

VAN BUREN 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 Van Buren 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 Van Buren 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 Van Buren County Community Diagnosis Document, which details the process the Van Buren 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 Van Buren 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 Van Buren County Health Council in February 1998 with an initial group of seven community representatives. The Van Buren County Health Council has now developed into a council of thirty-three members. This council consists of various community leaders such as the county executive, school superintendent, industry representation, health care providers, local law enforcement, various community agencies, and other concerned community leaders as determined appropriate by the council members. (Appendix 1) The 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 Van Buren 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 Tuesday of each month from 12:00 to 1:00 p.m. where meetings are open to the public.

County Description

Geographic

- Van Buren County is located in the Upper Cumberland Region of middle Tennessee.
- Van Buren County is located 60 miles from Chattanooga, and 28 miles from Cookeville.
- This county is predominantly rural and is surrounded by rolling hills and valleys.
- Warren, White, Bledsoe, Sequatchie, and Cumberland counties in Tennessee surround Van Buren County.
- The county is 28 miles from Interstate 40 and 44 miles from Interstate 24.
- The annual average precipitation for Van Buren County is 53.4 inches.
- Van Buren County is located 1,920 feet above sea level.

Land Area

- Fall Creek Falls State Park is located in Van Buren County.
- Van Buren County consists of 273.5 square miles of land area with population per square mile being 17.7.
- The nearest navigable waterway is the Tennessee River located 60 miles away in Chattanooga, Tennessee.

Economic Base

- The county's median family personal income is \$23,242.
- The county's median household personal income is \$20,676.
- Van Buren County's per capita personal income is \$13,610.
- The individual poverty rate for Van Buren County is 19.2%.
- The family poverty rate for Van Buren County is 16.1%.
- The 1998 average labor-force total was 2,370, of those, 2,210 were employed and 160 were unemployed giving Van Buren County an unemployment rate of 6.8%.
- The major manufacturers in Van Buren County include Townsend Engineered Products, Spencer Shirt Mfg. Co., Hastings & Son Lumber Co., and Caldwell Mfg. Co.

Demographics

- Van Buren County's public education system consists of 1 elementary school and 1 Junior /Senior High School.
- The number of TennCare enrollees in Van Buren County as of 05-07-99 was 1,537.
- The 1998 population estimate for Van Buren County was 5,071 with projected population for the year 2000 being 5,014.
- The median age for a Van Buren County resident is 33.8 years.

Medical Community

- There is no local hospital in Van Buren County.
- The 1997 resident health profile indicates that 37.2% of Van Buren County residents use the Warren County Hospital, 21.8% use the White County Hospital and 17.9% utilize the Davidson County Hospitals.
- Van Buren County has one nursing home facility that has a total of 60 licensed beds.
- There is one medical doctor practicing in Van Buren County.

References: Tennessee Department of Health, Upper Cumberland Development District

Community Needs Assessment

Primary Data

Van Buren 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 Van Buren County based on the survey results.

		Top Ten Issues Highlighted
Smoking	71%	
Teen Alcohol/Drug Abuse	55%	
Adult Alcohol Abuse	52%	
Adult Drug Abuse	48%	
Teen Pregnancy	47%	
Smokeless Tobacco	46%	
High Blood Pressure	45%	
Breast Cancer	38%	
Heart Conditions	36%	
Obesity	33%	
Lung Cancer	32%	
Lack of Sex Education	32%	
Arthritis	32%	
Stress	32%	
Diabetes	31%	
Unemployment	31%	
School Dropout	30%	
Other Cancer	28%	
Poverty	22%	
Child Abuse/Neglect	22%	
Depression	19%	
Prostrate Cancer	17%	
Domestic Violence	17%	
Colon Cancer	16%	
Asthma	16%	

Eating Disorders	16%
Poor Nutrition for Children	16%
Motor Vehicle Deaths	16%
Sexually Transmitted Diseases	15%
Poor Nutrition for Elderly	15%
Water Pollution	10%
Crime	8%
Toxic Waste	8%
Air Pollution	8%
Influenza	8%
School Safety	8%
HIV/AIDS	8%
Pneumonia	5%
Hepatitis	5%
Youth Violence	5%
Other Accidental Deaths	4%
Homelessness	4%
Tuberculosis	3%
On the Job Safety	3%
Lack of Childhood Vaccinations	2%
Gangs	2%
Adult Suicide	2%
Teen Suicide	2%
Homicide	0%

Van Buren County Availability of Services

“Adequate” (50% or greater)		“Not Adequate” (25% or greater)	
1) County Health Dept. Services	79%	1) Local Family Doctors	51%
2) Nursing Home Care	75%	2) Recreational Activities	47%
3) Ambulance/Emergency Services	62%	3) Pharmacy Services	42%
4) Transportation for Medical Care	53%	4) Dental Care	41%
		5) Specialized Doctors	38%
		6) Women’s Health Services	37%
		7) Adult Day Care	33%
		8) Child Day Care	32%
		9) Eye Care	31%
		10) Child Abuse/Neglect Services	30%
		11) Emergency Room Care	29%
		12) Day Care for Home Bound Patients	28%
		12) Pediatric Care	28%
		12) Pregnancy Care	28%
		13) Alcohol/Drug Treatment	27%
		14) Health Education/Wellness Services	26%
		15) Family Planning	25%
		15) Medical Equipment Suppliers	25%

Personal Information

- The majority of the people completing the survey were from Spencer, and 69% have lived in the county for more than ten years.
- The average age for the survey respondents was between 18-29 years of age with 28% being single and 63% married.
- The participant response noted that 84% had health insurance, 21% were TennCare enrollees, and 4% receive either SSI or AFDC.
- The personal information reported on the survey revealed that 66% of the respondents were currently employed, 32% were not employed.

The Community Health Assessment Survey was given to members of the Van Buren County Health Council and these members distributed the survey through out the community. Initially there were only 80 surveys returned but the council members decided to redistribute the questionnaires and from this effort a total of 130 were collected for analysis. The council felt that the survey results were indicative of the perceptions of the health care needs and issues in Van Buren County. The result of the Community Health Assessment Survey was discussed with the council members along with profile information about the survey respondents. The findings of the survey revealed that **smoking, teen alcohol/drug abuse, adult alcohol abuse, adult drug abuse, and teen pregnancy** 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 Van Buren County. About half of all deaths occurring annually are now attributed to modifiable behavioral risks. In addition to determining what types of health risks are most prevalent in the population, the BRFS data will be very useful in determining what types of interventions are most needed for other health problems such as excess deaths from a particular chronic disease. A modified version of the standard BRFS was developed specifically for the “Community Diagnosis” process. In addition to the questions on the standard BRFS survey, a series of health issues are listed. The respondent is asked if the issue is a “Definite Problem”, “Somewhat of a Problem”, “Not a Problem”, or “Not Sure”. The list of the health issues with frequency of response as a “Definite Problem” is as follows:

Tobacco Use	69%	Top Ten Issues Highlighted
Cancer	57%	
High Blood Pressure	48%	
Heart Conditions	47%	
Alcohol Abuse	47%	
Drug Abuse	43%	
Arthritis	42%	
Obesity	31%	
Teen Pregnancy	30%	
Health Problems of the Lungs	28%	
Diabetes	27%	
Animal Control	24%	
Environmental Issues	23%	
Violence in the Home	11%	
Mental Health Problems	11%	
STD's	6%	
Other Violence	3%	
Suicide	1%	

Van Buren County's Access to Care Issues Percent Saying Definite Problem

Access to Hospitals	41%
Access to Physicians or Doctors	32%
Access to Dental Care	31%
Access to Pharmacies, Medicines	25%
Access to Prenatal Care	16%
Transportation to Health Care	10%
Access to Nursing Home Care	9%

Access to Assisted Living Services	6%
Access to Birth Control Methods	5%

Other Issues to Consider

Tobacco Use

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

Yes:	47%
No:	53%

Percent of respondents that report current cigarette use:

Daily Use:	61%
Some Use:	4%
Not At All:	35%

Questions Regarding Mammograms

Percent of women reporting having a mammogram:

Yes:	57%
No:	43%

Reasons reported for not having a mammogram:

Doctor not recommended:	7%
Not needed:	6%
Too young:	48%
No reason:	30%
Not sure/other:	4%

When was last mammogram performed:

In last year:	60%
1-2 years:	23%
> than 2 years:	16%

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, cancer, high blood pressure, heart conditions, and alcohol abuse** as top health problems facing the community.

In analyzing the access to care issues as perceived by the community, **access to hospitals, access to physicians or doctors, and access to dental care** were identified as the top concerns.

Secondary Data

Summary of Data Use

Health Indicator Trends Van Buren 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	Increasing	Below	Below
2. Percent births to unwed women	Increasing	Below	Below
3. Number teenage pregnancies	Unstable	Below	Below
4. Number pregnancies/1,000 females	Increasing	Below	Below
5. Number pregnancies/1,000 females ages 10-14	Unstable	Below	Below
6. Number pregnancies/1,000 females ages 15-17	Unstable	Below	Below
7. Number pregnancies/1,000 females ages 18-19	Unstable	Above	Above
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	Increasing	Above	Above
11. Percent births w/ 1 or more high risk characteristic	Increasing	Equal	Equal
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:

- Number of births/1,000 females
- Percent births to unwed women
- Number of pregnancies/1000 females
- Percent of pregnancies to unwed women
- Percent of live births classified as very low birthweight
- 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.

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	Stable	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	Stable	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	Below	Above
21. Violent death rates/100,000 population	Unstable	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.

HEALTH INDICATOR	COUNTY TREND	COUNTY COMPARED TO REGION	COUNTY COMPARED TO STATE
22. Vaccine preventable disease rate/100,000 population	Unstable	Below	Below
23. Tuberculosis disease rate/100,000 population	Stable	Below	Below
24. Chlamydia rate/100,000 population	Increasing	Above	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 Van Buren County. The data used for Van Buren County is based on 1994-96 three year moving averages.

Healthy People 2000 Compared to Van Buren County

Health Status Indicators	Van Buren County Rate	Tennessee Rate	Nation's Rate
Death from all causes	481.2	563.1	No Objective
Coronary Heart Disease	124.7	134.8	100
Deaths from Stroke	14.7	34	20
Deaths of Females from Breast Cancer	40.9	22.4	20.6
Deaths from Lung Cancer	37.7	47.5	42
Deaths from Motor Vehicle Accidents	16.5	23.6	16.8
Deaths from Homicide	12.3	12.1	7.2
Deaths from Suicide	7.1	12.6	10.5
Infant Deaths	11.0	9.6	7.0
Percent of Births to Adolescent Mothers	6.0	6.6	None
Low Birthweight	7.1	8.7	5.0
Late Prenatal Care	19.2	19.9	10.0
Incidence of AIDS	*	14.1	-----
Incidence of Tuberculosis	0	11.6	3.5

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

The health status indicators in bold are the rates for Van Buren 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:

- **Number of births/1,000 females**
- **Percent births to unwed women**
- **Number pregnancies/1000 females**
- **Percent pregnancies to unwed women**
- **Percent of live births classified as very low birthweight**
- **Percent 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. There was much discussion about the increasing incidence of female breast cancer mortality rate. Van Buren County is above the state and region for female breast cancer mortality rate per 100,000 women ages 40 years and older.

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.

VAN BUREN COUNTY PRIORITIZATION TABLE

Priority Issue	Comm. Quest.	BRFS	Health Indicator Trends (Secondary Data)
Tobacco Use/Smoking	(1)	(1)	Malignant Neoplasms showing an increase in ages 25-44. Malignant Neoplasms showing a decrease in ages 45-64. Malignant Neoplasms showing an increase in ages 65+.
Teen Alcohol & Drug Abuse	(1)	(5/6) Addressed Total Population	Suicide rates are showing a stable trend for ages 25-44.
Smokeless Tobacco	(7)	Not Addressed	See Tobacco Use/Smoking
Teen Pregnancy	(2)	(9)	Teen Pregnancy showed an increase in ages 10-14 in the years 88-90 through 91-93, but are now below the state and region. Teen Pregnancy in ages 15-17 is below the state and region. Teen Pregnancy is showing an increase in ages 18-19, and is above the state and region in the years 94-96.
Adult Alcohol Abuse	(3)	(5)	Chronic Liver Disease is showing an increasing trend in ages 45-64. There were 15 total fatal traffic accidents in the 8-year period of 1990-1997. Out of these crashes 9 were alcohol related. Out of these total fatal crashes there were 18 total fatalities with 12 alcohol related.
Adult Drug Abuse	(4)	(6)	
High Blood Pressure	(5)	(3)	Cerebrovascular Disease is showing a decreasing trend in ages 65+.
Cancer Lung Cancer Other Cancer Breast Cancer	(11) (14) (8)	(2)	Malignant Neoplasms are showing an increasing trend in ages 25-44. Malignant Neoplasms are showing a decreasing trend in age 45-64. Malignant Neoplasms are showing an increasing trend in ages 65+. There were 3 reported cases of lung cancer in 1995 with an incidence rate of 46.9. This is below the state in 1995. There were 5 reported cases of breast cancer in 1995 with an incidence rate of 148.0. This is above the state in 1995.

Priority Issue	Comm. Quest.	BRFS	Health Indicator Trends (Secondary Data)
Heart Conditions	(6)	(4)	Diseases of the Heart are showing a decreasing trend in ages 25-44. Diseases of the Heart are showing an increasing trend in ages 45-64 and ages 65+.
Obesity	(9)	(8)	See High Blood Pressure: Cerebrovascular Disease trends: See Heart Conditions: Diseases of the Heart Trends
Stress	(6)	Not Addressed	
School Dropout	(7)	Not Addressed	
Lack of Sex Education	(10)	Teen Pregnancy (9)	See Teen Pregnancy Trends

Van Buren 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 10.

Seriousness: The most serious problem will be ranked 1.

The least serious problem will be ranked 10.

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)

10 being the lowest rank (the smallest percentage)

Assign a rank for seriousness.

1 being the most serious

10 being the least serious

STEP 2: Add size and seriousness

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

The results of the Score and Rank Process were:

TOP ISSUES

- 1) Teen Alcohol and Drug Abuse
- 2) Tobacco Use
- 3) Teen Pregnancy
- 4) Adult Alcohol Abuse
- 5) Cancer
- 6) Adult Drug Abuse
- 7) Heart Conditions
- 8) High Blood Pressure
- 9) Obesity
- 10) Health Problems of the Lungs

At this point in the prioritization process, the Van Buren 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?

After reviewing the PEARL Test the Council decided to focus on Teen Alcohol and Drug Abuse.

Future Planning

Through the Community Diagnosis Process, it was determined that the top issue of concern was the teen alcohol and drug problem in Van Buren County. The future plans of the Van Buren 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

Van Buren County Health Council

Michelle Hitchcock
Generations of spencer
P.O. Box 135
Spencer, TN 38585

Zeda Hillis
City Hall
P.O. Box 187
Spencer, TN 38585

Johnny Crain
Citizens Bank of Spencer
P.O. Box 158
Spencer, TN 38585

Art Reed
P.O. Box 431
Spencer, Tn 38585

Kelly Dishman
County Executive
P.O. Box 217
Spencer, TN 38585

Donnie Evans
Van Buren County Sheriff
P.O. Box 87
Spencer, TN 38585

Neal O'Neal
Van Buren Board of Education
P.O. Box 98
Spencer, TN 38585

Lofton Graves
P.O. Box 247
Spencer, TN 38585

Darlene Walling
Department of Human Services
P.O. Box 361
Spencer, TN 38585

Shirley Measles
Van Buren County Health Department

Shirley Brock
Townsend Engineered Products
P.O. Box 856
Spencer, TN 38585

Teena Hodges
Route 3 Box 144A
Sparta, TN 38583

D. L. Dodson
Route 1 Box 506B
Doyle, TN 38559
Karla Cochran
Headstart
Rouet 1, Box 167
Spencer, TN 38585

Joe Moffitt
Van Buren County School System

Norene Land
Mentoring Program
Route 1
Spencer, TN 38585

Bonnie Hensley
P.O. Box 128
Spencer, TN 38585

Verana Manus
Route 1 Box 100
Spencer, TN 38585

Valerie Pollard
Route 1 Box 546 B-3
Spencer, TN 38585

Alene Miller
Route 1 Box 167
Spencer, TN 38585

J. Darin Lance
Haston Building
1906 Hwy 30 Courthouse Square
Spencer, TN 38585

Lee Ann Jolly
P.O. Box 136
Spencer, TN 38585

Lynn Mitchell
Youth Services Officer
White County Courthouse
Room 310
Sparta, TN 38583

Eddie Carter
P.O. Box 187
Spencer, TN 38585

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

Gen Savage
P.O. Box 27
Doyle, TN 38559

Peggy Welch
Van Buren County Health Department

Clydene Roberts
Family Resource Center
P.O. Box 3281
Spencer, TN 38585

Cecil Vanwinkle, Principal
Spencer Elementary School
P.O. Box 218
Spencer, TN 38585

Agnes Jones
H.C. 69
Spencer, TN 38585

Samantha Worrix
Route 1 Box 671
Spencer, TN 38585
Angie Beaty
American Cancer Society
508 State Street
Cookeville, TN 38501

Mr. C. Crawford
P.O. Box 218
Spencer, TN 38585
Carrie Simmons
HC 69 Box 737
Spencer, TN 38585

Kristy Miller
Warren County Health Department

Sandy Crain
P.O. Box 838
Spencer, TN 38585

Appendix 2

BY LAWS FOR VAV BUREN COUNTY HEALTH COUNCIL

ARTICLE 1. NAME

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

ARTICLE II. MISSION

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

ARTICLE III. GOALS

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

ARTICLE IV-AUTHORITY

1. The Council shall exist as an advisory and support body to the Tennessee Department of Health solely for the purposes stated herein and shall 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 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 behalf. Further, the Council shall not generate or receive any moneys or property on behalf of the 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 The Tennessee Department of Health for appropriate accounting and allocation according to The Tennessee Department of Health applicable Department of Health policy.

ARTICLE V. OFFICERS

Section 1: Officers

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

Section 2: Chairman

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

Section 3: Vice-Chairman

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

Section 4: Secretary

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, will issue notice of all meetings and perform such duties as assigned by the Council.

Section 5: Term of Office

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

ARTICLE VI: MEMBERS

Membership in the Council shall be voluntary and selected by the Board of Directors. The Board of Directors will be composed of the current elected officers of the Council. The Council shall consist of an adequate number of voting members as to be effectively representative of all segments of the community. 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 representatives from diverse socioeconomic backgrounds.

ARTICLE VII. MEETINGS

Section 1: Regular Meetings

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

Section 2: Special Meetings

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

Section 3: Quorum

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

ARTICLE VIII. 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 IX. APPROVAL AND AMENDMENTS

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

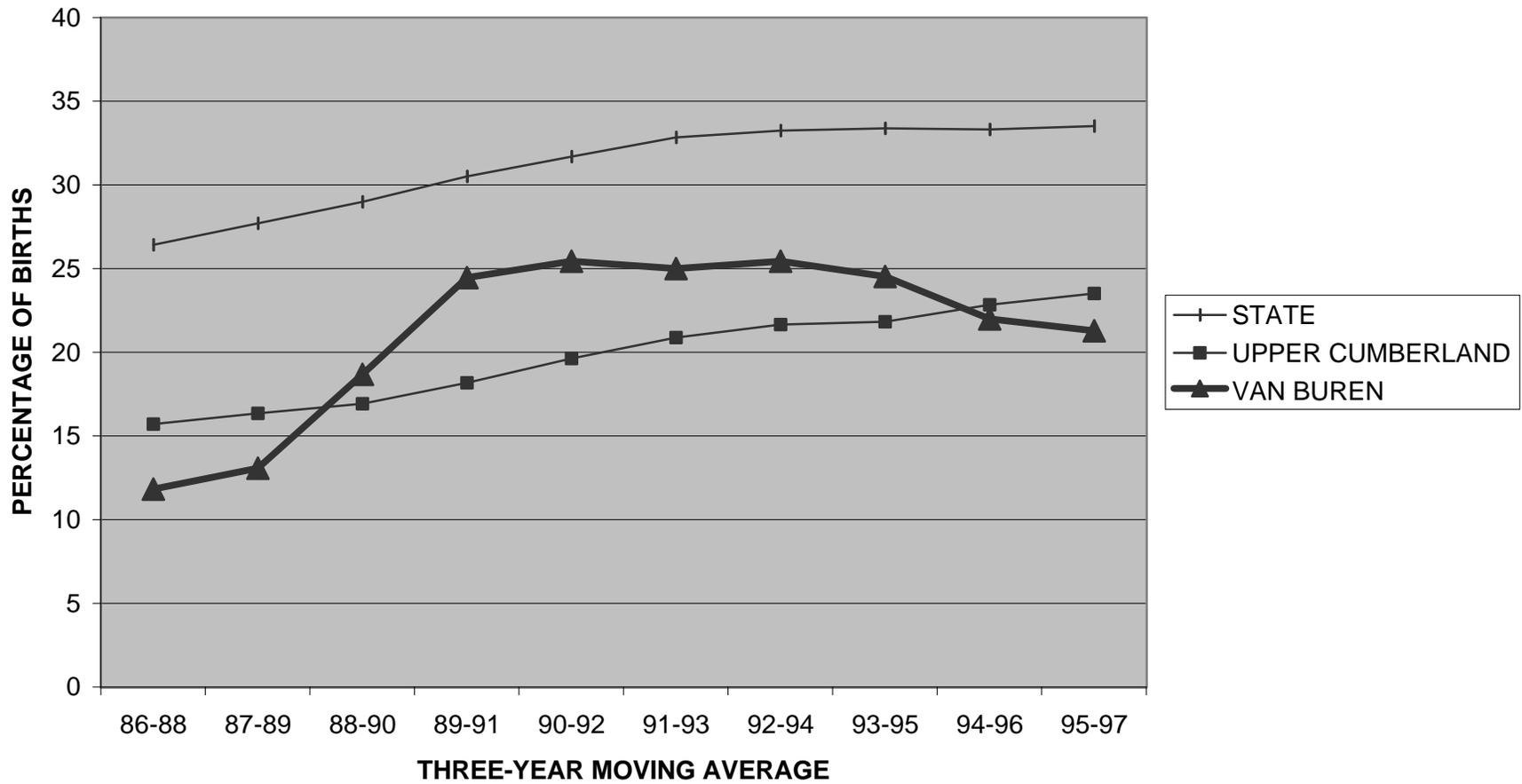
ADOPTED BY THE VAN BUREN COUNTY HEALTH COUNCIL

Appendix 3

Pregnancy and Birth Data

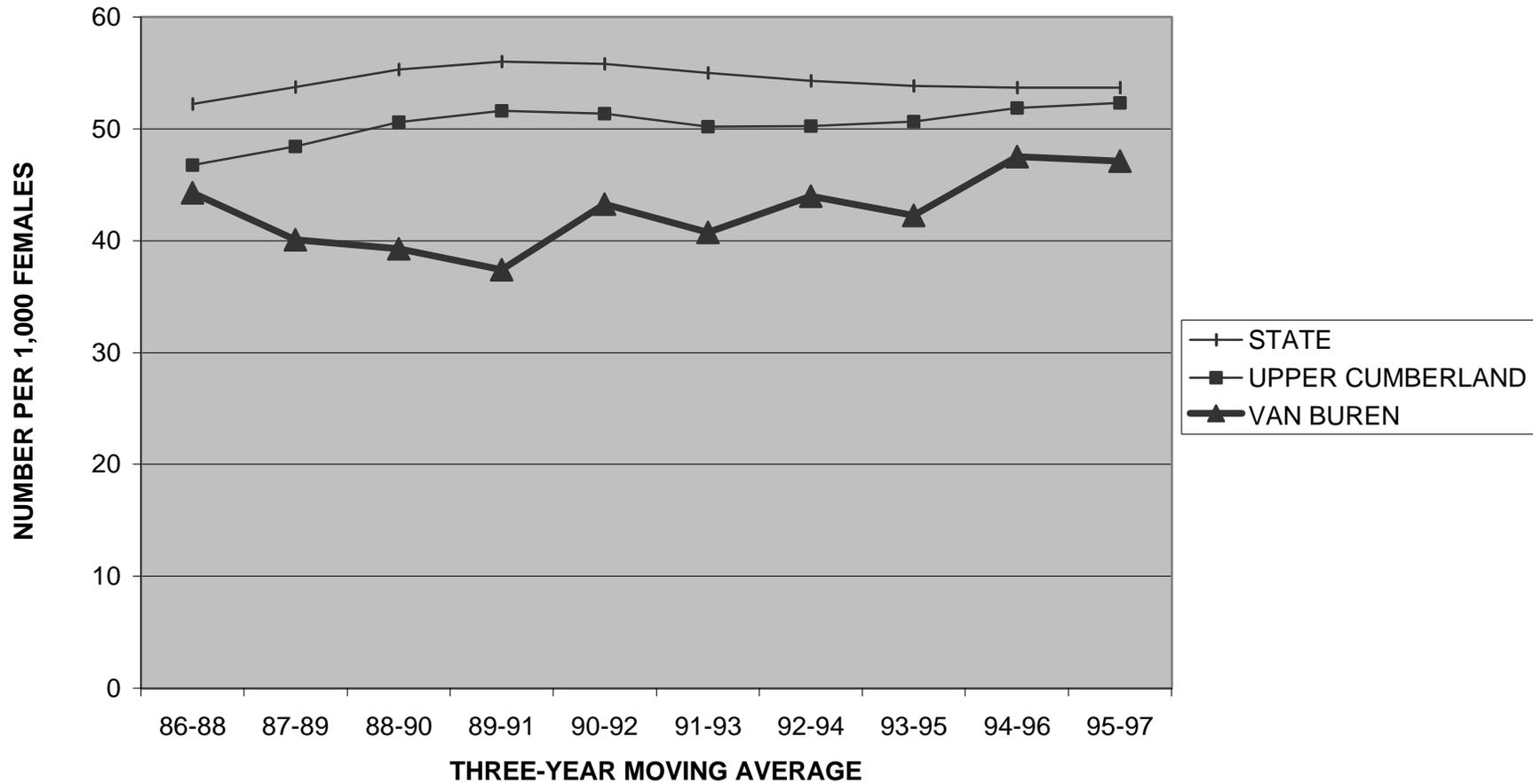
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	26.4	27.7	29.0	30.5	31.7	32.8	33.2	33.4	33.3	33.5	
UPPER CUMBERLAND	15.7	16.4	16.9	18.2	19.6	20.9	21.7	21.8	22.9	23.5	
VAN BUREN	11.8	13.1	18.7	24.5	25.5	25.0	25.4	24.5	22.0	21.3	

PERCENTAGE OF LIVE BIRTHS TO UNWED MOTHERS AGES 10-44



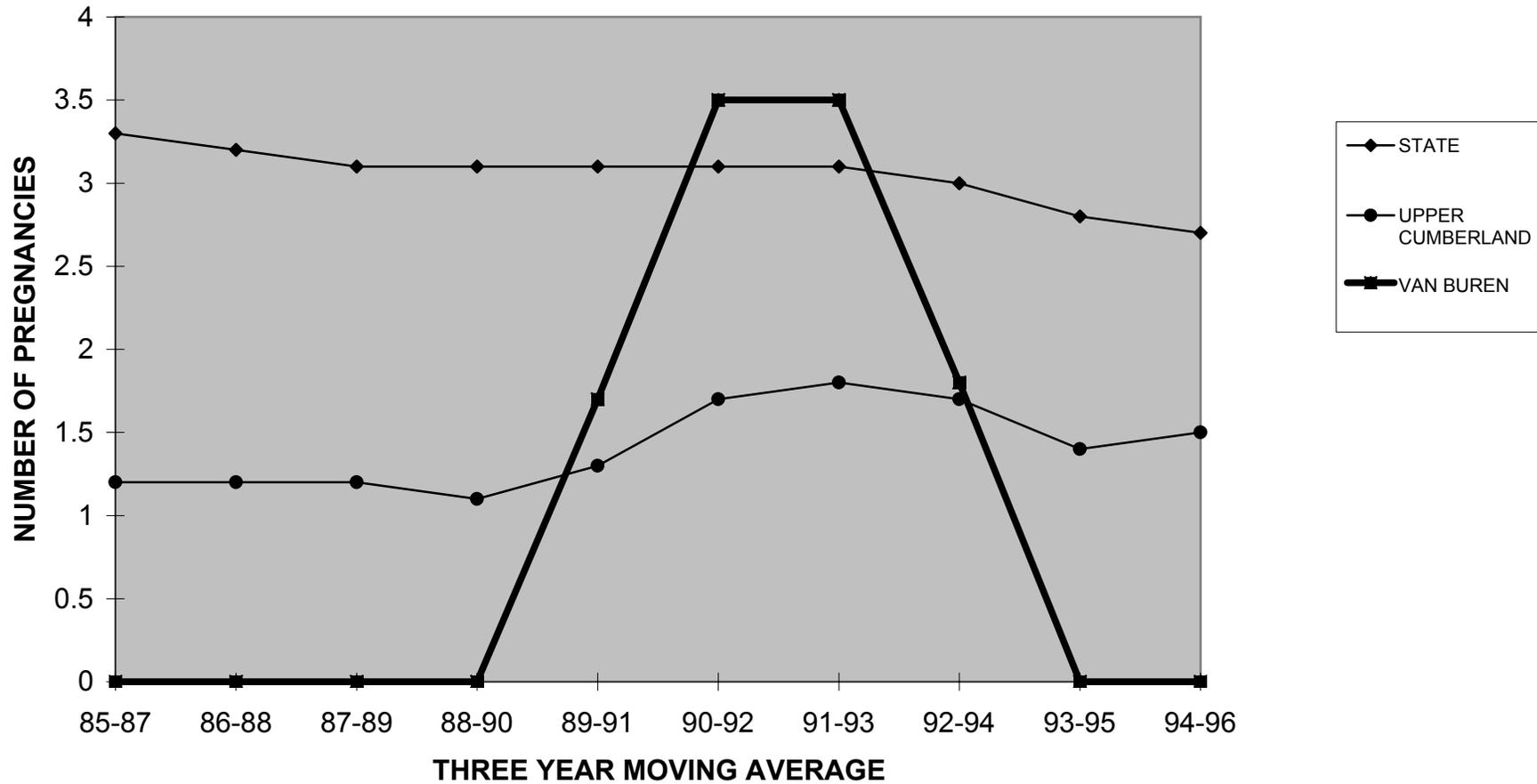
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	52.2	53.7	55.3	56.0	55.8	55.0	54.3	53.9	53.7	53.7	
UPPER CUMBERLAND	46.8	48.4	50.6	51.6	51.4	50.2	50.2	50.6	51.8	52.3	
VAN BUREN	44.3	40.1	39.3	37.4	43.3	40.7	44.0	42.2	47.5	47.1	

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



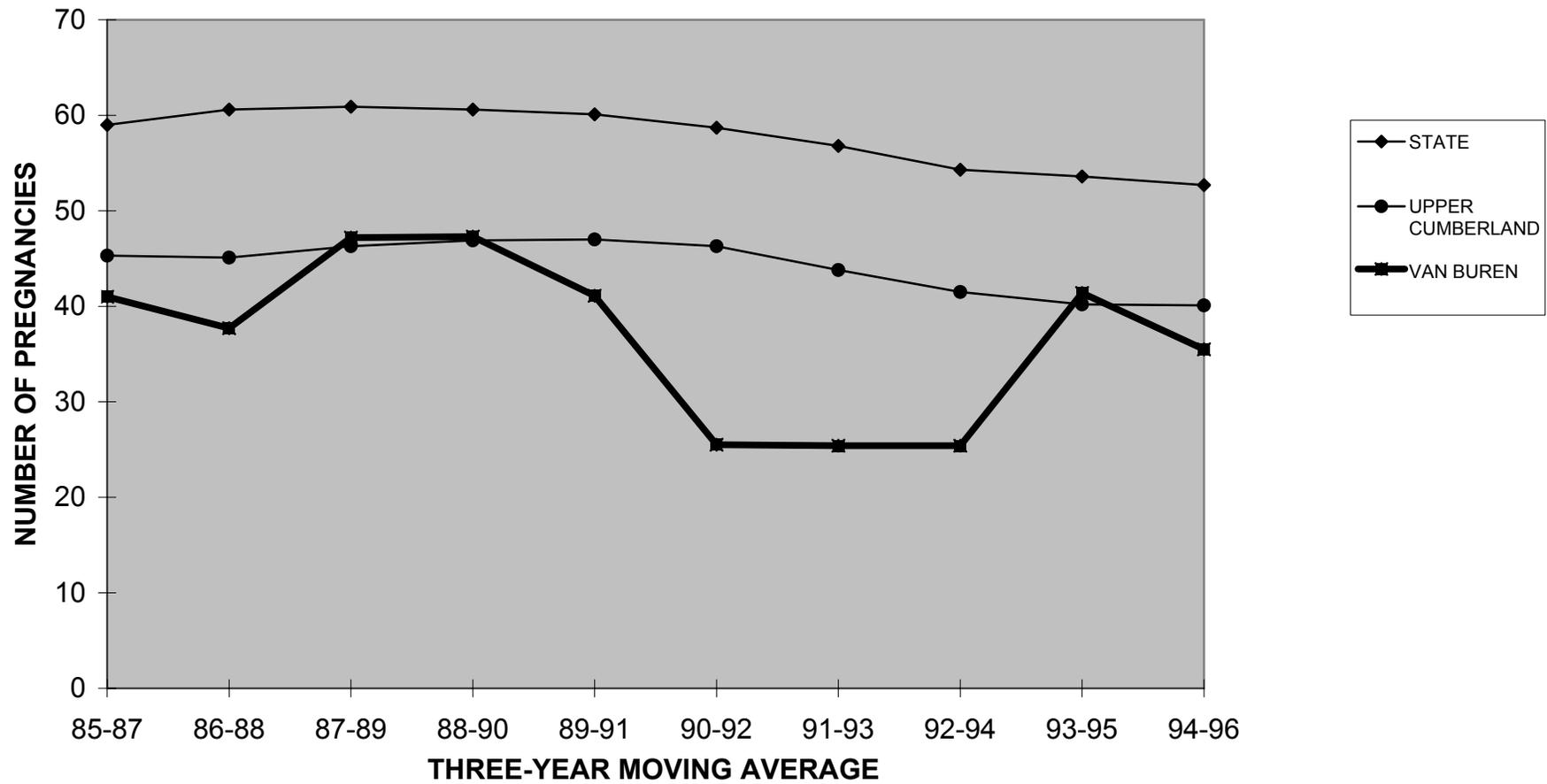
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	3.3	3.2	3.1	3.1	3.1	3.1	3.1	3	2.8	2.7	
UPPER CUMBERLAND	1.2	1.2	1.2	1.1	1.3	1.7	1.8	1.7	1.4	1.5	
VAN BUREN	0	0	0	0	1.7	3.5	3.5	1.8	0	0	

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



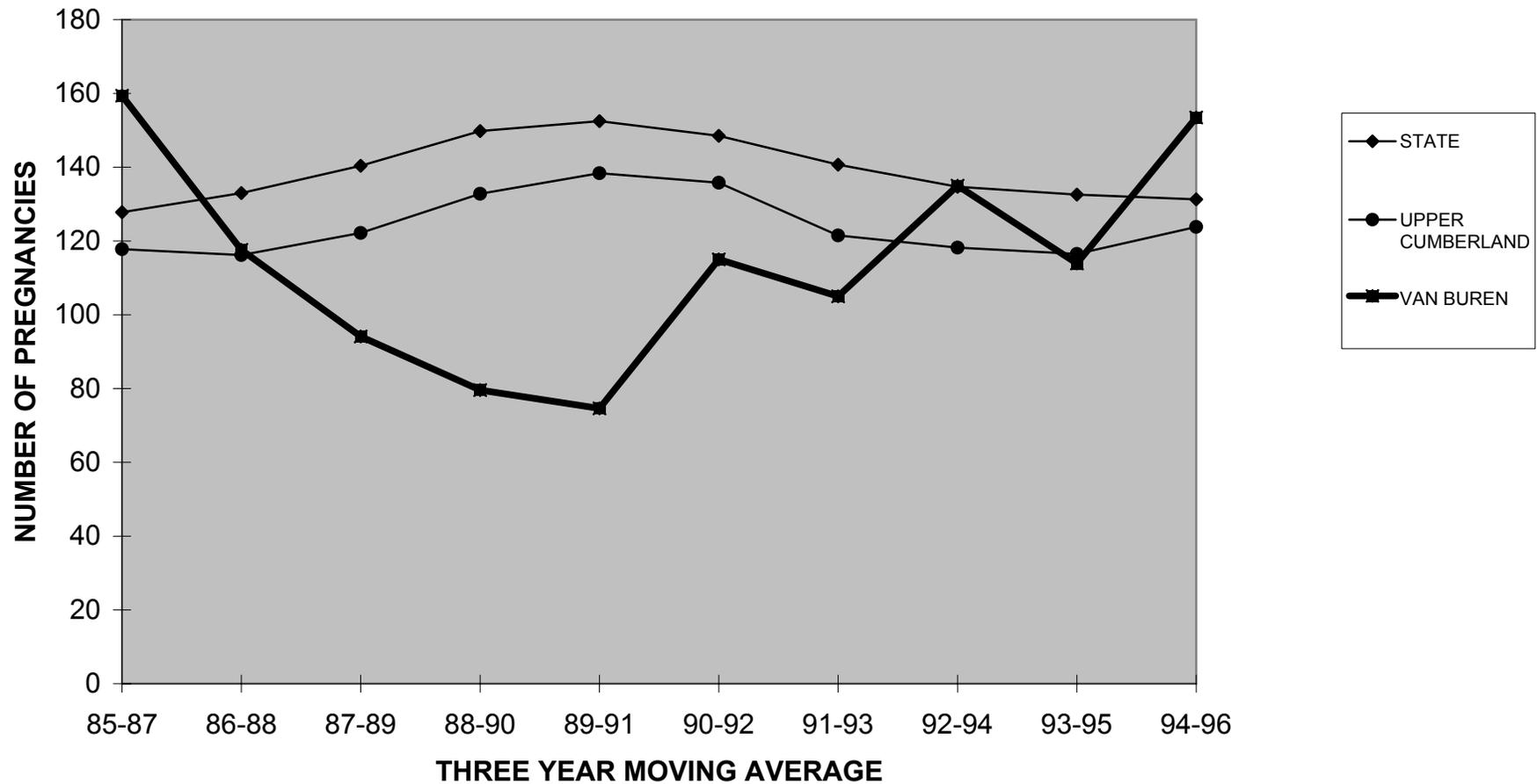
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96
STATE	59	60.6	60.9	60.6	60.1	58.7	56.8	54.3	53.6	52.7
UPPER CUMBERLAND	45.3	45.1	46.3	46.9	47	46.3	43.8	41.5	40.2	40.1
VAN BUREN	41	37.7	47.2	47.3	41.1	25.5	25.4	25.4	41.4	35.5

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



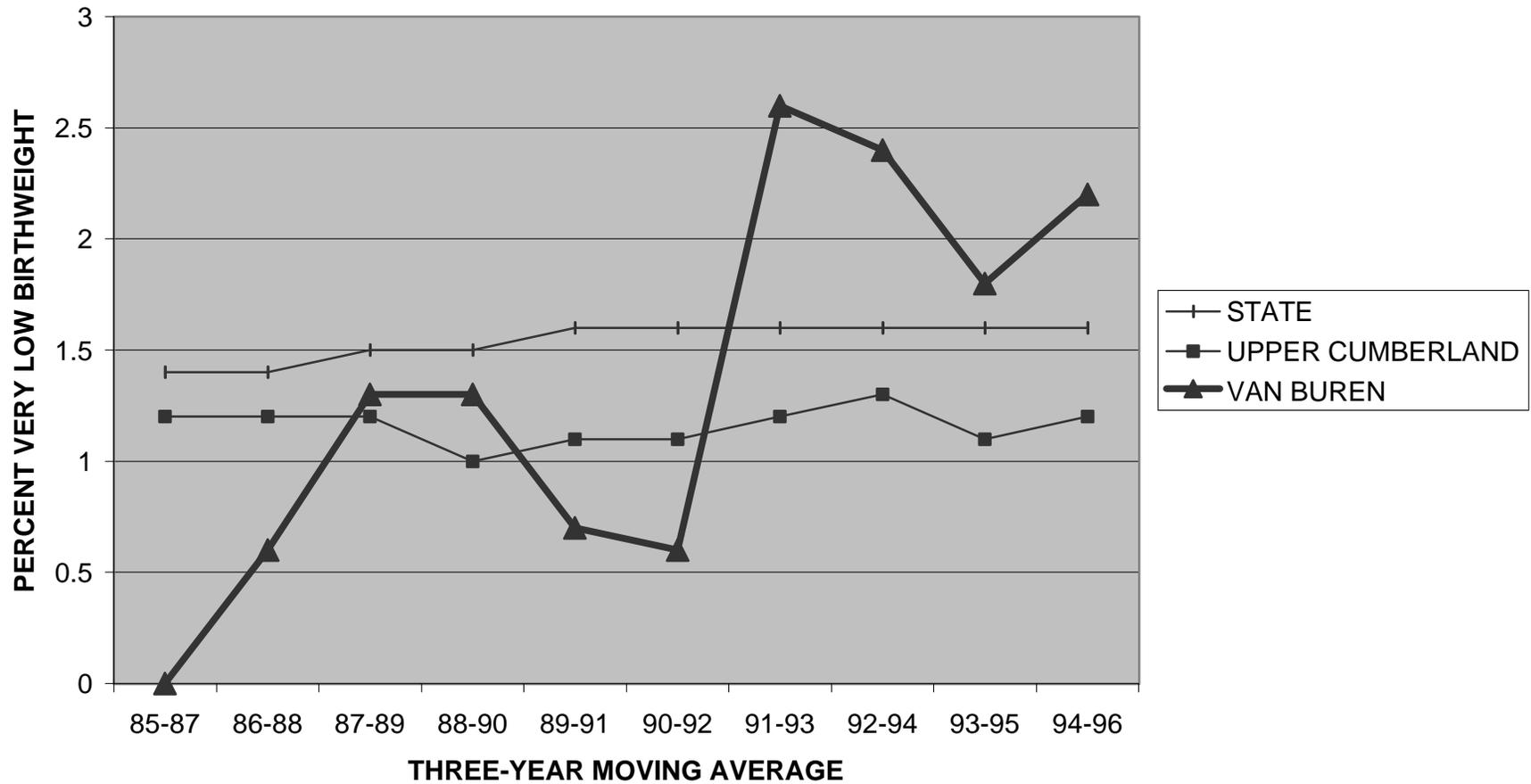
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	127.8	133	140.4	149.8	152.5	148.5	140.7	134.7	132.6	131.3	
UPPER CUMBERLAND	117.8	116.2	122.2	132.8	138.4	135.8	121.5	118.2	116.5	123.8	
VAN BUREN	159.4	117.6	94.1	79.6	74.6	115	105	135	113.9	153.5	

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



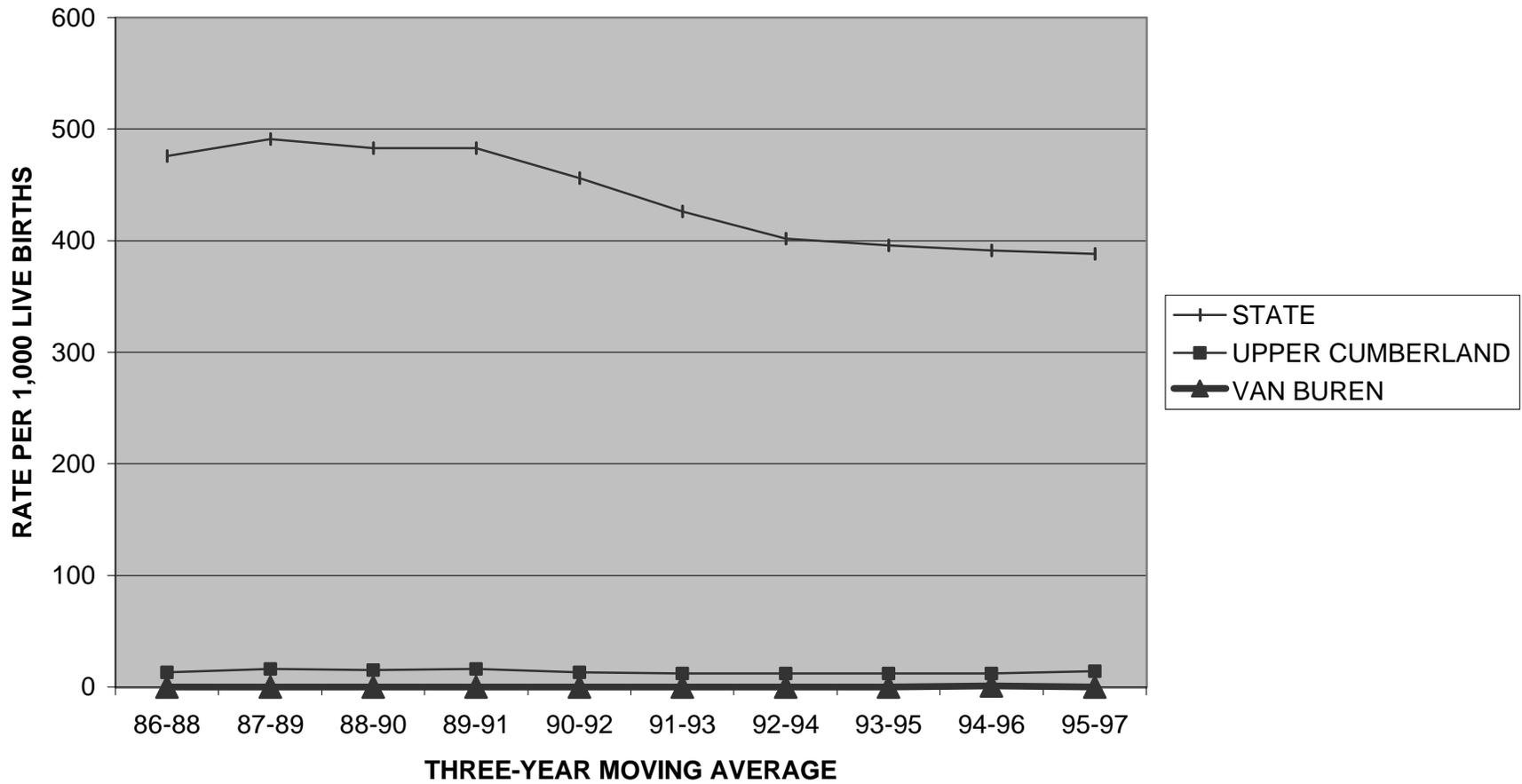
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96
STATE	1.4	1.4	1.5	1.5	1.6	1.6	1.6	1.6	1.6	1.6
UPPER CUMBERLAND	1.2	1.2	1.2	1	1.1	1.1	1.2	1.3	1.1	1.2
VAN BUREN	0	0.6	1.3	1.3	0.7	0.6	2.6	2.4	1.8	2.2

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



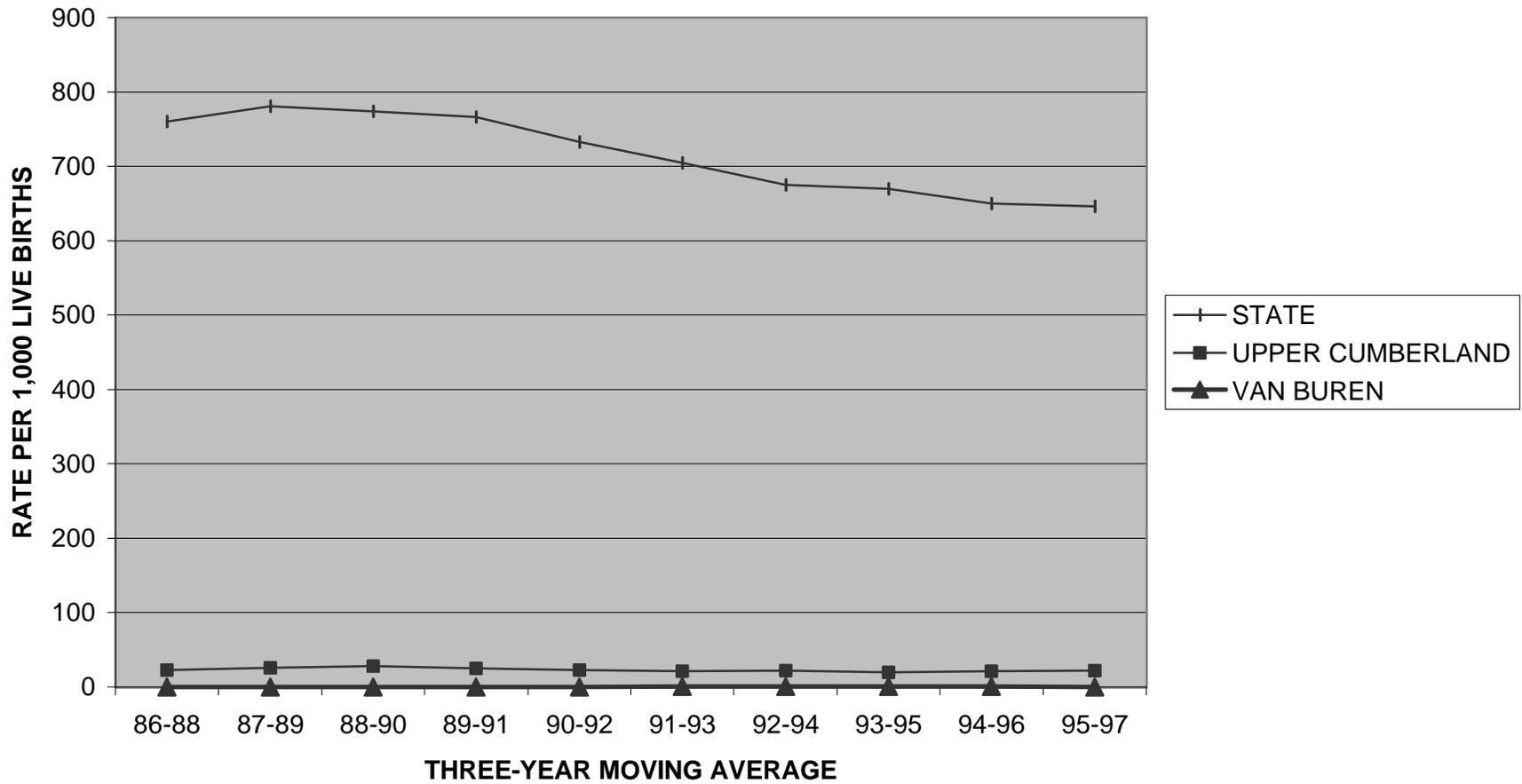
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	476	491	483	483	456	426	402	396	391	388	
UPPER CUMBERLAND	13	16	15	16	13	12	12	12	12	14	
VAN BUREN	0	0	0	0	0	0	0	0	1	0	

NEONATAL DEATHS PER 1,000 LIVE BIRTHS



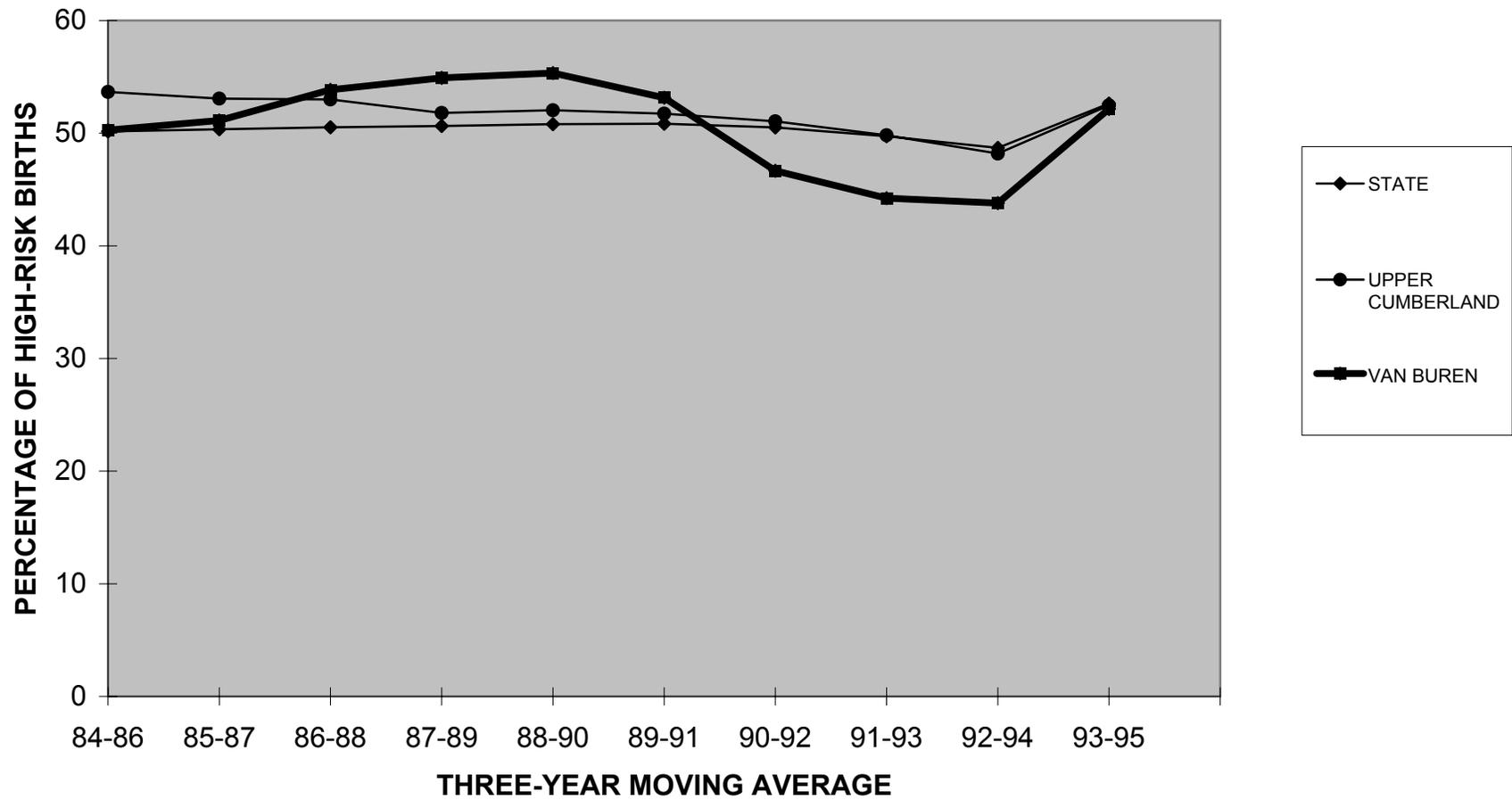
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	760	781	774	766	733	705	675	670	650	646	
UPPER CUMBERLAND	23	26	28	25	23	21	22	20	21	22	
VAN BUREN	0	0	0	0	0	1	1	1	1	0	

INFANT DEATHS PER 1,000 LIVE BIRTHS



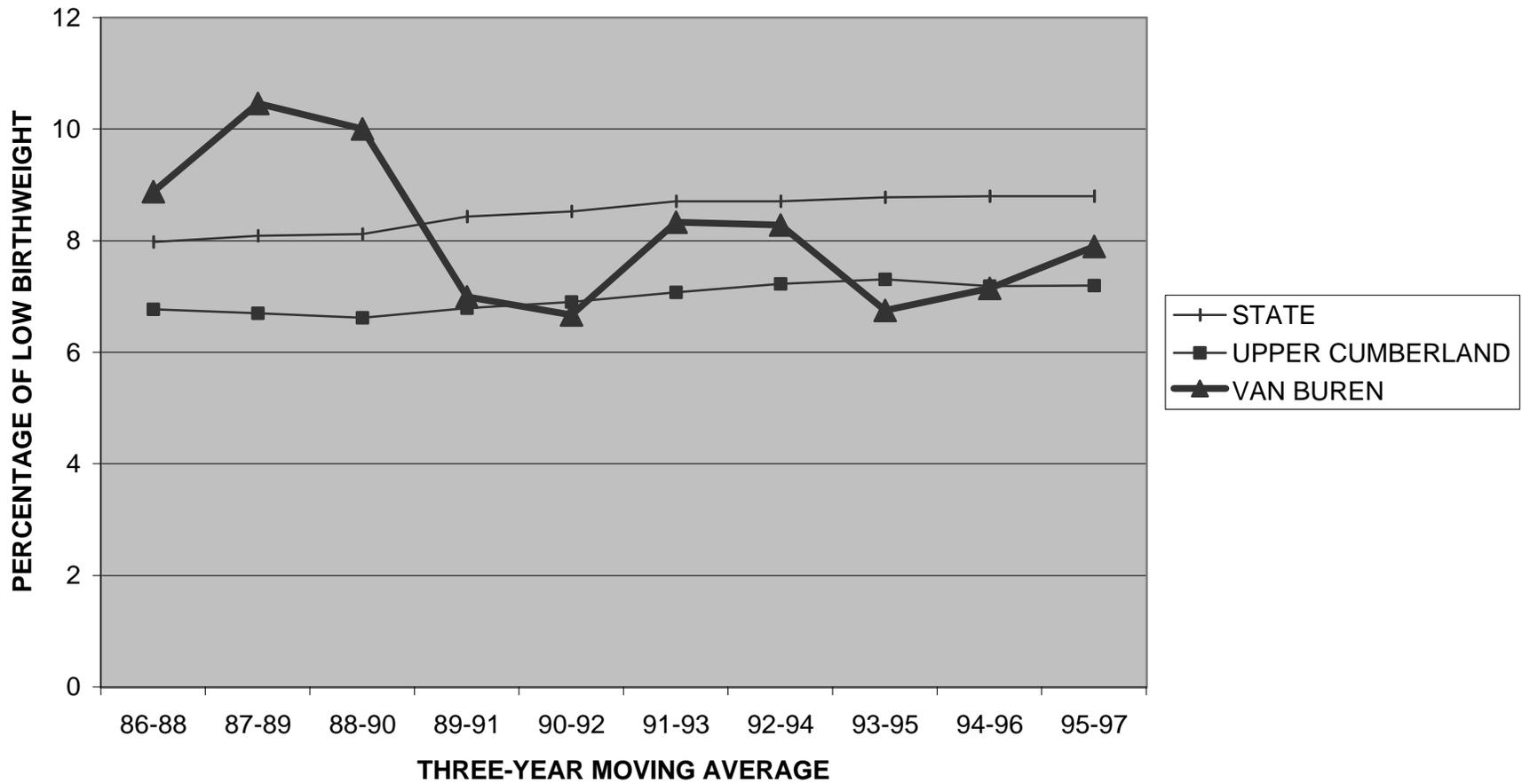
	84-86	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95
STATE	50.1	50.3	50.5	50.6	50.8	50.8	50.5	49.7	48.7	52.6
UPPER CUMBERLAND	53.7	53.1	53.0	51.8	52.0	51.7	51.0	49.8	48.2	52.5
VAN BUREN	50.3	51.1	53.8	54.9	55.3	53.1	46.7	44.2	43.8	52.1

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



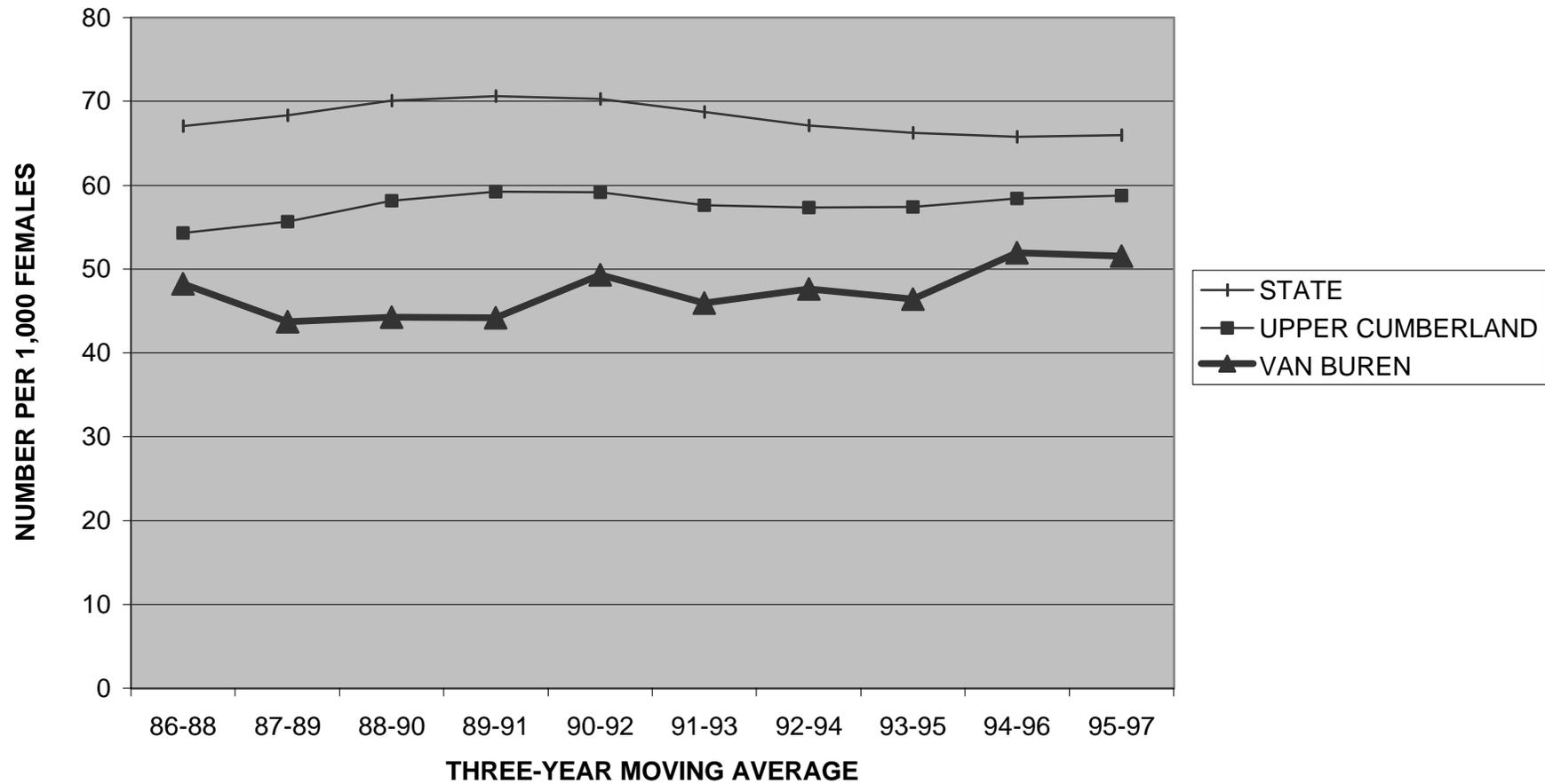
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	8.0	8.1	8.1	8.4	8.5	8.7	8.7	8.8	8.8	8.8
UPPER CUMBERLAND	6.8	6.7	6.6	6.8	6.9	7.1	7.2	7.3	7.2	7.2
VAN BUREN	8.9	10.5	10.0	7.0	6.7	8.3	8.3	6.7	7.1	7.9

PERCENTAGE OF BIRTHS WHICH WERE LOW BIRTHWEIGHT



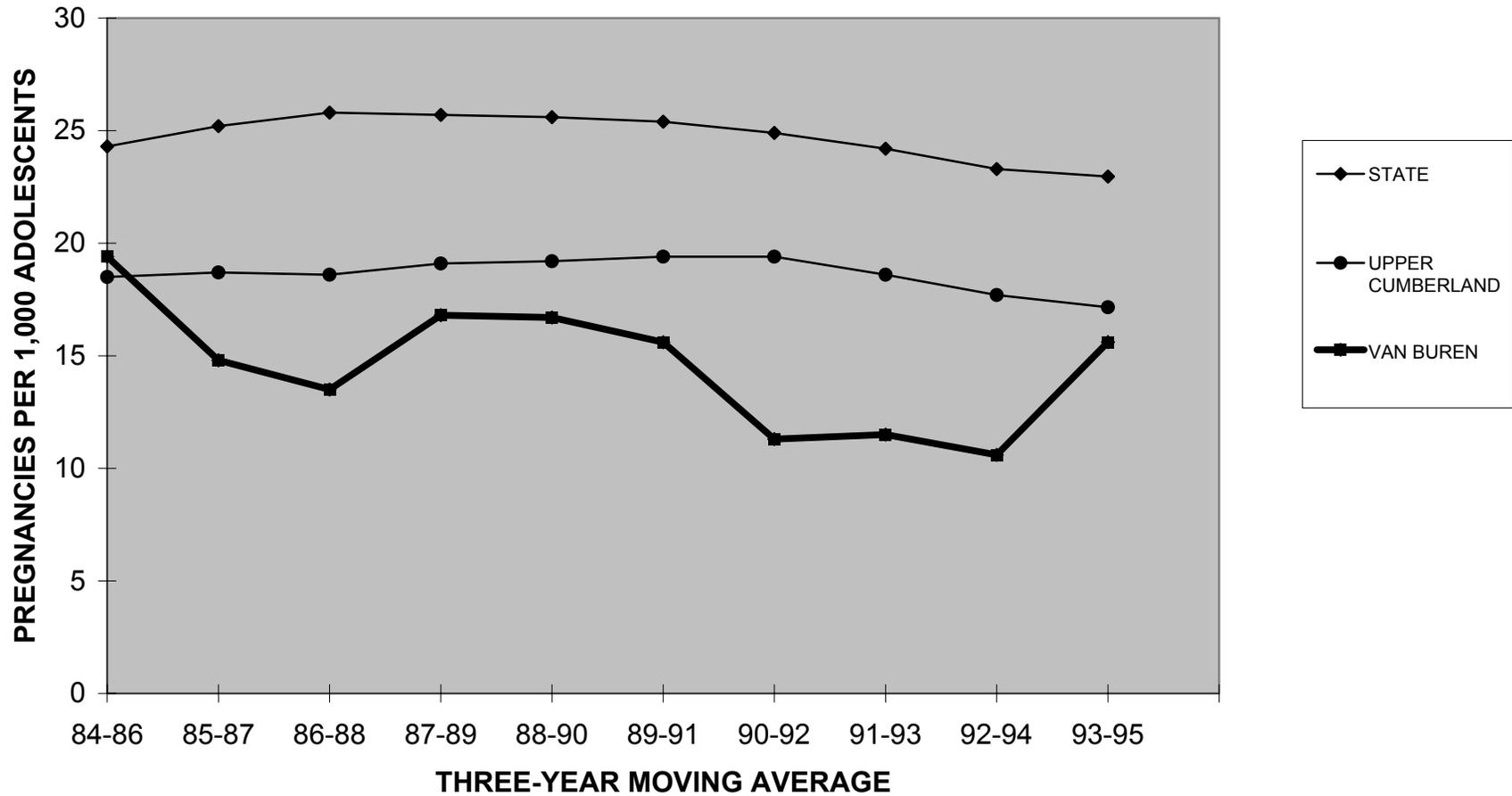
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	67.1	68.4	70.1	70.6	70.3	68.7	67.1	66.3	65.8	66.0	
UPPER CUMBERLAND	54.3	55.6	58.2	59.2	59.2	57.6	57.3	57.4	58.4	58.7	
VAN BUREN	48.2	43.7	44.2	44.2	49.3	45.9	47.6	46.4	52.0	51.5	

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
VAN BUREN	19.4	14.8	13.5	16.8	16.7	15.6	11.3	11.5	10.6	15.6

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

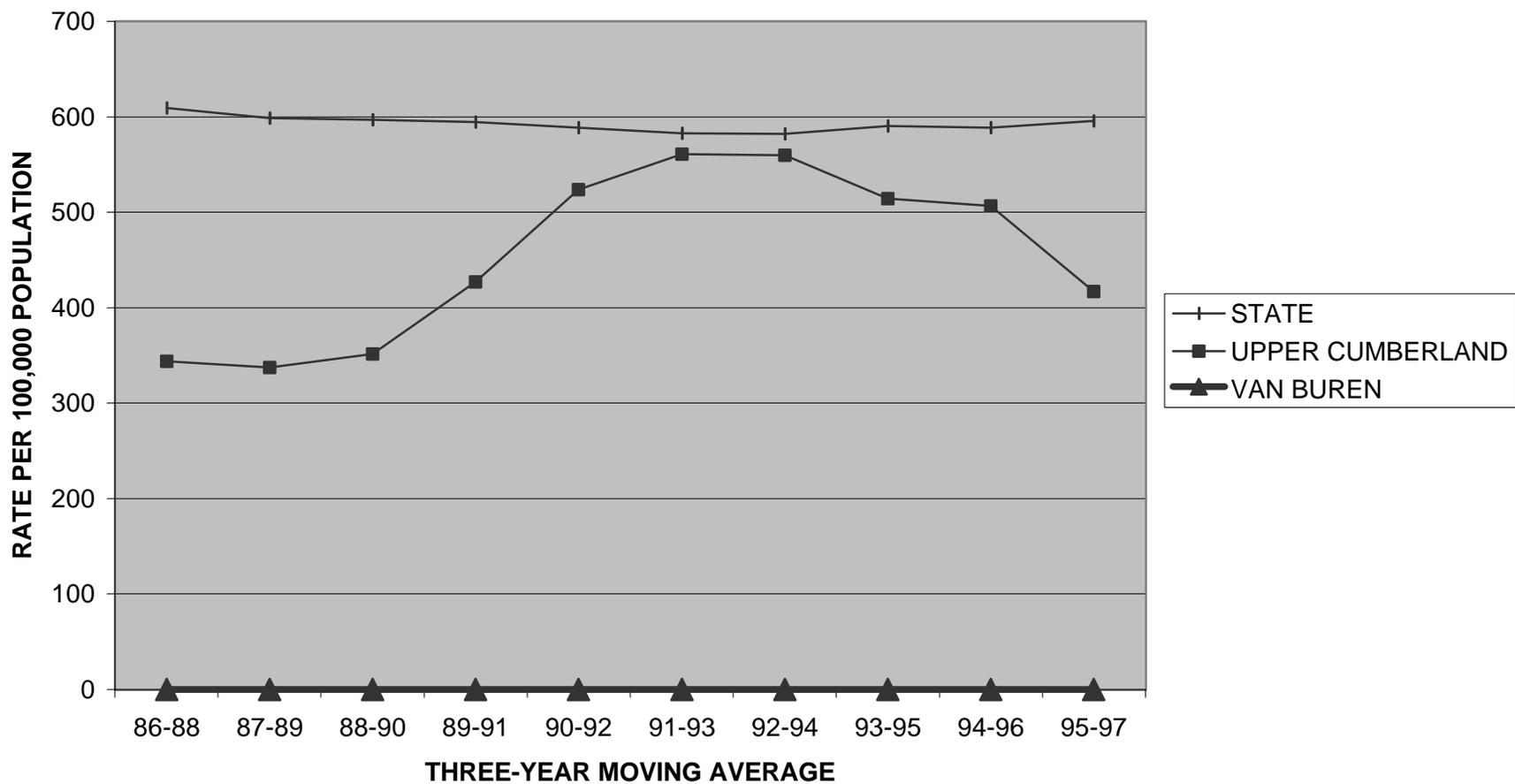


Appendix 4

Mortality Data

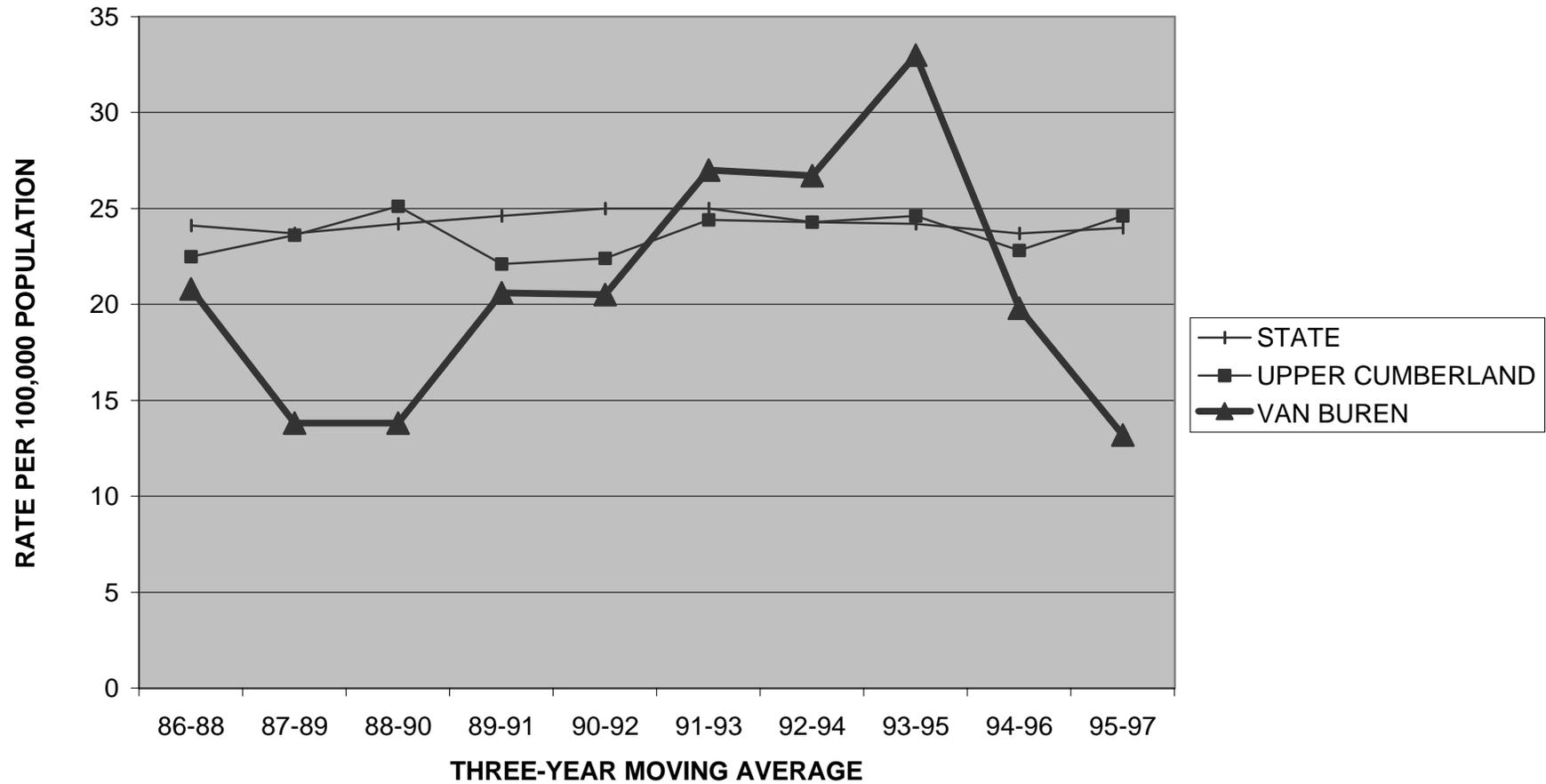
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	608.9	598.3	596.8	594.4	588.8	582.7	582.2	590.6	588.7	595.7	
UPPER CUMBERLAND	344.0	337.6	351.2	427.2	523.4	560.8	559.5	514.1	506.7	416.7	
VAN BUREN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

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



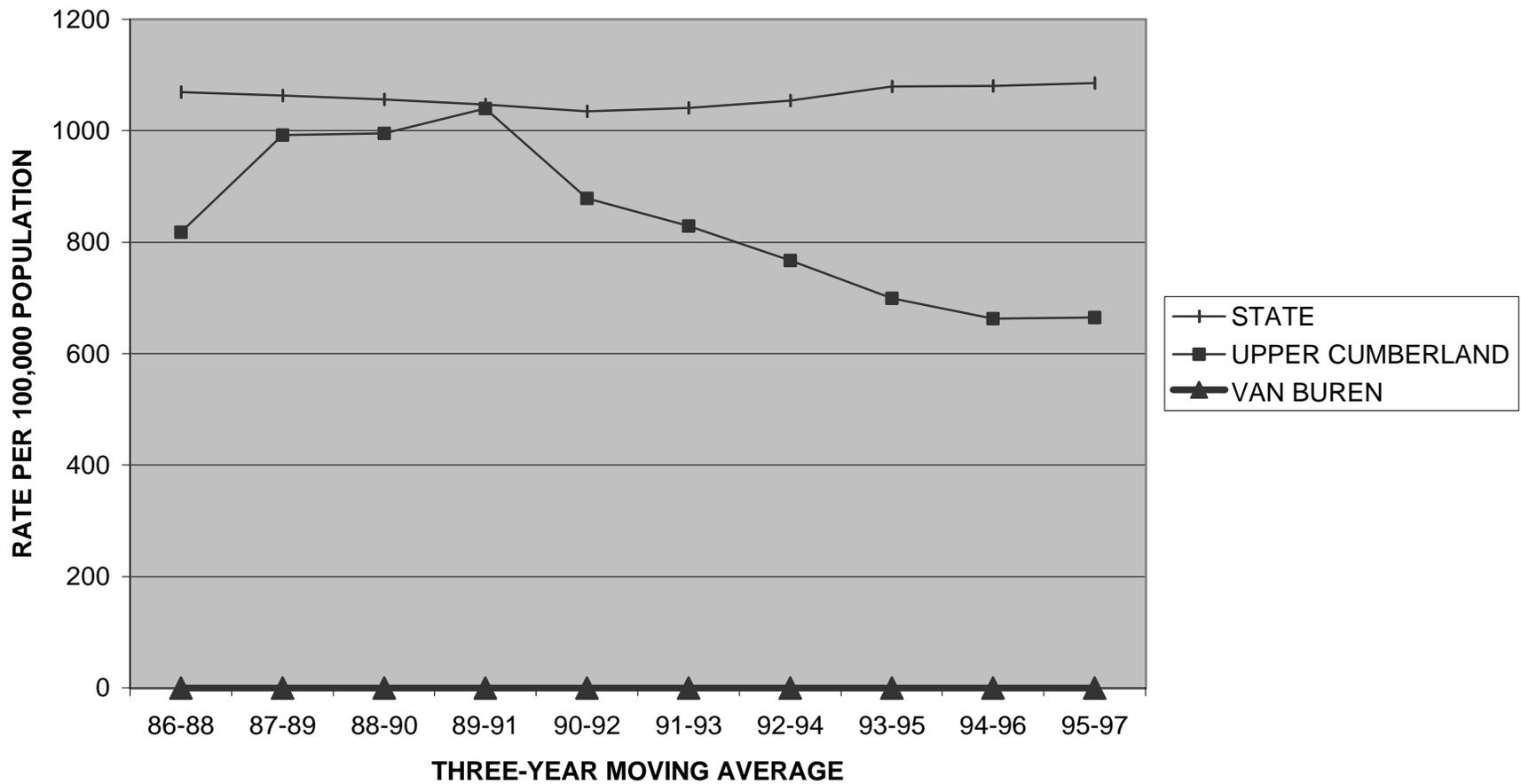
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	24.1	23.7	24.2	24.6	25.0	25.0	24.3	24.2	23.7	24.0	
UPPER CUMBERLAND	22.5	23.6	25.1	22.1	22.4	24.4	24.3	24.6	22.8	24.6	
VAN BUREN	20.8	13.8	13.8	20.6	20.5	27.0	26.7	33.0	19.8	13.2	

VIOLENT DEATH RATE PER 100,000 POPULATION



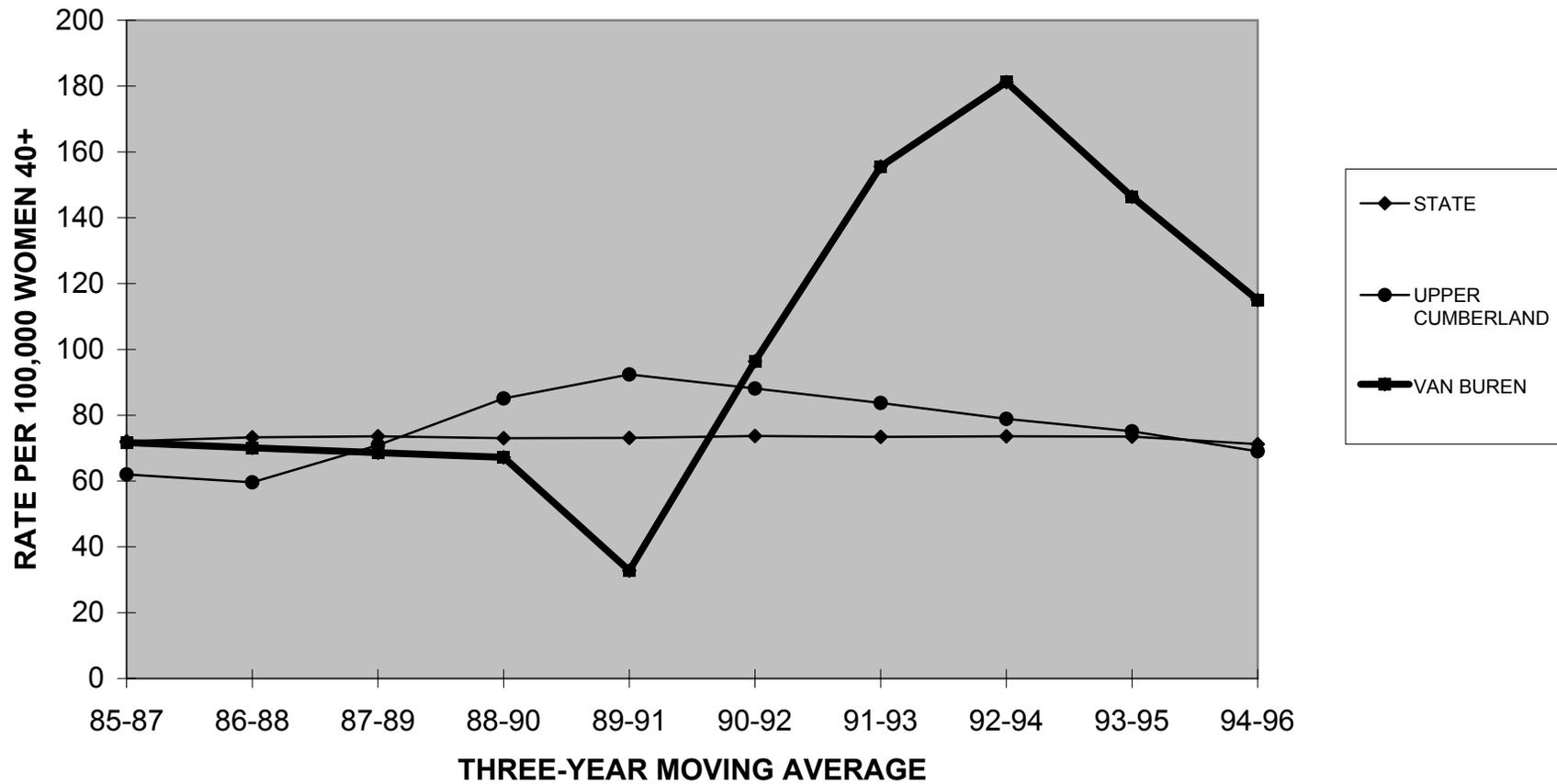
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	1,068.8	1,063.0	1,056.2	1,046.5	1,034.4	1,040.8	1,054.3	1,079.7	1,080.0	1,085.8
UPPER CUMBERLAND	817.8	992.0	995.6	1,039.8	878.9	829.4	766.8	699.8	663.0	665.1
VAN BUREN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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



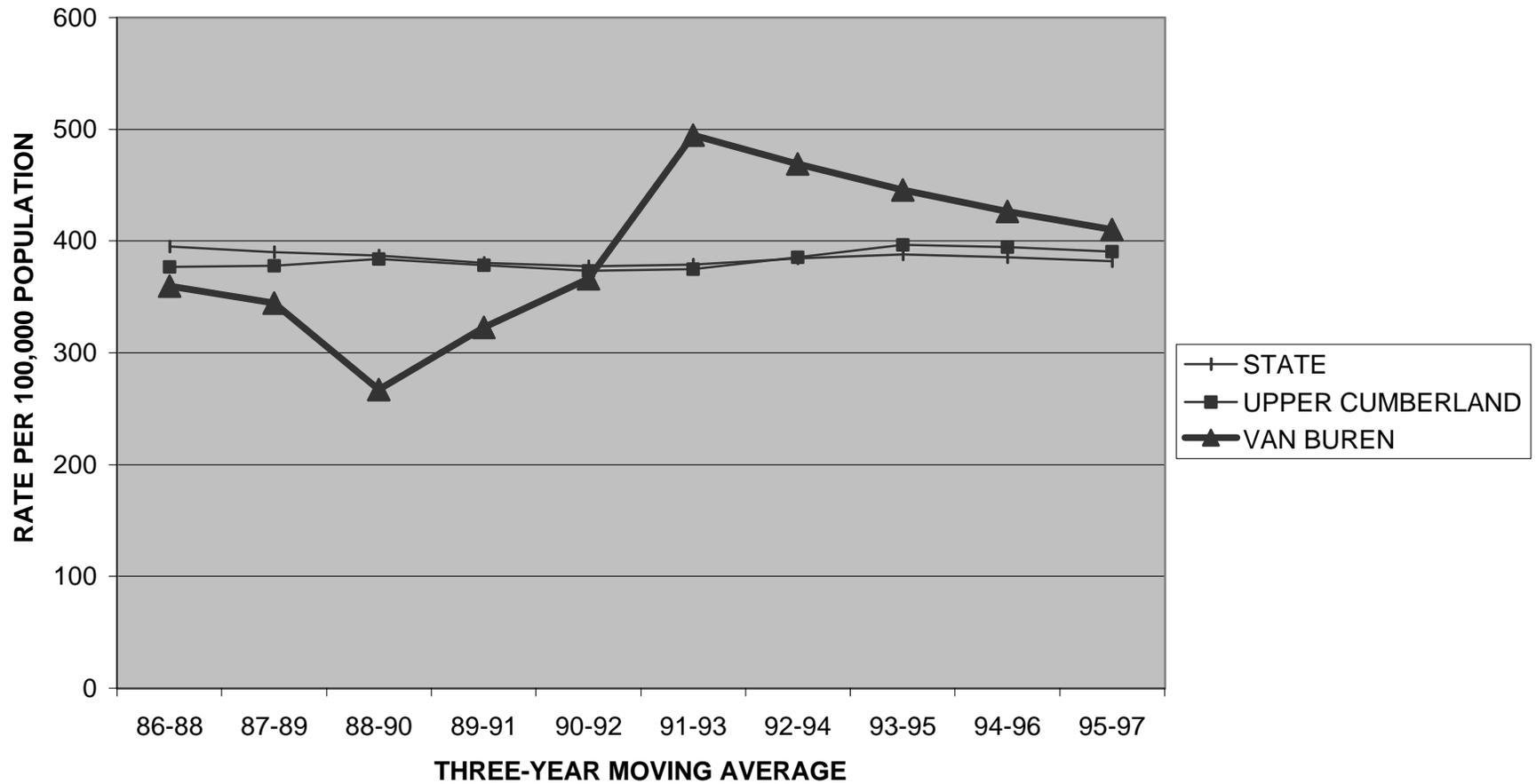
	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	72.1	73.3	73.6	73	73.1	73.7	73.4	73.6	73.5	71.2	
UPPER CUMBERLAND	62	59.6	70.9	85.1	92.4	88.1	83.7	78.9	75.1	69	
VAN BUREN	71.7	70.1	68.6	67.2	32.8	96.4	155.6	181.2	146.4	115	

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



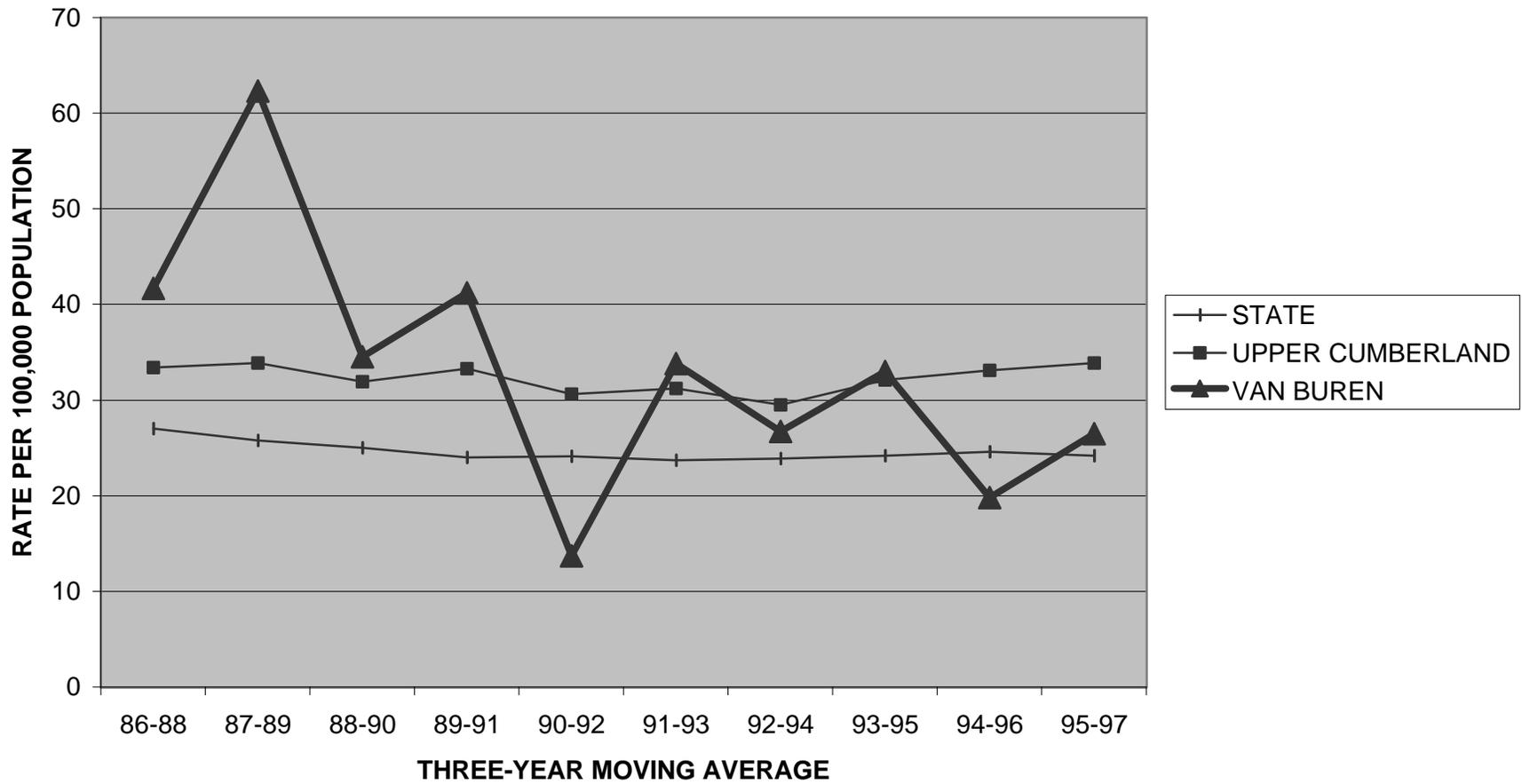
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	395.1	390.0	387.1	380.2	377.2	379.0	384.3	388.0	385.3	381.9	
UPPER CUMBERLAND	377.1	378.1	384.2	378.2	373.6	374.7	385.7	396.6	394.7	390.5	
VAN BUREN	359.8	344.7	267.1	322.6	366.5	494.8	469.2	445.8	426.4	410.4	

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



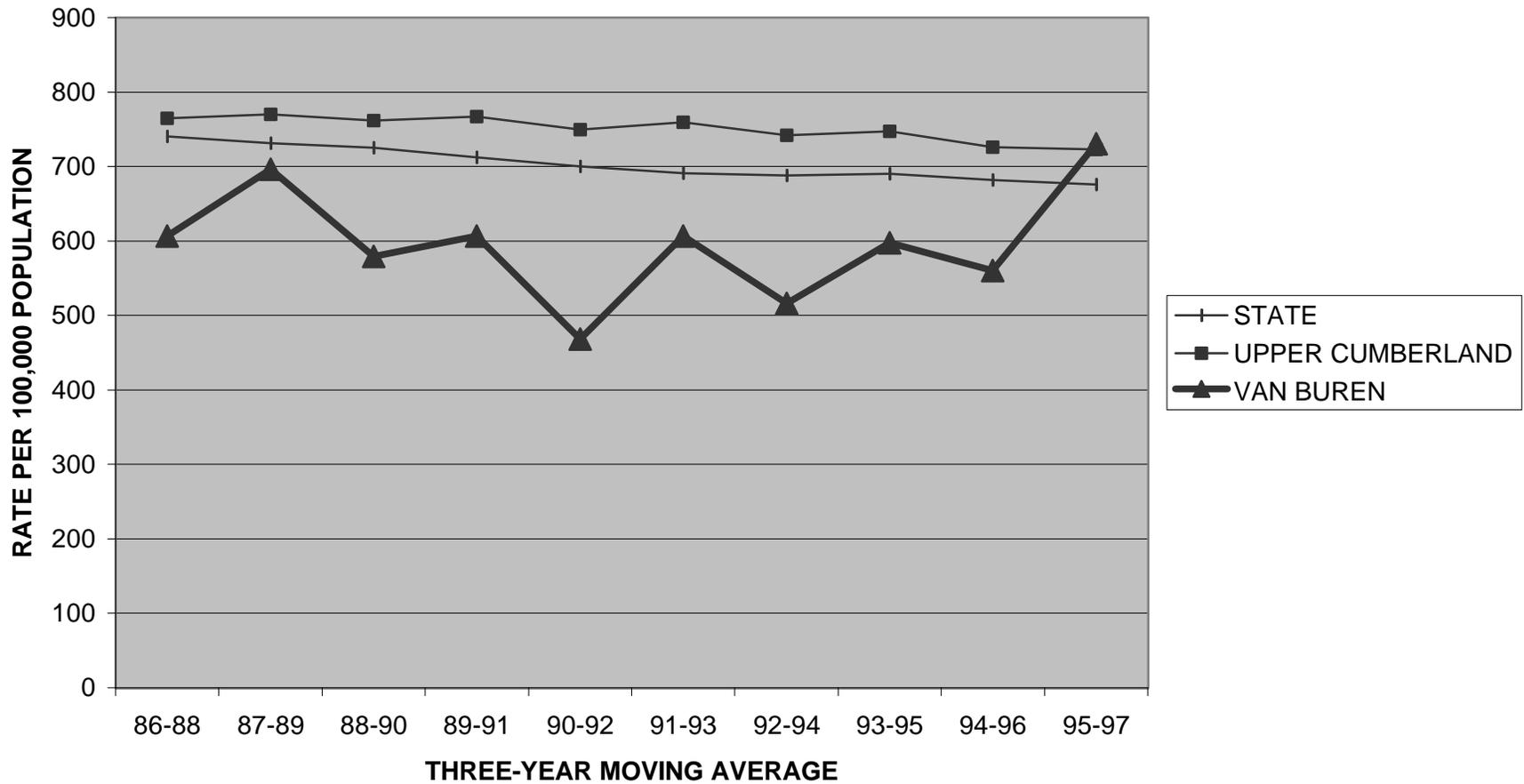
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	27.0	25.8	25.0	24.0	24.1	23.7	23.9	24.2	24.6	24.2	
UPPER CUMBERLAND	33.4	33.9	31.9	33.3	30.6	31.2	29.5	32.1	33.1	33.9	
VAN BUREN	41.7	62.3	34.5	41.2	13.7	33.8	26.7	33.0	19.8	26.5	

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	
VAN BUREN	606.5	696.3	579.0	606.5	468.2	606.6	515.8	597.2	560.0	730.2	

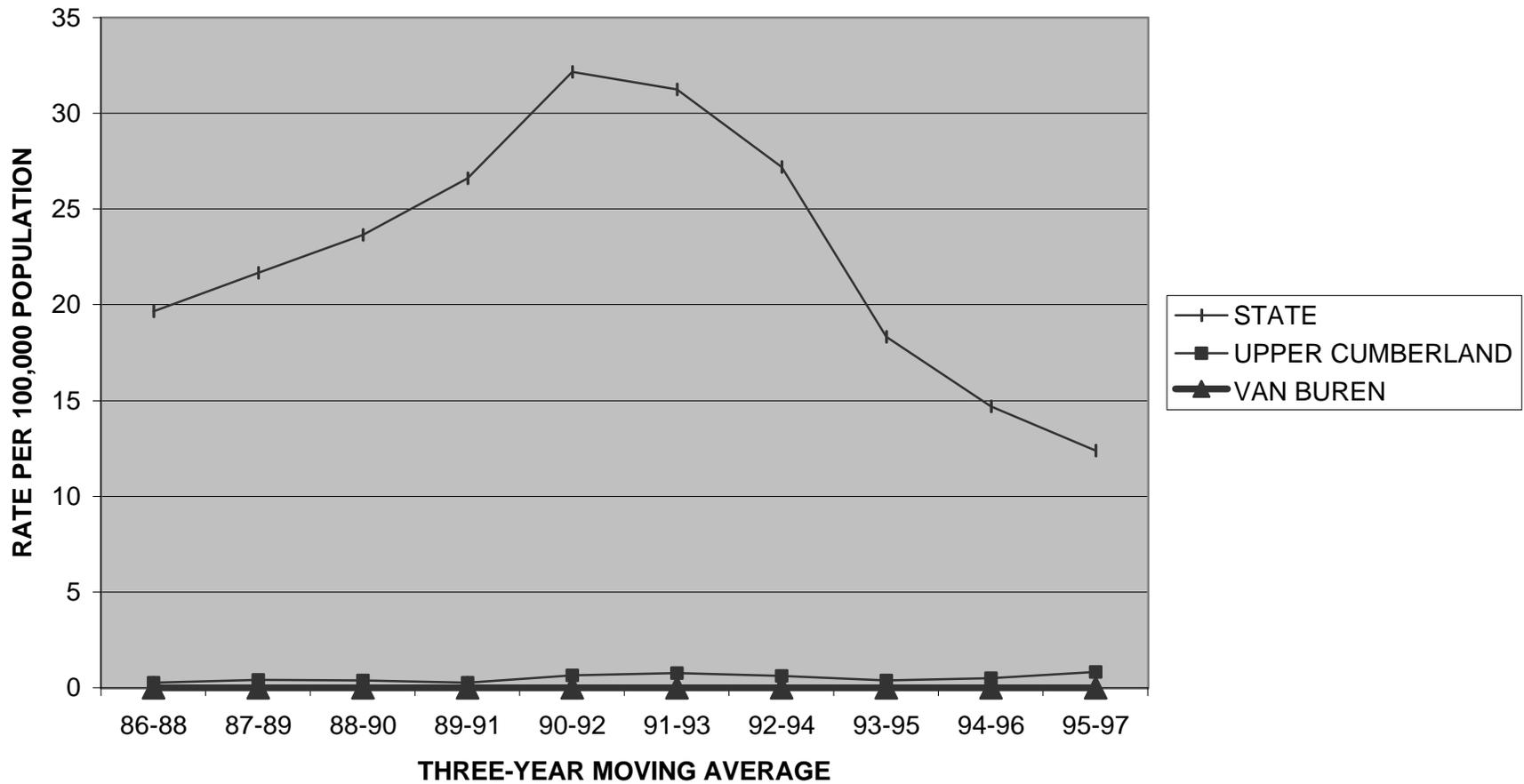
WHITE MALE AGE-ADJUSTED MORTALITY RATE PER 100,000 POPULATION



Appendix 5
Morbidity Data

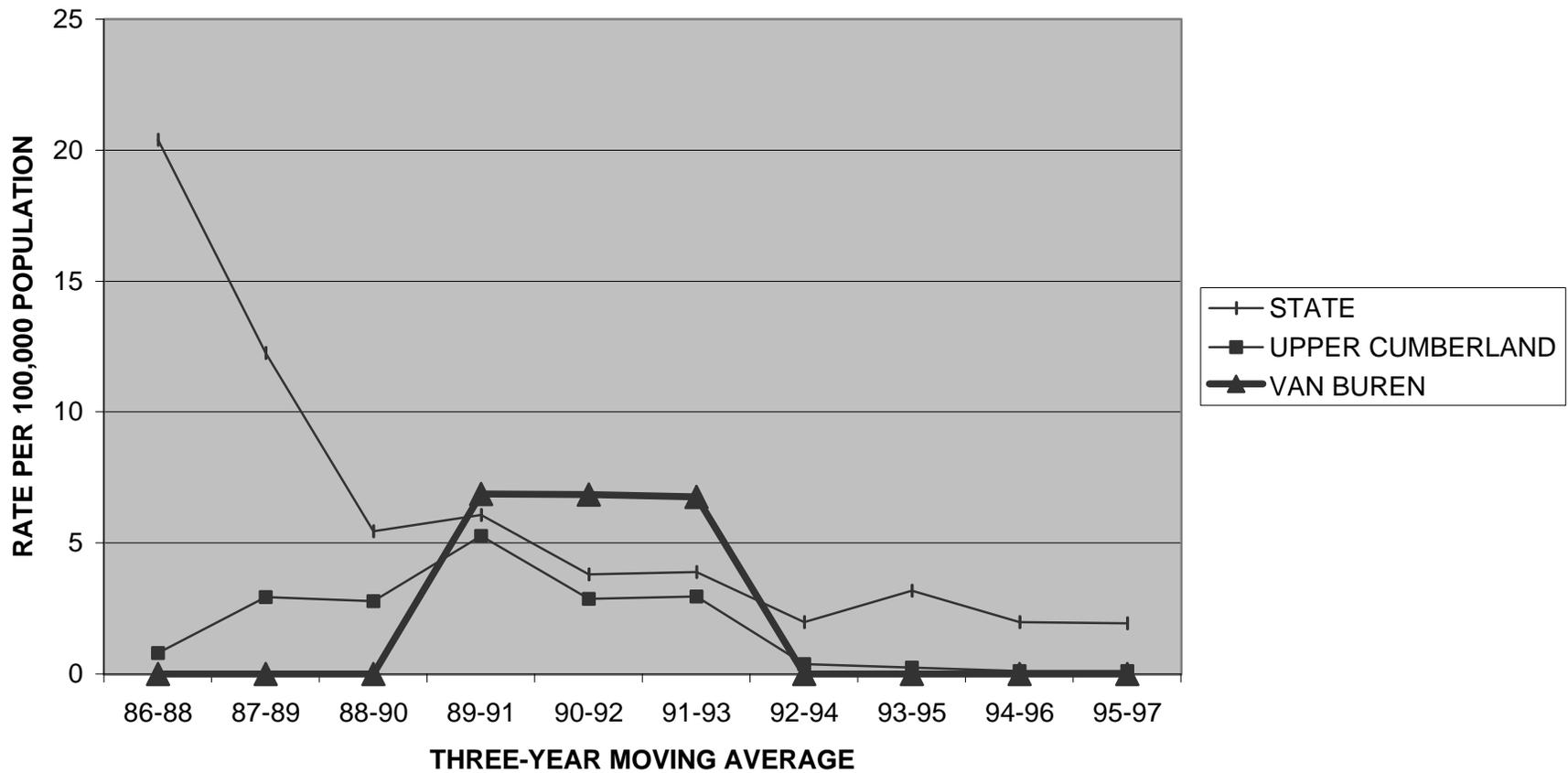
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	19.6	21.7	23.7	26.6	32.2	31.2	27.2	18.3	14.7	12.4	
UPPER CUMBERLAND	0.3	0.4	0.4	0.3	0.7	0.8	0.6	0.4	0.5	0.8	
VAN BUREN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

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



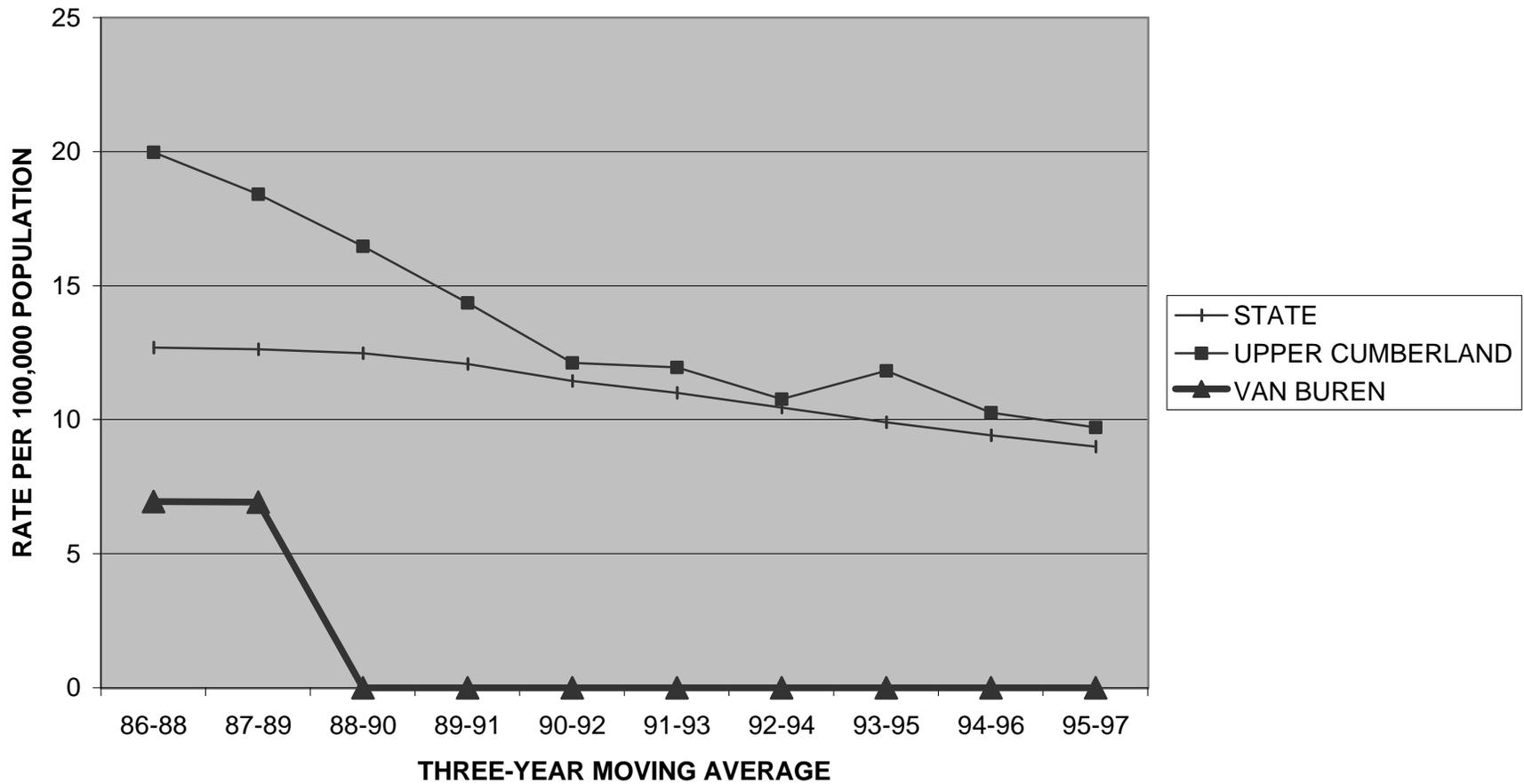
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	20.4	12.3	5.5	6.1	3.8	3.9	2.0	3.2	2.0	1.9
UPPER CUMBERLAND	0.8	2.9	2.8	5.3	2.9	3.0	0.4	0.2	0.1	0.1
VAN BUREN	0.0	0.0	0.0	6.9	6.8	6.8	0.0	0.0	0.0	0.0

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



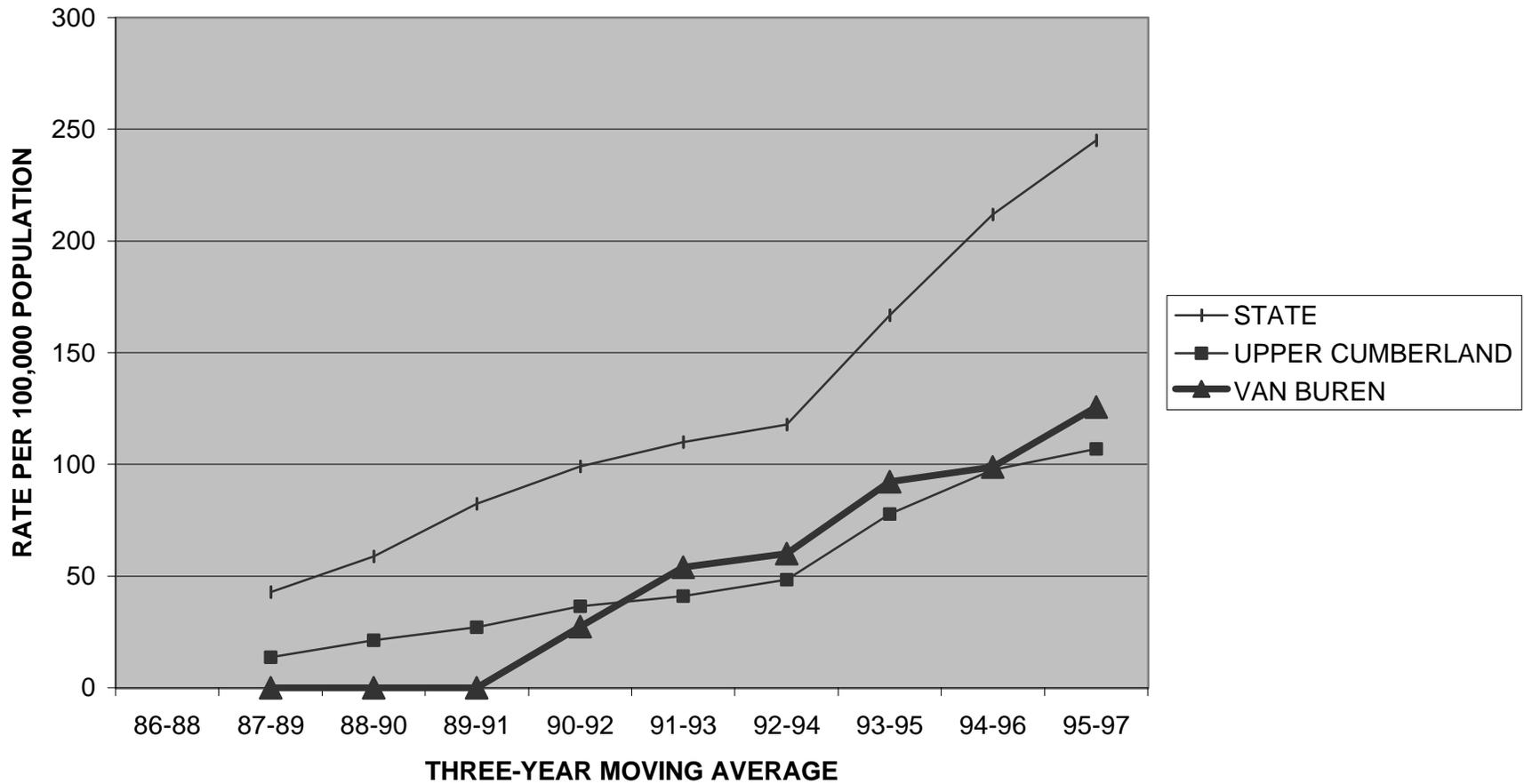
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE	12.7	12.6	12.5	12.1	11.4	11.0	10.5	9.9	9.4	9.0
UPPER CUMBERLAND	20.0	18.4	16.5	14.4	12.1	12.0	10.8	11.8	10.3	9.7
VAN BUREN	6.9	6.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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



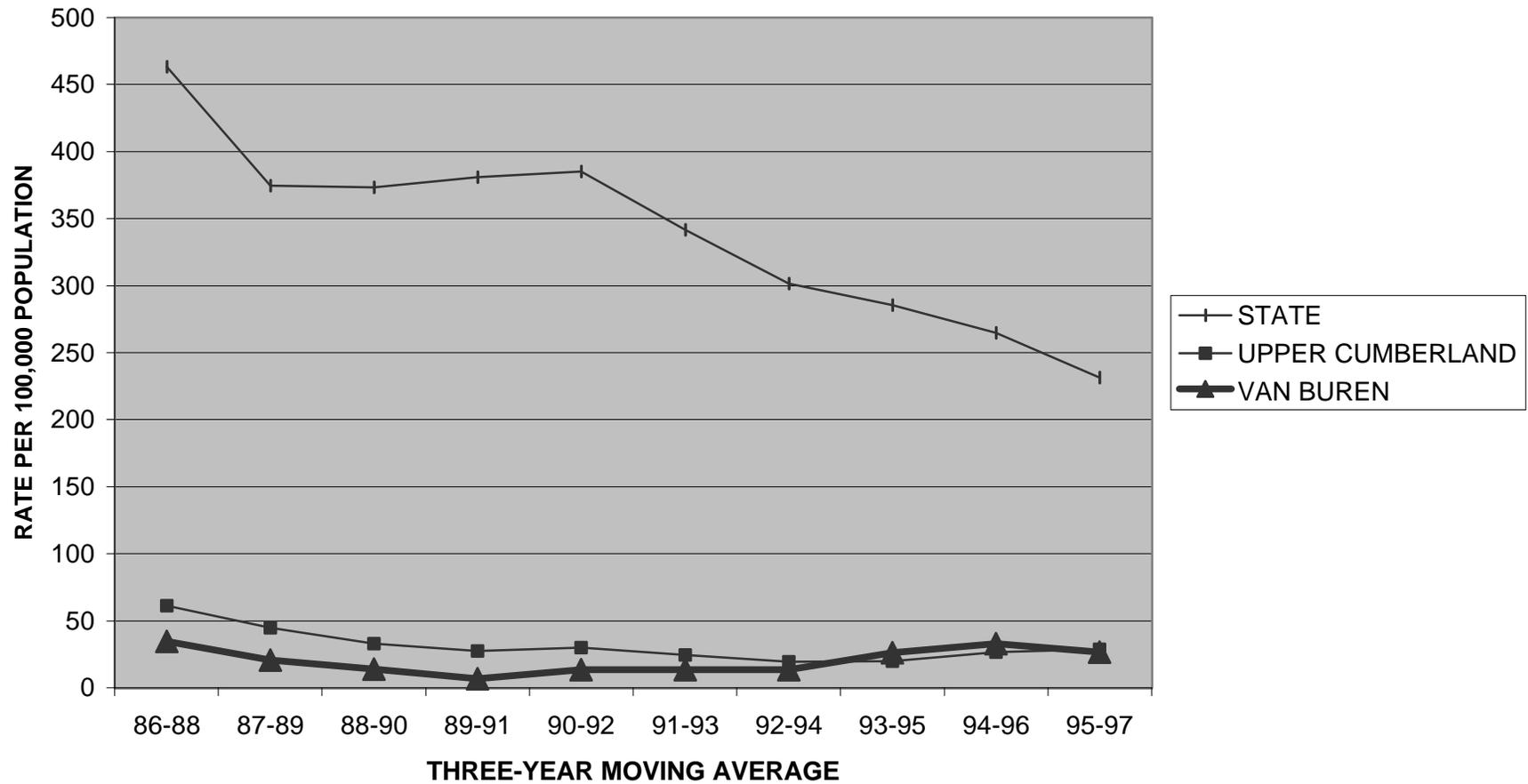
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97
STATE		42.8	58.8	82.3	99.1	109.9	117.7	166.7	211.8	245.0
UPPER CUMBERLAND		13.6	21.4	27.0	36.4	41.1	48.5	77.9	97.7	106.8
VAN BUREN		0.0	0.0	0.0	27.4	54.0	60.1	92.3	98.8	125.7

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	
VAN BUREN	34.7	20.8	13.8	6.9	13.7	13.5	13.4	26.4	32.9	26.5	

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: hitspot.utk.edu