

Reducing Risks, Expanding Opportunities

A Report on Community Health
Presented to
The Greater Chattanooga Community
May 1996

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Pulse of the Community - 1996

"Pulse" has just about every statistict or fact you ever wanted to know about the health of folks in Hamilton Hamilton County Tennessee and its environs. Look at it...it's good for you.

Introduction

For well over a decade, the people of the Chattanooga community have been engaged in a rebuilding process. We have restored the environment, developed our natural assets, and renewed blighted areas. In the process, we have rediscovered the capacity of people to solve their own problems and the power of working together in partnerships.

This same period has been a time of upheaval in the health care system. Various interests have struggled over ways to balance the escalating costs of care with the need to extend care to the uninsured, to those with poor access to services, and to those who are the victims of catastrophic illnesses. As a result, new models for the health care system have emerged—managed competition, managed care, health maintenance organizations.

We have also become attuned to a new concept of health. Health is no longer defined primarily as the avoidance or treatment of disease. Instead it has come to be regarded as the pursuit of wellness, involving a range of "nonmedical quality of life factors." 1

What this implies, from the community perspective, is that the symptoms of poor health can be seen in social, economic, and environmental conditions as well as in the incidence of diseases, accidents, and disabilities. Personal health, in fact, is often closely related to such factors as education, employment, and housing. At the same time, it is highly dependent on the ways in which we choose to live—the extent to which we engage in health-promoting practices and avoid risks.

Community health, therefore, calls for the personal and social dimensions to be brought together into a unified whole. On the one hand, each citizen has an individual responsibility to engage in activities that promote sound physical and mental development and to avoid those that don't. On the other hand, the community has a collective responsibility not only to provide accessible health care but also to offer good opportunities in areas such as education, employment, and civic involvement. When the personal and social factors are merged, the fundamental strategy for promoting health becomes the two-pronged approach of reducing risks and expanding opportunities.²

I. Assessing Health

The Process. An assessment of community health addresses questions such as these—How well is the community doing in providing an environment conducive to health? How committed are our people to healthy lifestyles? How well are we doing in reducing risks?

Answering such questions, however, is not the final aim of the assessment. The ultimate purpose is to provide a background for the development of initiatives to improve the health of our people. That was the challenge taken on by the Greater Chattanooga Health Assessment Task Force. Seventeen volunteers - representing a cross section of the health-related interests in the community - met regularly for the greater part of a year to 1) review and interpret research data, 2) identify critical issues, and 3) outline recommendations for improving the health of people in the region. The assessment revolved around three primary sources of information:

- A community profile;
- An inventory of services; and
- A telephone survey of households.

It also included

- Two group sessions to identify critical issues; and
- A consultation session with the Director of the Center for Public Health Practice of the Centers for Disease Control and Prevention in Atlanta, Georgia.

Community Profile. Members of the task force were given copies of *Life in Hamilton County: Indicators of Community Well-Being*, a reference work produced annually by the Metropolitan Council. The document tracks five year trends of 71 indicators in areas such as the economy, education, family life, health, housing, and public safety. Because Hamilton County's metropolitan influence permeates the surrounding counties, this document provided a glimpse of life in the region.

In addition, the task force was provided a supplementary research paper on the three counties chosen for the study (Hamilton County in Tennessee and Walker and Catoosa in Georgia). The study included the most recent U. S. Census data on education, employment, and other aspects of the economy. Overall, the three counties have similar concerns about their quality of life.

Regarding education, an average of 15.1% of those sixteen to nineteen years of age are not in high schools and have no diplomas. Of those twenty-five years and older, an average of 32% do not have diplomas. However, all three counties have earmarked education as critical to economic and social well-being and have targeted it as an area in which to devote energy and resources.

Economically, growth in the greater Chattanooga community has been slow. Indeed, certain industries-most notably textiles-have been suffering serious declines due to global pressures. Also, poverty has been persistent at levels of 12% to 14%. In the face of all this, significant initiatives are in place in Chattanooga to provide the catalyst for an economic upswing. Extensive riverfront development has attracted people and businesses back downtown, providing an expanded tax base.

Moreover, Chattanooga's southside business plan is in the early stages of implementation with the prospect of creating good jobs in what is to be a national model of environmental and economic sustainability. The proof of its promises will be the degree to which opportunities are offered to all socio-economic levels when the plan reaches fruition.

While the region still has serious problems, some communities are developing their own visions of renewal. By doing this, the region is recapturing a pride in itself that, not too many years ago, was thought to have left with the factories.

Inventory of Services. Researchers working with the task force identified all primary care physicians in Hamilton County (general practitioners, pediatricians, internists, and those specializing in obstetrics and gynecology). These were mapped by location to give a pictorial representation of where physicians are and where they are not.

Chattanooga is the focus of health care resources in the region, and the hospitals are the hubs within the city. Physicians practice predominantly in clusters around the major health care facilities. In addition, the inventory indicated a realignment of resources (such as the formation of physician and hospital groups) as providers prepare for managed care.

Community Survey. The task force conducted a telephone survey of one adult from each of 1,111 households in Hamilton County in Tennessee and Catoosa and Walker in Georgia. These counties were chosen because together they represent a much larger region that depends on resources in the Chattanooga area for tertiary care. The sample size provided 95% reliability with a margin of error of plus or minus 3%.

The survey instrument was the Centers for Disease Control and Prevention's "Behavioral Risk Factor Surveillance." It covered general health status, access to care, participation in routine health screenings, and the prevalence of practices that compromise health. The "Behavioral Risk Factor Surveillance" is administered regularly throughout the nation by states and was selected by the task force primarily because of the availability of state level data with which the findings for our region could be compared.

There are three ways to interpret the findings of such a survey. The first is to use the initial results as a baseline and to update the findings on a regular basis to determine if progress is being made. The second is to make comparisons with other similar communities, the state as a whole, or the nation. The third is to make comparisons with objectives to determine how far the community is from where it ought to be. The Greater Chattanooga Health Assessment Task Force intends, over time, to make use of all three interpretations.

Research Results. The key findings of the survey and the other research activities are summarized in a detachable unit included with this report ("Pulse of the Community"). The task force dealt with this information in the context of underlying basic human needs, the building blocks for personal health. From discussions of the data and deliberations of the task force, the two broad strategies-reducing risks and expanding opportunities-emerged.

II. A Framework for Personal Health

Throughout the process, the Task Force realized that data alone was not sufficient to guide the deliberations and the formulation of recommendations. A framework was needed within which these discussions could take place in a meaningful way.

Good health is more than just a lack of symptoms, more than a physical regimen. It is the pursuit of wellness, predicated on an environment responsive to a core of basic human needs. To be in a good position to adopt a healthy lifestyle, people need to

- find valued places in social groups,
- have close and durable relationships with others,
- feel a sense of personal worth,
- be socially competent,
- develop reliable bases for making informed choices,
- find constructive ways to have fun,

find ways to be useful to others, and believe in a promising future. 3

It is within this framework that people can best develop healthy lifestyles. Along with this, communities should work together to reduce risks to personal health and to expand the opportunities for strengthening those institutions and practices that encourage good health.

III. Risks and Their Reduction

Major Health Risks. No matter what lifestyles we practice, a degree of risk is inherent in living. Some of this we have come to accept as a part of contemporary life. For example, the mobility that Americans have achieved with the automobile carries with it a certain level of accidental injury and death. Although the effects are potentially catastrophic, most of us go ahead with what we regard as a low-risk activity. Driving, then, has come to be thought of as a "necessary" risk. Indeed, some element of adventure enhances the quality of life. If the world existed only of "bunny" slopes and training wheels, individual growth and satisfaction would be stifled.

The willingness to risk for the sake of reward should be balanced with safety. If certain principles for safety are not followed, at some point the risk becomes untenable. For example, just as we have accepted driving as a necessary risk, we have declared that driving under the influence of alcohol is an excessive risk to the driver and to others.

Moreover, certain risky behaviors have proven to be physical and economic burdens to individuals and, ultimately, to the community. The Centers for Disease Control and Prevention track some of the more obvious health-compromising behaviors. These include:

- smoking,
- obesity and diet,
- excessive alcohol consumption,
- failure to use seat belts,
- lack of physical activity, and
- failure to make use of preventive screenings (for blood pressure, cholesterol, etc.). 4

The task, then, is to find ways to reduce these kinds of risk.

The Causes of Premature Death. In an article published in a 1993 issue of the Journal of the American Medical Association, Michael McGinnis and William Foege reported the results of their research into the underlying causes of death. In reviewing deaths occurring in 1990, they found that approximately half could be attributed to behavioral factors. The leading contributor to mortality was the use of tobacco followed in order by diet and activity patterns and the misuse of alcohol. Other contributors included infections, poisons, firearms, sexual behavior, motor vehicle accidents, and drugs.⁵The environment and biological factors each account for about 20% of premature deaths. The lack of access to health care accounts for the remaining 10%.⁶

The Prevalence of Health-Compromising Practices. Not all risky behaviors lead directly to death, but their prevalence can greatly diminish health. One-fourth of the people in the region covered by the survey smoke. Slightly more than a quarter (27%) are overweight while slightly less than a quarter (23%) do not engage in any kind of leisure-time physical activity. Ten percent say that they drink chronically; four percent in binges. Two percent report that they drive after consuming alcohol. Only 66% say that they use safety belts regularly. (Some of the survey figures tend to be underreported because of the sensitivity of questions. Nevertheless, the results for the region are worse than for the nation as a whole except those on drinking.) These behaviors, over time, become statistically significant contributors to the death rate of groups of people who engage in them.

Reinforcing Behaviors. An analysis of the survey results shows that the same people are often engaging in multiple behavioral risks. The person who smokes, for example, is also more likely than the non-smoker to drink alcohol in binges, to fail to use a seat belt consistently, and not to exercise regularly. These behaviors reinforce one another, and they point to an underlying outlook on life with weak commitments to health. A disregard for one risk tends to carry with it a disregard for other risks.

However, health-promoting behaviors can also be mutually reinforcing. Someone who exercises regularly is more likely than the sedentary person to practice good eating habits and to refrain from smoking. These activities and disciplines may be pursued to lower the risk of the so-called "civilized" diseases or to enhance performance as with athletic endeavors. In any case, they should be regarded as contributors to human excellence along with intellectual stimulation and ethical behavior.

Normative Behavior and the Motivation to Comply. How do we get at the phenomenon of sometimes compromising our health even when we know that some of the things we do cause harm and that some of the things we do not do would be good for us? Practicing a healthy lifestyle requires at least some effort and discipline. To be committed to activities that for the moment are unpleasant or can be perceived as deprivation, one must at least believe that the benefits outweigh the costs. But there is more to it than that. The rewards of healthy practices and the consequences of unhealthy ones are not necessarily immediate while gratification from some risk-taking behaviors is. This helps to explain why the impetus for doing what we know is good for us sometimes has to reach a "critical mass" as may happen when people are told by their physicians that death is imminent if changes are not made. In such cases, two important factors are at play. The first is normative behavior. The second is the motivation to comply. Both are subject to revision.

Within given groups, there are various norms about such functions as eating, drinking, driving, and exercise. In some communities, for example, the norm is to drive to almost all destinations. Other places, however, have developed local cultures in which the norm is to walk as much as possible. Still others have become communities of runners or cyclists in which people are incorporating exercise into their daily lives. The norm, then, can be molded as attitudes change.

Of special significance is the influence of parents in the lives of their children. Various analyses show that adults tend to repeat the behavior patterns they saw in their families. Children of alcoholics are more likely to abuse alcohol than the children of non-alcoholics; children of smokers are more likely to smoke than the children of non-smokers. Almost all survey respondents reported that they use child restraints with babies in their cars. High percentages of children at young ages use seat belts. But with the onset of adolescence, the percentage using seat belts regularly mirrors the percentage of

adults (66%).

The motivation to comply is tied in with a person's basic beliefs, including a sense of hope for the future (see list on page 4). If prospects appear to be bleak, behaviors that compromise health may seem less risky than they otherwise might. Under such circumstances, a person might assume a "nothing to lose" attitude. Some evidence for this exists in the high rates of violence and substance abuse among those whose social and economic roles offer little fulfillment.

Human behavior, however, is extremely complex. It is not always fully rational from the perspective of any one set of principles. People who seem to have very bright prospects sometimes take enormous risks while some who appear relegated to dead-end possibilities practice model lifestyles. It is difficult to do anything more than simply to point out this apparent inconsistency as an observation.⁷ What we can say is that human behavior is not entirely intractable. Habits can be changed.

Personal Goals. We are now armed with a great deal of information about the kinds of personal behaviors that either promote health or detract from it. The longitudinal study of the people of Framingham, Massachusetts, identified a number of risk factors for heart disease. Other studies have shown the importance of diet, vigorous exercise, and appropriate rest for longevity. From these, a consensus on goals for personal health has emerged.

Don't smoke;
Keep weight down;
Eat breakfast, eat moderately, and keep fat intake low;
Exercise regularly;
Drink alcohol, if at all, only in moderation; and
Get at least seven hours of sleep each night.⁸

People who have lifestyles based on these goals can be expected, as a group, to have lower incidences of health problems than those who do not. Benefits follow not only in terms of personal well-being but also for the health care system.

Access to Care. Even if wholesome norms and the motivation to comply are in place, some risk to health can be imposed from without. Indeed, a significant risk to some segments of the population is the lack of access to proper medical care. As previously indicated, primary care practitioners are clustered around the hospitals. Making use of these providers, for most people, is highly dependent on transportation. This may present difficulties for those who do not have private automobiles, particularly those who live beyond the city bus routes.

Notable gaps in access to health care are found among those with no coverage. Eleven percent of people in the three county area have no health insurance. They are, as a group, less likely to have a usual place for medical care (46% versus 83% of those with health care coverage). Almost one-third reported they were unable to see a doctor for needed medical care within the past year due to the cost—a rate triple that of the insured population. Nevertheless, 64% of the uninsured report having had a routine checkup within the past year.

Some influence of TennCare can be seen in Hamilton County, the one Tennessee county included in the survey. Ninety percent of Hamilton County's people are covered by some kind of insurance. Prior to TennCare, the percentage of people in the county with coverage was estimated to be between 85% and 87%.⁹ TennCare, then, can be considered at least partly responsible for boosting coverage to its current level. In Hamilton County, however, it has fallen short of its objective of assuring coverage for 95% of the population.

Of special note are the medical resources that the Chattanooga community provides in the effort to extend access to care. First, the Health Department offers clinical services in its central location and at four other sites with an emphasis on mother and child health. Second, two federally funded community health centers, Dodson Avenue and Alton Park, operate under the auspices of Erlanger Medical Center. Third, the Homeless Health Care Center provides basic medical care along with mental health services, substance abuse treatment, and case management. Fourth, the Medical Home, also operated under the auspices of Erlanger, recently opened in the College Hill Courts Housing Development to offer primary care in conjunction with a number of other services that will be provided in the newly renovated James A. Henry school building. Fifth, Memorial Hospital recently opened a primary care clinic in North Chattanooga and will provide services in coordination with several human service organizations. In all of these facilities, care is provided either on a sliding scale based on ability to pay or at no cost.

IV. Expanding Opportunities

Reducing risks, however, is only one side of the health coin. It may prevent a decline in community health but does not, in itself, constitute the pursuit of wellness. The key to maximizing community health lies in risk reduction along with expanded opportunities.

Economic Development and Sustainability. Some ten years ago, with a community visioning process, Chattanooga entered into a period of remarkable transformation—a time of reflection, discovery, and restructuring. Its origins lay in the realization that some of our economic mainstays were, in the long run, doing about as much harm as good. There were times, for example, when Chattanooga's air quality was considered to be among the worst in the nation.

Throughout the last decade, the community has sought to strike a balance between cleaning up the environment and offering economic opportunity. Chattanooga can now lay legitimate claim to the title, "environmental city."

However, while Chattanooga was beginning to clean up the environment, it concurrently experienced a sharp reduction in manufacturing and its relative abundance of high-paying jobs. In fact, the decline in the number of good-wage jobs was such that the city of Chattanooga lost about 10% of its population between the counts of 1980 and 1990. In the meantime, other similar areas throughout the Southeast were experiencing significant growth. It is clear that many of our people were moving elsewhere in search of better economic opportunities.

Communities without good jobs will suffer, and not just in economic terms. As the Metropolitan Council's 1994 needs assessment pointed out, the lack of economic opportunity "is inherently destabilizing."¹⁰ It undermines the most fundamental unit of society, the family, leaving some parents unable to afford such basics as decent housing and adequate nutrition.

The key to the creation of good jobs, however, is sustainability. This is the broad-scale strategy that is being followed by RiverValley Partners, the organization that has taken on the challenge of economic development for Chattanooga. It is also the neighborhood-based strategy of communities like the Westside (see discussion of community goals below).

Sustainable development means the creation of economic opportunities that are in harmony with the community and its environment. The primary difficulty with the industries that characterized the economy of Chattanooga for most of the last century was that some of their by-products were simply wastes. Disposing of these wastes by venting them into the air or dumping them in streams did serious harm to the environment. The effects are still evident in the "super-fund" sites along Chattanooga Creek. Sustainability focuses, not on an industry in isolation, but on its relationship to its surroundings. For example, two industries can be mutually sustainable if the waste products of each one can become the raw materials for the other.

The notion of sustainability also has application to the ways people interact in communities. Though groups may have different emphases, they can relate to one another in ways that are mutually beneficial. For example, two political parties, though supporting opposing candidates, might work together to sponsor a forum. A computer club might provide technical assistance to a local library while the library provides the club with a place to hold its meetings. Or a health clinic might help a neighborhood to organize a community fair while the fair offers the clinic an opportunity to distribute information. Even groups as disparate as those for and against gun control might find common ground in supporting a neighborhood watch program.

Economic development implies new wealth coming into the community primarily through new and expanded industries. The main attractions for recruitment or retention will have financial overtones, but the community need not sell its soul for some sort of manufacturing plum. Instead, we should put ourselves in a position to offer long-term savings by having low health care costs, top level education, and good, affordable housing.

Community Goals. The community, like the individual, has a responsibility for its own well-being. Without a collective commitment to economic development, education, health, and public safety, neighborhoods will be subject to decay.

The Westside in Chattanooga (primarily the College Hill Courts Housing Development) is committed to a resident-driven initiative for renewal. Over the past few years, a vision has emerged that finds expression in six goals. The Westside aspires to be a place where

The residents are free of fear, because the use and sale of drugs are gone, gangs are gone, and stealing has stopped. It will be a safe neighborhood where people of all ages will be able to move around their buildings and on the streets without any threat to their security.

Residents are healthier, because they eat better, exercise more, stop their bad habits, and get better medical care.

All the children are headed toward college, because they and their families and their teachers believe in and support each other in the pursuit of that goal. Everyone who works with children in the neighborhood, from ministers to doctors to recreation directors, contributes to that goal.

Many more residents are employed, because they have access to training, transportation, and child care. Some of the jobs will have been created in the neighborhood by residents themselves as they develop businesses to meet the needs of their neighbors. Decent behavior is expected of both the residents and the people they bring into their homes. People who mistreat other people will not be welcome. Young people will be encouraged in the ways of decency by everyone who works with them. Opportunities for home ownership are being developed for as many residents as possible.¹¹

With these goals, the residents of the Westside have created a vision that is bigger than the neighborhood. It is a vision that can serve the entire greater Chattanooga community. Economic viability, education, and public safety are integrated with personal practices and behaviors. Individual and collective responsibilities are mutually reinforcing.

Sustainable Health. Such a vision can be translated more specifically into traditional concepts of health. Safe communities reduce the burden placed on the health care system. Higher levels of education go hand-in-hand with better health. And enhanced employment offers greater opportunities for health care coverage.

The Compartmentalization of Functions. The building blocks for health cannot be fully met by health care providers on their own. The same is true for the schools or even for families. Yet communities have typically followed the principle of specialization in such areas as economic development, education, health care, and public safety. Economic development has been the business of chambers of commerce, education the business of the public schools, health care the business of physicians and hospitals, and public safety the business of the police. The broad view of community health, however, is inclusive of all of these elements with strong implications about the interdependence of our institutions. Only when their functions are brought together can the underlying threats to community health be adequately addressed. Rather than viewing each as a separate function of society, a healthy community should view health, education, faith, safety, and business as different facets of the same diamond, each integral and interdependent.

Key Institutions. Key community institutions are positioned to have significant impacts on community health—the family, the schools, businesses, religious organizations, nonprofits, health care providers, law enforcement, and the media. Many commentators suggest, however, that our once central social structures have lost influence. It is common, for example, to hear or to read about the "breakdown" of the family. The Carnegie Commission on Adolescent Development says of our institutions that they "have fallen behind in their vital functions...."¹²

A first step, therefore, is to strengthen and reinforce our institutions. Health should then be fully integrated into their frameworks with a conscious focus on meeting basic human needs. Furthermore, these institutions should be linked together so that their functions are mutually reinforcing.

V. Recommendations

The Greater Chattanooga Community Health Assessment Task Force makes the following recommendations.

First, a formal coalition of key organizations working in economic development, education, health care, and public safety should be established to guarantee that our community institutions are linked together and that their functions are complementary. Representation should come from the highest executive levels of participating entities. The coalition should adopt a structured health planning process, making sure to involve people at the grassroots level. Members of the coalition should put the full force of their reputations on the line to see that

Health becomes an integral component of economic development and community revitalization;

Health is fully integrated into the curricula, physical education classes, extracurricular activities, and the breakfast and lunch programs of the public schools;

Health is integrated into public safety through community policing; and that

Health programs, in turn, support economic development, education, and public safety.

Second, the coalition should adopt goals similar to those of the Westside and should support other neighborhoods in the development of their own goals.

Third, the coalition should support neighborhood programs for revitalization and help in the development of resources to assist resident-driven initiatives.

Fourth, the coalition should support annual campaigns aimed at reducing specific behavioral risks.

VI. Conclusion

Health is no longer defined primarily as the avoidance of disease. It is instead the pursuit of wellness, involving a wide range of quality of life factors. It moves beyond basic human needs to embrace economic viability, social competencies, and lifestyle choices.

Improving community health calls for economic development, education, faith, and safety to be integrated with personal practices and behaviors. When the personal and social dimensions are merged, the basic strategy for improving health becomes the two-pronged approach of reducing risks and expanding opportunities.

Key institutions are positioned to have significant impacts on community well-being. Health should be fully integrated into their frameworks, and they should be linked together so that their functions are mutually reinforcing.

Notes

1. What Creates Health? The Healthcare Forum, San Francisco, CA, 1994, p. 1.
2. Adapted from Reducing Risks, Enhancing Opportunities," the title of chapter 4 of the Carnegie Council on Adolescent Development's Great Transitions: Preparing Adolescents for a New Century, The Carnegie Corporation, New York, October, 1995, p. 49. Hereinafter referred to as Great Transitions.
3. Great Transitions, p. 49.
4. Centers for Disease Control and Prevention, Atlanta, GA.
5. J. Michael McGinnis and William H. Foege, "Actual Causes of Death in the United States," Journal of the American Medical Association, November 10, 1993, p. 2207.
6. Ed Baker, M. D., Director, Center for Public Health Practice, Centers for Disease Control and Prevention, Atlanta, GA, in a presentation to the Greater Chattanooga Health Assessment Task Force on January 30, 1996.
7. Discussions about the apparent discrepancy between what people know and what they sometimes do go back at least to the time of the ancient Greek philosophers and the so-called Socratic Paradox. Socrates argued that one who knows the good cannot fail to do it, an assertion that to many seems contradicted by everyday experience.
8. Adapted from guidelines based on actuarial studies by Metropolitan Life.
9. "Medical and Dental Care in Hamilton County," a research paper prepared for the Needs Assessment Partnership, Metropolitan Council for Community Services, Chattanooga, TN, 1993.
10. Coming to Terms: The Problems and the Possibilities of Our Community, Metropolitan Council for Community Services, Chattanooga, TN, 1994, p. 2.
11. The Westside Community Development Corporation, Chattanooga, TN.
12. Great Transitions, p. 11.

Members of the Health Assessment Task Force

- **Paul Neely**, Task Force Chairman, *Chattanooga Times*
- **Oscar Brock**, Chamber of Commerce
- **Marvin Ernst**, Metropolitan Council
- **Kathy Etherton**, Wellness Council
- **Dan Gray**, Alexian Village of Tennessee
- **Pam Holder**, U.T.C. School of Nursing
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Demographics of the Community (Walker, Catoosa, Hamilton Counties: 1990 U. S. Census)

Total Population: 386,340

Race: White: 325,014 Black: 56,723 Other: 4,603

Gender: Male: 183,557 Female: 202,783

Household Income:

<\$15,000

28.4%

\$15,000-\$25,000

19.3%

\$25,000-\$50,000

33.5%

\$50,000-\$100,000

15.8%

\$100,000+

3.0%

% Poverty: 12.9%

% Persons 25 and over with no high school diploma: 32.0%

Economic Data (for Metropolitan Statistical Area: Hamilton, Marion, Walker, Dade, and Catoosa Counties for 1995)

Available Jobs: 215,400

Labor Force: 223,605

Average Weekly Wages (Production Workers): \$426.37

Unemployed: 11,005

% Unemployed: 5.7%

% Population 25 Years and Over with No Diploma or Equivalent: 32.0%

% Health Insurance Through Employer: 59.0%

Inventory of Medical Services

Primary Care Doctors:

Hamilton County: 338

Catoosa County: 22

Walker County: 14

People per Doctor:

Hamilton County: 845

Catoosa County: 1,930

Walker County: 4,167

General Hospitals:

Hamilton County: 6

Catoosa County: 1

Walker County: 0

Hospital Beds:

Hamilton County: 1,877

Catoosa County: 212

Walker County: 0

Pulse of the Community

Access to Health Care

Percentage of Area Residents with No Health Care Coverage

Sex

| | |
|--------|-----|
| Male | 14% |
| Female | 8% |

Race

| | |
|-----------|-----|
| White | 10% |
| Non-White | 16% |

Could Not See Doctor Due to Cost Last Year

Sex

| | |
|--------|-----|
| Male | 10% |
| Female | 14% |

Race

| | |
|-----------|-----|
| White | 12% |
| Non-White | 15% |

Income

| | |
|-------------|-----|
| < \$15,000 | 16% |
| \$15-25,000 | 22% |
| \$25-35,000 | 11% |
| \$35-50,000 | 8% |
| >\$50,000 | 3% |

Behavioral Risk Factor Surveillance Prevalence Trends*

| | 1995 |
|---------------------------------|-------------|
| Smoking | 25% |
| Inconsistent or No Seat Belt Us | 34% |
| Overweight/120% Median | 32% |
| Alcohol Consumption | |
| Current Drinker | 40% |
| Chronic | 4% |
| Binge | 10% |
| Drink and Drive | 2% |
| High Blood Pressure | 15% |
| Never Had Cholesterol Tested | 32% |
| No Leisure Time Physical Activi | 23% |

**1995 is baseline data*

Top Five Leading Causes of Death for Area Residents

| Cause of Death | Rate Per 100,000 Population |
|-------------------------------|-----------------------------|
| Diseases of the Heart | 322.8 |
| Malignant Neoplasms | 232.6 |
| Cerebrovascular Disease | 67.3 |
| Pneumonia and Influenza | 42.4 |
| Chronic Obstructive Pulmonary | 40 |

Has a Usual Place for Medical Care

| | |
|-----------|-----|
| White | 80% |
| Non-white | 75% |

How long since routine checkup

| | < 1 Year | > 5 Years |
|--------|----------|-----------|
| Male | 57 | 13 |
| Female | 76 | 4 |

Mammogram within 2 Years

| Age | | Education | |
|-------|-----|---------------|-----|
| 35-44 | 52% | < High School | 40% |
| 45-54 | 72% | High School | 51% |
| 55-64 | 72% | > High School | 47% |
| 65+ | 60% | | |

Had Pap Smear within 2 Years

| Age | | Education | |
|-------|-----|---------------|-----|
| 35-44 | 89% | < High School | 78% |
| 45-54 | 83% | High School | 78% |
| 55-64 | 75% | > High School | 88% |
| 65+ | 57% | | |

Flu Shot in Past Year

| | |
|---------|-----|
| Age 65+ | 59% |
|---------|-----|

Ever Had Pneumonia Vaccination

| | |
|---------|-----|
| Age 65+ | 35% |
|---------|-----|

Health Status

General Health (as reported by respondent)

| | |
|-----------|-----|
| Excellent | 22% |
| Very Good | 34% |
| Good | 27% |
| Fair | 11% |
| Poor | 6% |

Number of Days in Past Month Physical/ Mental Health Not Good

| | Physical | Mental |
|-------|----------|--------|
| None | 71% | 66% |
| 1-3 | 13% | 13% |
| 4-7 | 4% | 7% |
| 8-14 | 3% | 3% |
| 15-30 | 9% | 11% |

Number of Days in Past Month Activities Limited Due to Poor Physical or Mental Health

| | |
|-------|-----|
| None | 70% |
| 1-3 | 11% |
| 4-7 | 6% |
| 8-14 | 3% |
| 15-30 | 10% |

Overweight

| | |
|--------|-----|
| Male | 29% |
| Female | 25% |

Cholesterol Screening: Ever Checked

| Sex | | Race | | Income | |
|------------|-----|-------------|-----|---------------|-----|
| Male | 62% | White | 70% | <\$15,000 | 61% |
| Female | 73% | Non-White | 57% | \$15-25,000 | 56% |
| | | | | \$25-35,000 | 70% |
| | | | | \$35-45,000 | 70% |
| | | | | > \$50,000 | 85% |

Selected Year 2000 Health Objectives

| <i>Healthy People 2000 Objectives</i> | <i>Year 2000 Target</i> | <i>Area Residents 1995</i> |
|--|-------------------------|--------------------------------|
| Overweight (Objective #1) | | |
| Ages 18 and up | 20% or below | 27% |
| Cigarette Smoking (Objective 3.4) | | |
| Ages 18 and up | 15% or below | 25% |
| Non-White Ages 18 and up | 18% or below | 24% |
| Safety Belt Use (Objective 9.12) | | |
| Ages 18 and up | 85% or greater | 66% |
| Cholesterol Screening within Preceding 5 Years (Objective 15.14) | | |
| Ages 18 and up | 75% or greater | 64% |
| Clinical Breast Exam and Mammogram (had within two years) (Objective 16.11) | | |
| Women ages 50 and up | 60% or greater | 57% |
| Pap Smear, Women with Intact Uterine Cervix (ever had) (Objective 16.12) | | |
| Ages 18 and up | 95% or greater | 97% |

| Indicator | 1990 | 1991 | 1992 | 1993 | 1994 | State '94 |
|--|-------------|-------------|-------------|-------------|-------------|------------------|
| Infant Mortality (1,000 Live Births) | 8 | 10.9 | 8.5 | 9.9 | 5.2 | 8.9 |
| Total Deaths* (100,000 Population) | 571.4 | 549.8 | 540.6 | 566.1 | 566.5 | 579.6 |
| Motor Vehicle Deaths* (100,000 Population) | 18.3 | 18.1 | 16.1 | 13 | 17.6 | 24.9 |
| Accidental Deaths* (100,000 Population) | 36.4 | 31.4 | 31.2 | 28.5 | 33.3 | 41.1 |
| Suicides* (100,000 Population) | 7.9 | 8.6 | 10.2 | 10.7 | 11.6 | 12.2 |
| Homicides* (100,000 Population) | 15.1 | 18.5 | 11.7 | 15.1 | 19.3 | 11.4 |
| Lung Cancer Deaths* (100,000 Population) | 43.7 | 38.6 | 45.2 | 50.9 | 51 | 49.4 |
| Female Breast Cancer Deaths* (100,000 Population) | 27.3 | 24.9 | 16.6 | 28.2 | 20.2 | 22.6 |
| Cardiovascular Disease Deaths* (100,000 Population) | 176.2 | 172.3 | 158 | 164.8 | 159.5 | 163.1 |
| Reported Incidence of AIDS (100,000 Population) | 11.2 | 10.8 | 17.1 | 28.1 | 18.8 | 12.8 |
| Reported Incidence of Measles (100,000 Population) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reported Incidence of TB (100,000 Population) | 17.2 | 13.7 | 14.1 | 14.1 | 15.7 | 7.7 |
| Reported Incidence of Primary and Secondary Syphilis (100,000 Population) | 3.2 | 8.3 | 25.8 | 41.8 | 32.1 | 19.7 |
| % Low Birth Weights | 7.9 | 9.1 | 9 | 8.7 | 8.5 | 8.8 |
| % Births to Teens | 6.3 | 7.7 | 7.1 | 7.1 | 7.3 | 6.6 |
| Prenatal Care (% adequate) | 75.1 | 69.2 | 70.3 | 70.6 | 68.9 | 71.3 |
| % Children Immunized by Age Two | 58 | 64 | 70 | 74 | 66 | 80 |

*Age Adjusted

Local Behavioral Risk Statistics:

| | |
|--|-----|
| Smoking | 25% |
| Being Overweight | 27% |
| Chronic Drinking | 4% |
| Binge Drinking | 10% |
| Inconsistent Seat Belt Usage | 34% |
| No Leisure Time Physical Activities | 23% |
| High Blood Pressure | 15% |
| No Cholesterol Screening in 5 Years | 36% |
| No Mammogram in Past Two Years, Age 35 and Older | 53% |
| No Pap Smear in Past Two Years, Age 35 and Older | 22% |
| No Rectal Exam, Age 40 and Older | 23% |

Percentage of Area Adults Engaged in Good Health Behaviors (based on 1995 survey)

| | |
|---|-----|
| Losing/Maintaining Weight | 78% |
| Do Not Drink Alcohol | 60% |
| Never Smoked | 51% |
| Smokers Who Quit Smoking | 50% |
| Regular Physical Activity, Three or More Times Per We | 46% |
| No Permanent Tooth Loss | 36% |
| Five or More Servings of Fruits/Vegetables Per Day | 19% |

Relationships Among Reinforcing Behaviors

- *A very significant relationship exists among smoking, drinking, and seatbelt usage.
- *A significant relationship exists between seatbelt usage and exercise habits.
- *A slight relationship exists among smoking, drinking, and exercise.
- *Smoking, lack of seatbelt usage, and binge drinking tend to have a negative influence on how people rate their general health.

Health Care Gaps

Insurance Coverage

| | |
|---------------------|-----|
| Private Insurance | 66% |
| Government Coverage | 23% |
| No Coverage | 11% |

- *The uninsured are least likely to receive regular medical checkups and routine health screenings.
- *The majority of the uninsured were employed and had a total family income below \$25,000.00
- *Over one-third of the uninsured have children under age five.
- *The uninsured have a high prevalence for several risk factors, most notably smoking and failure to use seat belts regularly.

Five Leading Causes of Death

- *Heart Disease
- *Cancer
- *Stroke
- *Pneumonia and Influenza
- *Lung Disease

Determinants of Premature Death

| | |
|-------------|-----|
| Behavior | 50% |
| Biology | 20% |
| Environment | 20% |
| Access | 10% |