24.4	24.3	24.6	22.8	24.6	
SMITH	32.5	25.7	23.5	16.4	16.3	20.7	18.3	24.7	17.5	12.8	

VIOLENT DEATH RATE PER 100,000 POPULATION



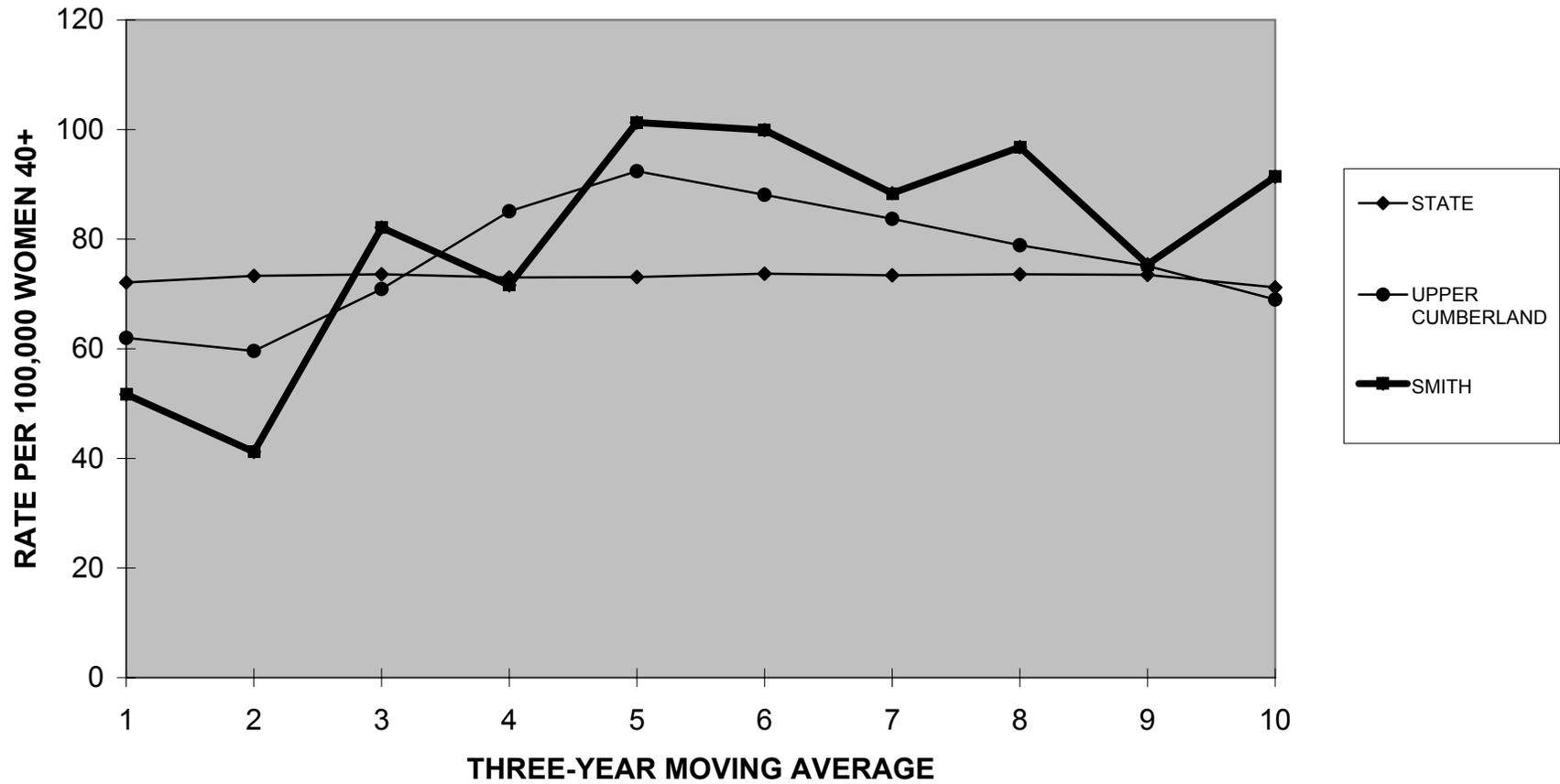
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	1,068.8	1,063.0	1,056.2	1,046.5	1,034.4	1,040.8	1,054.3	1,079.7	1,080.0	1,085.8
UPPER CUMBERLAND	817.8	992.0	995.6	1,039.8	878.9	829.4	766.8	699.8	663.0	665.1
SMITH	854.0	886.7	817.6	1,117.9	841.7	996.5	1,417.7	1,326.0	1,298.2	495.9

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



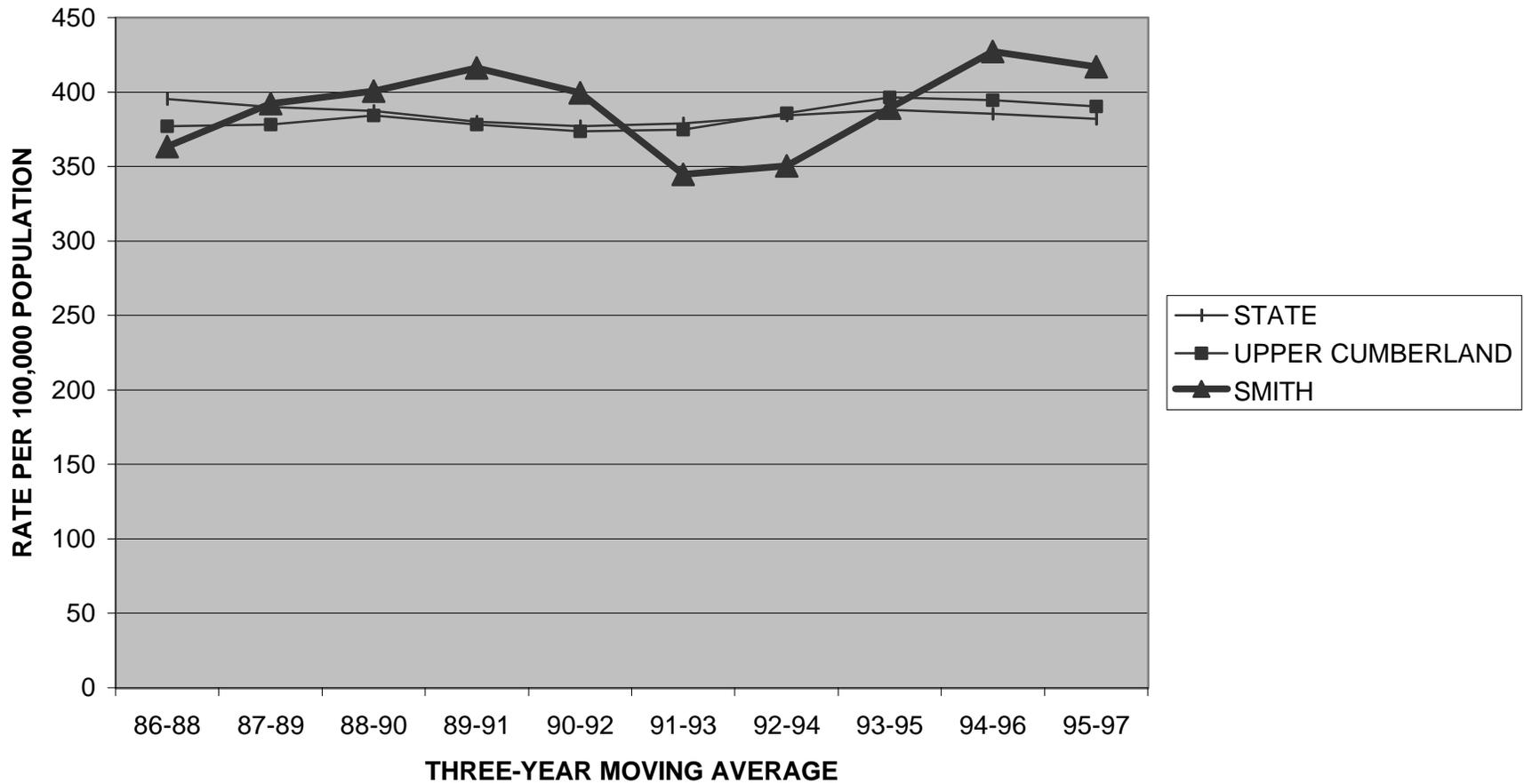
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	72.1	73.3	73.6	73	73.1	73.7	73.4	73.6	73.5	71.2	
UPPER CUMBERLAND	62	59.6	70.9	85.1	92.4	88.1	83.7	78.9	75.1	69	
SMITH	51.7	41.2	82.1	71.6	101.3	99.9	88.4	96.8	75.4	91.4	

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



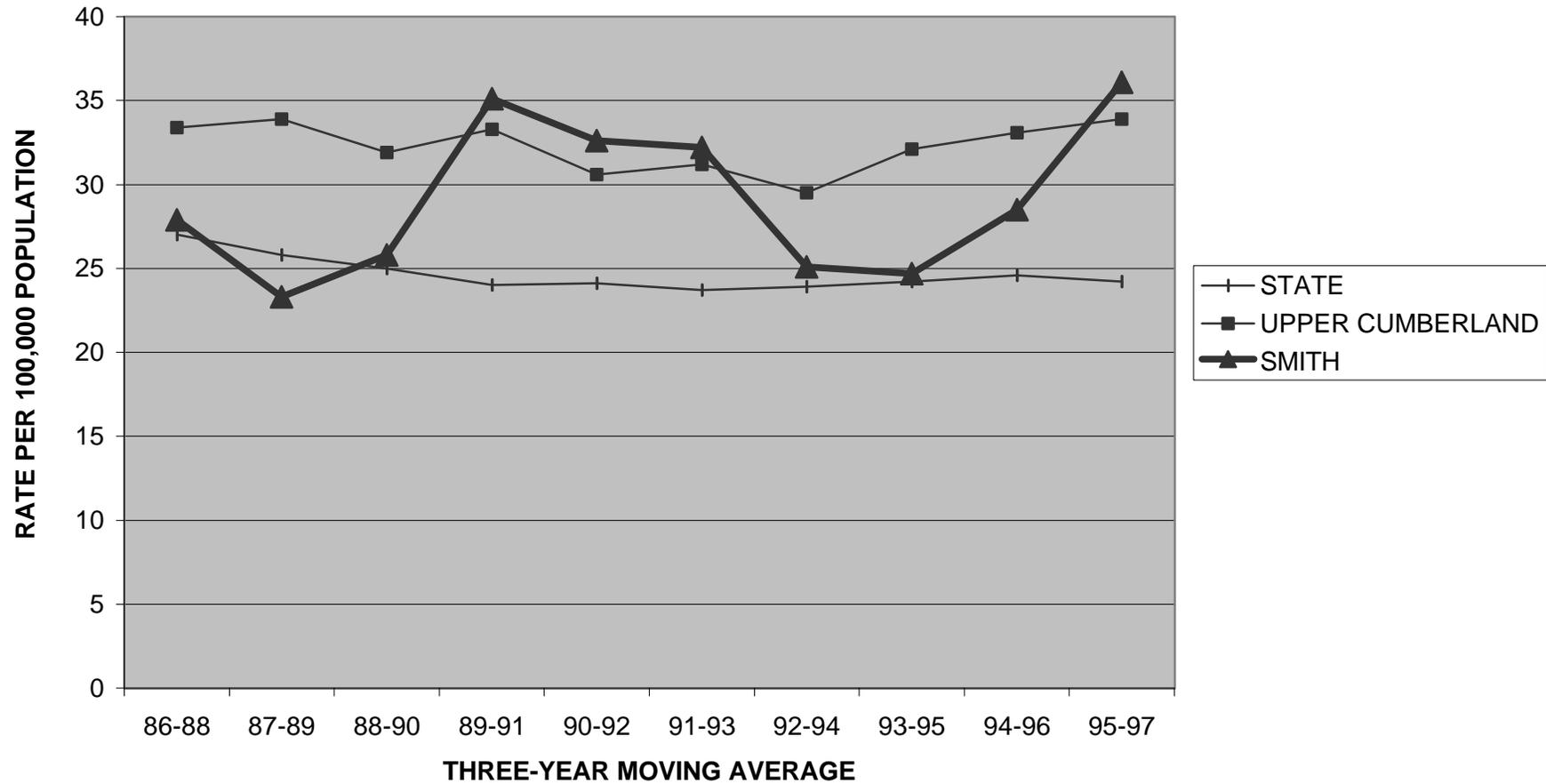
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	395.1	390.0	387.1	380.2	377.2	379.0	384.3	388.0	385.3	381.9	
UPPER CUMBERLAND	377.1	378.1	384.2	378.2	373.6	374.7	385.7	396.6	394.7	390.5	
SMITH	363.3	392.1	400.7	416.2	399.5	344.7	350.5	389.0	427.2	416.8	

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



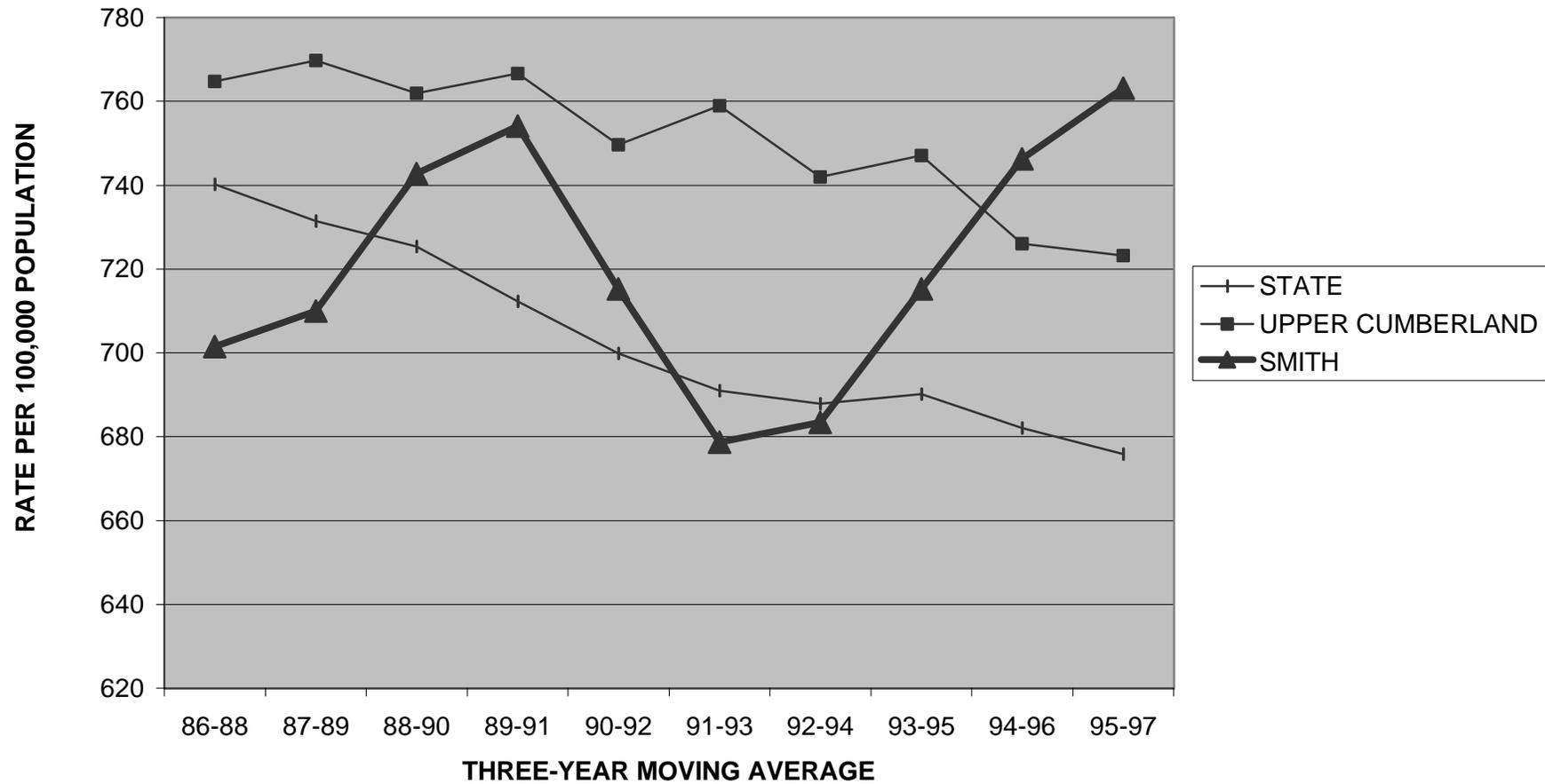
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	27.0	25.8	25.0	24.0	24.1	23.7	23.9	24.2	24.6	24.2	
UPPER CUMBERLAND	33.4	33.9	31.9	33.3	30.6	31.2	29.5	32.1	33.1	33.9	
SMITH	27.9	23.3	25.8	35.1	32.6	32.2	25.1	24.7	28.5	36.1	

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	
SMITH	701.5	710.0	742.8	754.1	715.2	678.7	683.4	715.2	746.3	763.1	

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

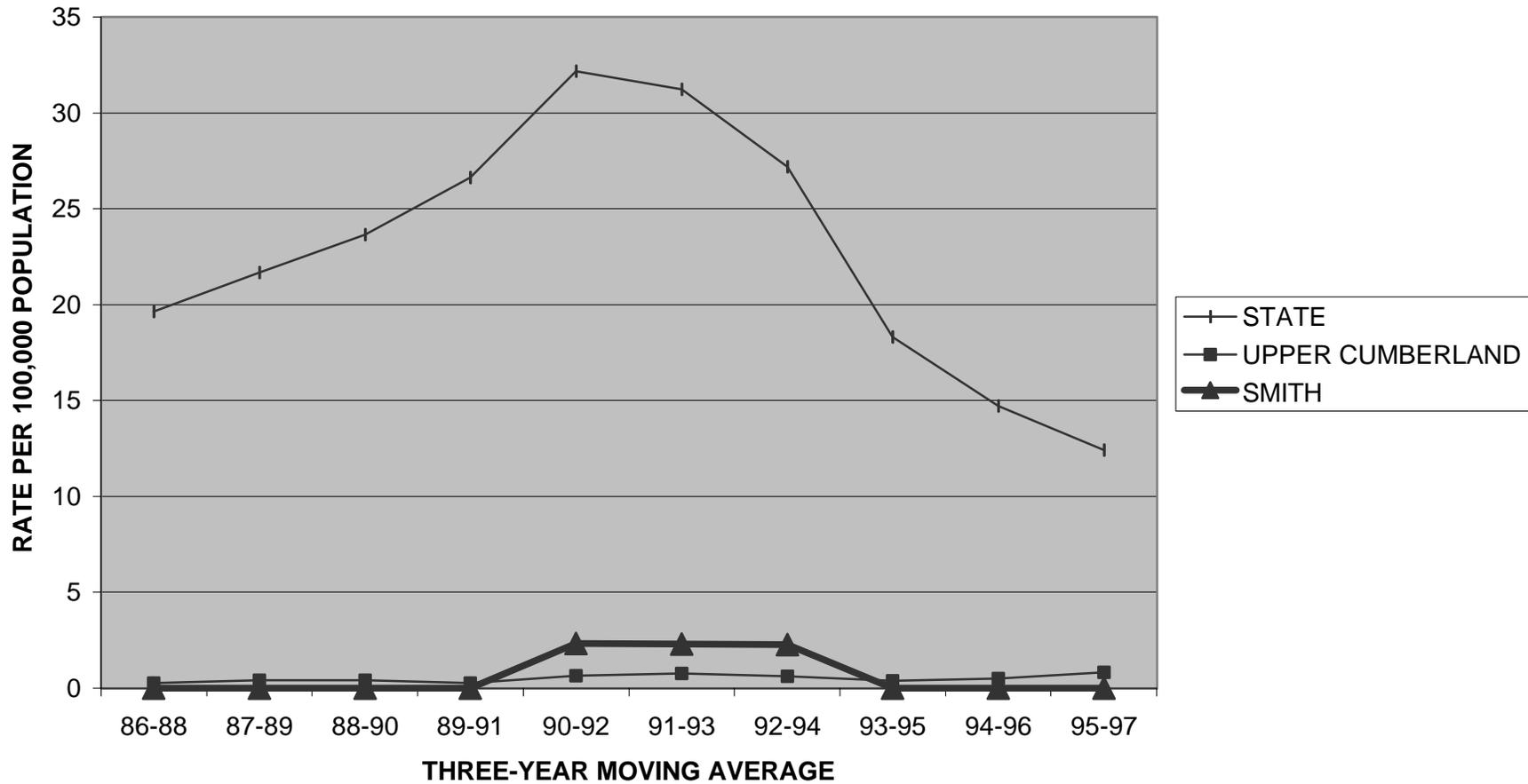


Appendix 5

Morbidity Data

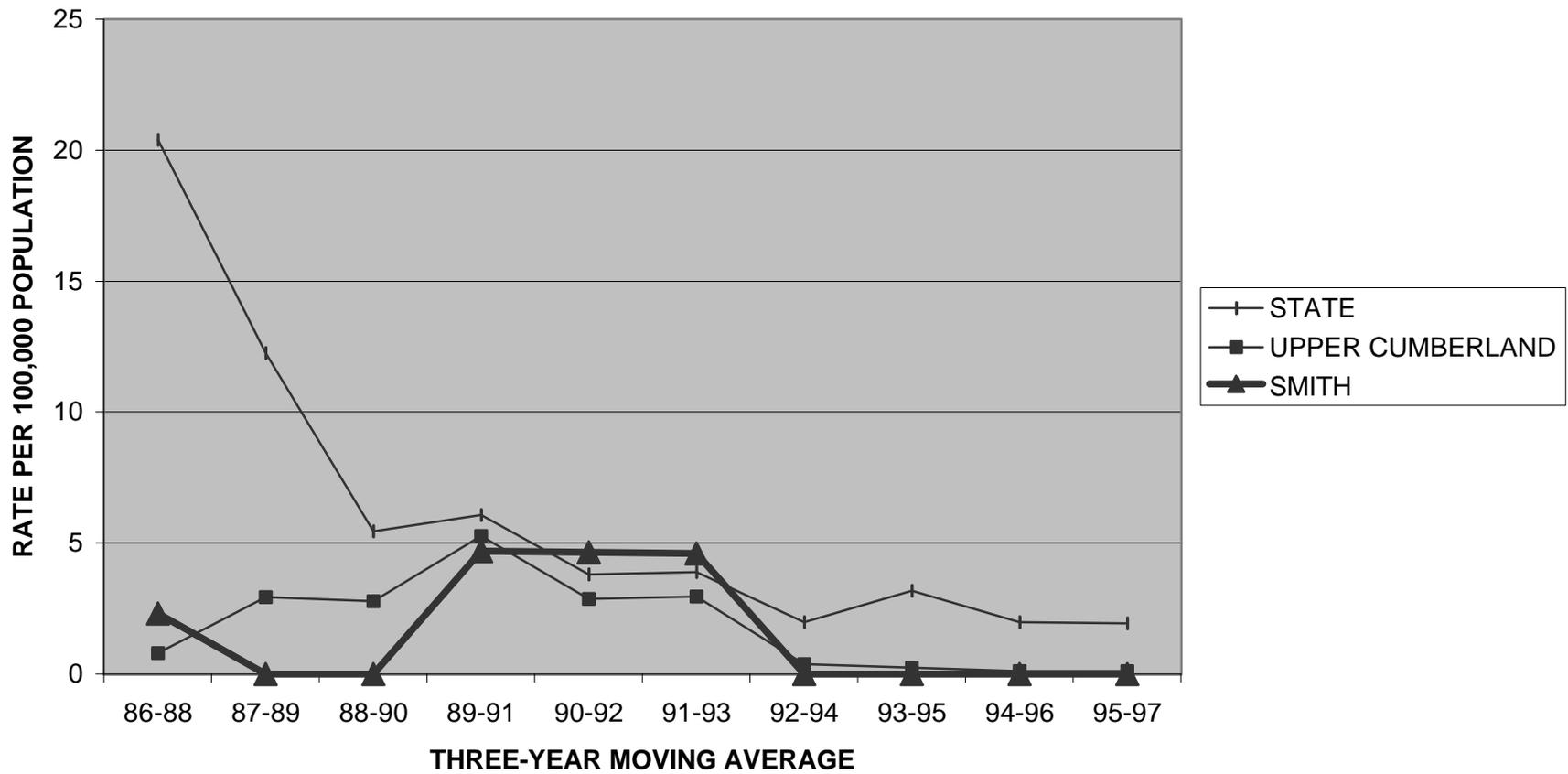
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	19.6	21.7	23.7	26.6	32.2	31.2	27.2	18.3	14.7	12.4	
UPPER CUMBERLAND	0.3	0.4	0.4	0.3	0.7	0.8	0.6	0.4	0.5	0.8	
SMITH	0.0	0.0	0.0	0.0	2.3	2.3	2.3	0.0	0.0	0.0	

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



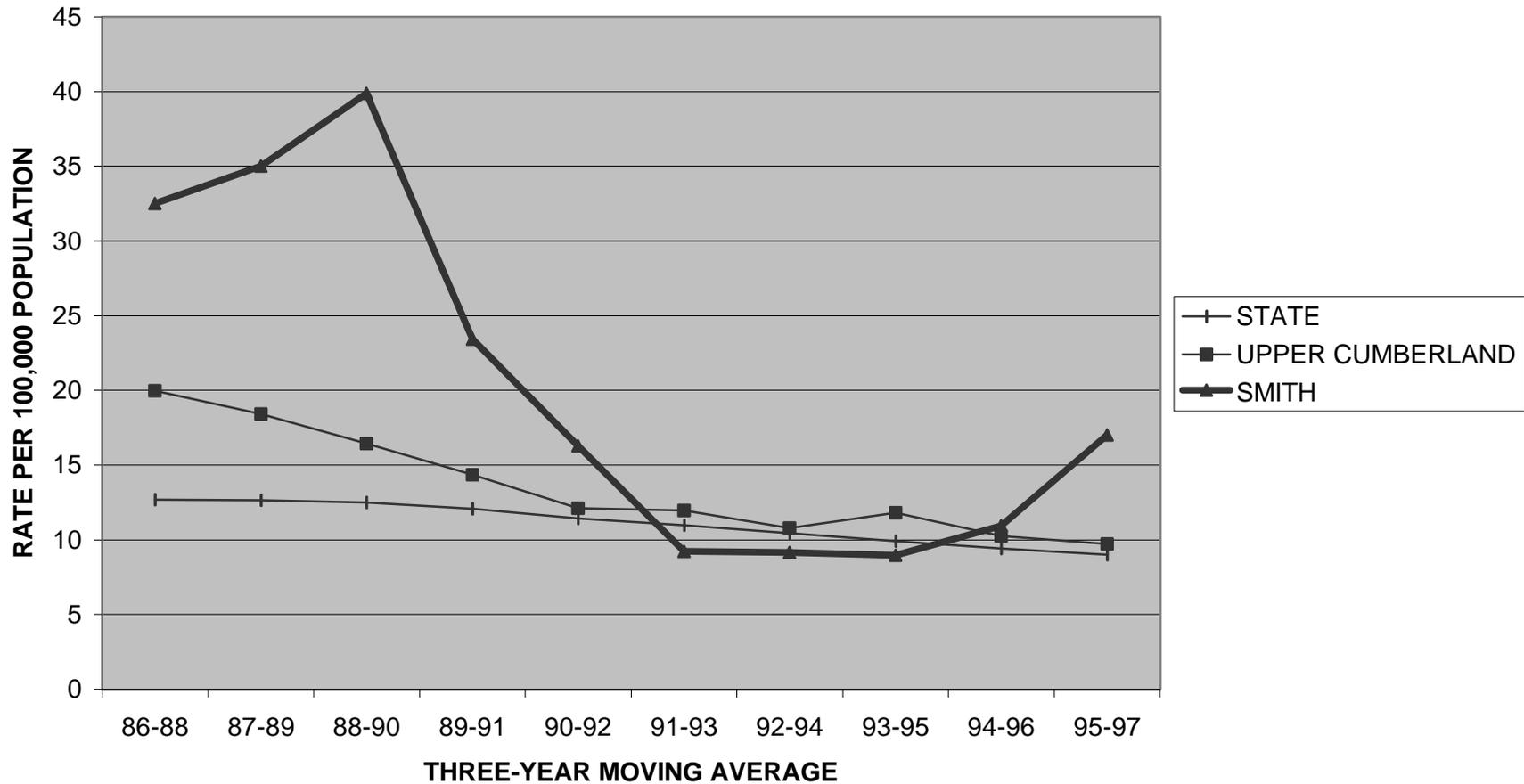
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	20.4	12.3	5.5	6.1	3.8	3.9	2.0	3.2	2.0	1.9	
UPPER CUMBERLAND	0.8	2.9	2.8	5.3	2.9	3.0	0.4	0.2	0.1	0.1	
SMITH	2.3	0.0	0.0	4.7	4.7	4.6	0.0	0.0	0.0	0.0	

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



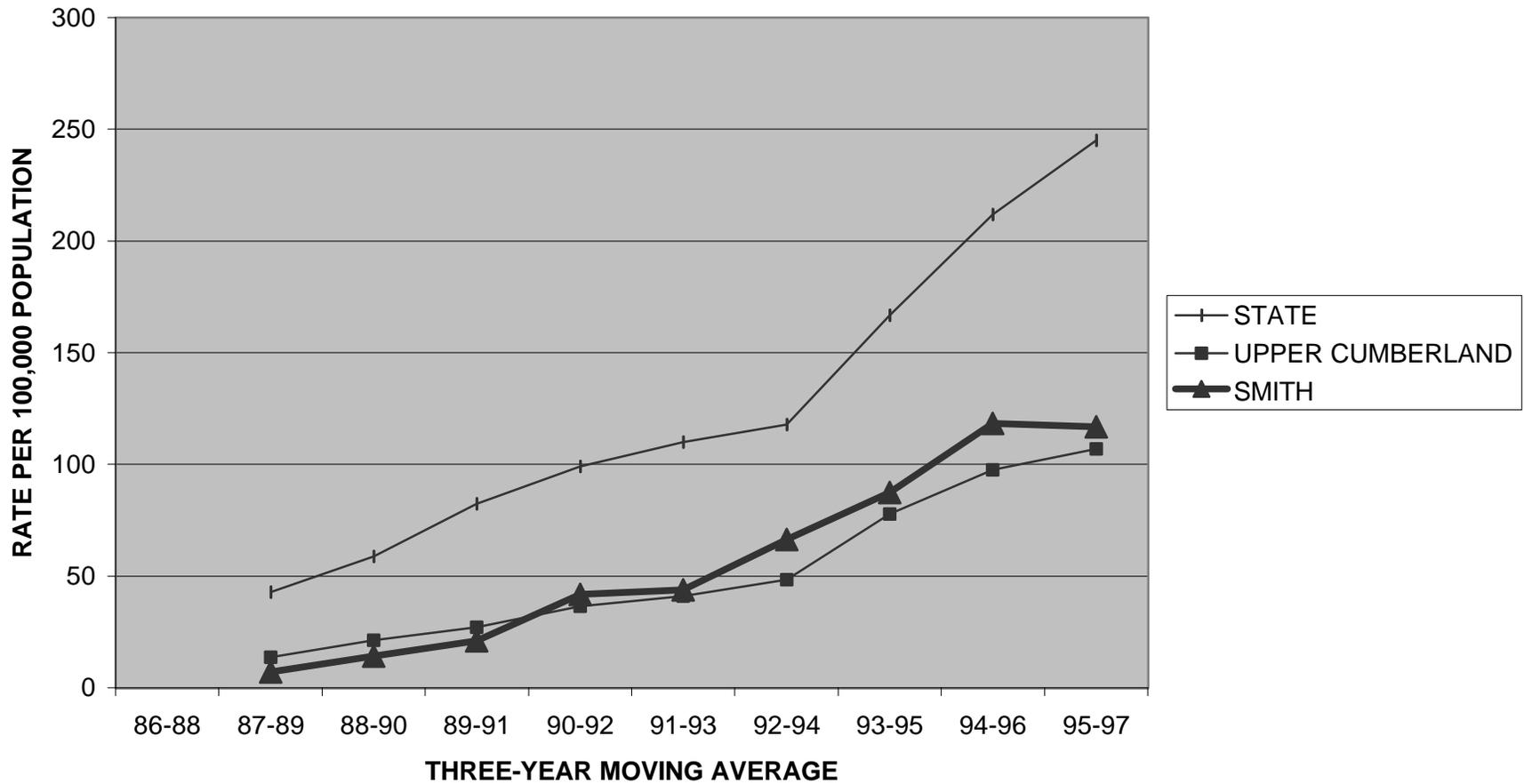
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	12.7	12.6	12.5	12.1	11.4	11.0	10.5	9.9	9.4	9.0
UPPER CUMBERLAND	20.0	18.4	16.5	14.4	12.1	12.0	10.8	11.8	10.3	9.7
SMITH	32.5	35.0	39.9	23.4	16.3	9.2	9.1	9.0	10.9	17.0

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



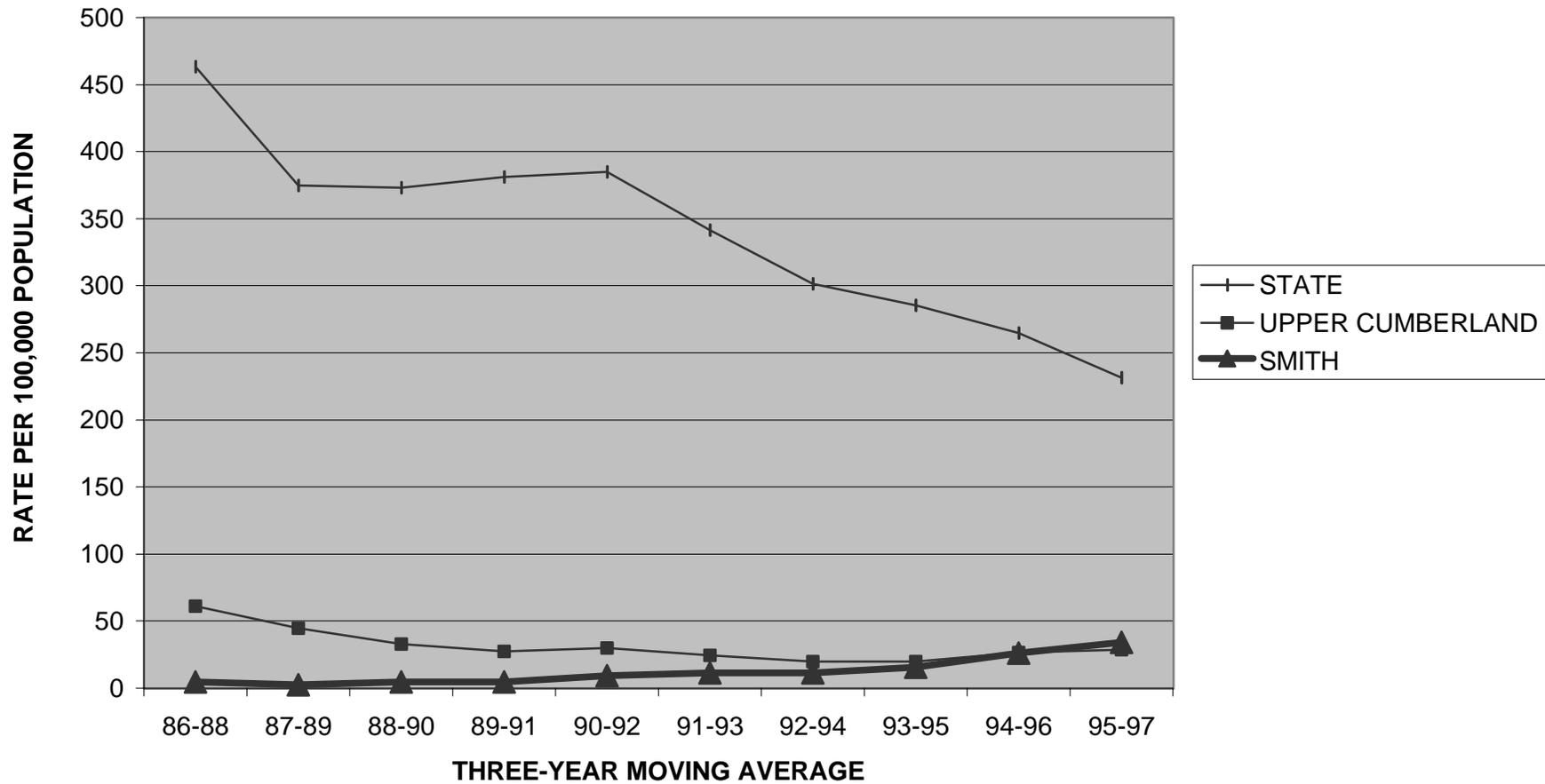
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE		42.8	58.8	82.3	99.1	109.9	117.7	166.7	211.8	245.0
UPPER CUMBERLAND		13.6	21.4	27.0	36.4	41.1	48.5	77.9	97.7	106.8
SMITH		7.0	14.1	21.1	41.9	43.8	66.3	87.5	118.2	116.9

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	
SMITH	4.6	2.3	4.7	4.7	9.3	11.5	11.4	15.7	26.3	34.0	

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